HOTEL EMPLOYEES
RESTAURANT EMPLOYEES

Health Trust Plan

UNITE
HERE!

Effective June 1, 2004

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.heretrust.com or call 1-844-411-0786. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-844-411-0786 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Providers: **$0** individual; Non-Preferred Providers: **$500** individual / **$1,500** family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services by a Preferred Provider are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Preferred Providers $2,500 individual / $7,500 family; for Non-Preferred Providers $10,000 individual / $30,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, deductibles, copayments, health care this plan doesn't cover, prescription drugs, penalties for failure to obtain preauthorization, charges in excess of allowed amounts, physical, occupational or speech therapy, repair of teeth following accidental injury, and neurodevelopmental therapy.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind and select "Aetna Choice® POS II (Open Access)" network for a list of network providers. For vision providers visit www.eyemedvisioncare.com or call 1-866-289-0614.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/office visit plus 10% coinsurance	$20 copay/office visit plus 40% coinsurance	All services must be medically necessary. Prescription required for massage therapy.
	Specialist visit	$20 copay/office visit plus 10% coinsurance	$20 copay/office visit plus 40% coinsurance	
	Preventive care/screening/ immunization	No charge	Not Covered	No coverage for routine preventive care tests performed by a Non-Preferred Provider, except mammograms at 40% coinsurance. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.savrx.com** or by calling 800-228-3108	Generic drugs (Tier 1)	$12 copay/prescription (retail & mail order)	$12 copay/prescription (retail & mail order)	Covers up to a 34-day supply at a retail pharmacy or up to a 90-day supply through Walk-In-Mail or mail order. Brand drugs when a generic is available require you to pay the difference in cost between the generic and brand, plus the copay. If you fill your prescription at a non-network pharmacy, you must pay the full cost of prescription and file a claim for reimbursement with Sav-Rx. Contraceptive coverage provided for female member, spouse and female dependent children.
	Preferred brand drugs (Tier 2)			
	Non-preferred brand drugs (Tier 3)			
	Specialty drugs (Tier 4)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	All services must be medically necessary. Preauthorization is required for certain procedures. Failure to do so will result in a $250 benefit reduction (not to exceed $500) for
	Physician/surgeon fees	$20 copay/visit plus 10% coinsurance	$20 copay/visit plus 40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				all related expenses incurred in excess of the deductible for each surgery that is not preauthorized when required.
If you need immediate medical attention	Emergency room care	$75 copay/visit plus 10% coinsurance	$75 copay/visit plus 10% coinsurance	Copay waived if admitted to hospital. Emergency room physician requires $20 copay.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$20 copay/visit plus 10% coinsurance	$20 copay/visit plus 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	All services must be medically necessary. Preauthorization is required. Failure to do so will result in a $250 benefit reduction (not to exceed $500) for all related expense incurred in excess of the deductible for each hospitalization that is not preauthorized.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit plus 10% coinsurance	$20 copay/visit plus 40% coinsurance	None
	Inpatient services	10% coinsurance	40% coinsurance	All services must be medically necessary. Preauthorization is required. Failure to do so will result in a $250 benefit reduction (not to exceed $500) for all related expense incurred in excess of the deductible for each hospitalization that is not preauthorized.
If you are pregnant	Office visits	$20 copay/office visit plus 10% coinsurance	$20 copay/office visit plus 40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment /coinsurance may apply. No Coverage for a dependent or child of dependent child.
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	$20 copay/visit plus 10% coinsurance	$20 copay/visit plus 40% coinsurance	Limited to 130 visits per calendar year.
	Rehabilitation services	10% coinsurance	40% coinsurance	All services must be medically necessary. Preauthorization is required for inpatient. If preauthorization is not obtained there will be a $250 benefit reduction (not to exceed $500) for

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				all related expenses incurred in excess of the deductible. Outpatient rehabilitation services require $20 copay/visit.
	Habilitation services	Not Covered	Not Covered	Neurodevelopmental therapy available to dependent children age 6 and under, $20 copay and PPO/Non-PPO coinsurance levels and deductible apply.
	Skilled nursing care	10% coinsurance	40% coinsurance	Limited to 90 days/year. Preauthorization is required, failure to do so will result in a $250 benefit reduction (not to exceed $500) for all related expense incurred in excess of the deductible.
	Durable medical equipment	10% coinsurance	40% coinsurance	Requires a prescription. Excludes equipment whose primary purpose is preventing illness or injury, for exercise, comfort, or hygiene. Special equipment and supplies 20% coinsurance.
	Hospice services	10% coinsurance	40% coinsurance	$20 copay applies to professional services. Inpatient care limited to 14 days within benefit period of 6 months.
If your child needs dental or eye care	Children's eye exam	No charge	Fees in excess of $72 and over UCR	Limited to one exam every 12 months.
	Children's glasses	No charge for single vision lenses and fees in excess of $120 for frames	Fees in excess of $60 for single vision lenses and fees in excess of $60 for frames	Lenses limited to one pair each 12 months. Frames are limited to once each 24 months.
	Children's dental check-up	Charges in excess of fee schedule	Charges in excess of fee schedule	Limited to 2 exams per calendar year. $2,000 annual maximum waived for children under age 18.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery (except to correct congenital anomalies or following mastectomy)
- Habilitation Services (except for treatment of neurodevelopmental conditions in children age 6 and under)
- Infertility treatment
- Long-term care
- Pregnancy for a dependent child
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (limited to 12 visits/year) • Chiropractic care (limited to 12 visits/year) • Dental care (Adult)	• Hearing Aids • Non-emergency care when traveling outside the US.	• Private-duty nursing • Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or contact the Administration Office at 1-844-411-0786.
Additionally, a consumer assistance program can help you file your appeal. Contact Washington Consumer Assistant Program at 1-800-562-6900 or www.insurance.wa.gov.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-844-411-0786.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $0
- **Specialist copayment + coinsurance** $20 + 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,330**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $0
- **Specialist copayment + coinsurance** $20 + 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $0
- **Specialist copayment + coinsurance** $20+10%
- **Hospital (facility) coinsurance** 10%+$75
- **Other coinsurance** 10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.heretrust.com or call 1-844-411-0786. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-844-411-0786 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Providers: **$0** individual; Non-Preferred Providers: **$500** individual.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services by a Preferred Provider are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Preferred Providers $2,500; for Non-Preferred Providers $10,000 individual	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, deductibles, copayments, health care this plan doesn't cover, prescription drugs, penalties for failure to obtain preauthorization, charges in excess of allowed amounts, physical, occupational or speech therapy, repair of teeth following accidental injury.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind and select "Aetna Choice® POS II (Open Access)" network for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/office visit plus 10% coinsurance	$20 copay/office visit plus 40% coinsurance	All services must be medically necessary. Prescription required for massage therapy.
	Specialist visit	$20 copay/office visit plus 10% coinsurance	$20 copay/office visit plus 40% coinsurance	
	Preventive care/screening/ immunization	No charge	Not Covered	No coverage for routine preventive care tests performed by a Non-Preferred Provider, except mammograms at 40% coinsurance. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.savrx.com** or by calling 800-228-3108	Generic drugs (Tier 1)	$12 copay/prescription (retail & mail order)	$12 copay/prescription (retail & mail order)	Covers up to a 34-day supply at a retail pharmacy or up to a 90-day supply through Walk-In-Mail or mail order. Brand drugs when a generic is available require you to pay the difference in cost between the generic and brand, plus the copay. If you fill your prescription at a non-network pharmacy, you must pay the full cost of prescription and file a claim for reimbursement with Sav-Rx. Contraceptive coverage provided for female member.
	Preferred brand drugs (Tier 2)			
	Non-preferred brand drugs (Tier 3)			
	Specialty drugs (Tier 4)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	All services must be medically necessary. Preauthorization is required for certain outpatient procedures. Failure to do so will result in a $250 benefit reduction (not to exceed $500) for all related expenses incurred in excess of the deductible for each surgery that is not preauthorized when required.
	Physician/surgeon fees	$20 copay/visit plus 10% coinsurance	$20 copay/visit plus 40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$75 copay/visit plus 10% coinsurance	$75 copay/visit plus 10% coinsurance	Facility copay waived if admitted to hospital. Emergency room physician requires $20 copay.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$20 copay/visit plus 10% coinsurance	$20 copay/visit plus 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	All services must be medically necessary. Preauthorization is required. Failure to do so will result in a $250 benefit reduction (not to exceed $500) for all related expense incurred in excess of the deductible for each hospitalization that is not preauthorized.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit plus 10% coinsurance	$20 copay/visit plus 40% coinsurance	None
	Inpatient services	10% coinsurance	40% coinsurance	All services must be medically necessary. Preauthorization is required. Failure to do so will result in a $250 benefit reduction (not to exceed $500) for all related expense incurred in excess of the deductible for each hospitalization that is not preauthorized.
If you are pregnant	Office visits	$20 copay/office visit plus 10% coinsurance	$20 copay/office visit plus 40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment /coinsurance may apply.
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	$20 copay/visit plus 10% coinsurance	$20 copay/visit plus 40% coinsurance	Limited to 130 visits per calendar year.
	Rehabilitation services	10% coinsurance	40% coinsurance	All services must be medically necessary. Preauthorization is required for inpatient. If preauthorization is not obtained there will be a $250 benefit reduction (not to exceed $500) for all related expenses incurred in excess of the

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				deductible. Outpatient rehabilitation services require $20 copay/visit.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	10% coinsurance	40% coinsurance	Limited to 90 days/year. Preauthorization is required, failure to do so will result in a $250 benefit reduction (not to exceed $500) for all related expense incurred in excess of the deductible.
	Durable medical equipment	10% coinsurance	40% coinsurance	Requires a prescription. Excludes equipment whose primary purpose is preventing illness or injury, for exercise, comfort, or hygiene. Special equipment and supplies 20% coinsurance.
	Hospice services	10% coinsurance	40% coinsurance	$20 copay applies to professional services. Inpatient care limited to 14 days within benefit period of 6 months.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery (except to correct congenital anomalies or following mastectomy)
- Dental Care (Adult)
- Habilitation Services
- Hearing aids
- Hearing care
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limited to 12 visits/year)
- Chiropractic care (limited to 12 visits/year)
- Non-emergency care when traveling outside the US.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be

available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or contact the Administration Office at 1-844-411-0786.
Additionally, a consumer assistance program can help you file your appeal. Contact Washington Consumer Assistant Program at 1-800-562-6900 or www.insurance.wa.gov.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-844-411-0786.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment + coinsurance** **$20 + 10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,330**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment + coinsurance** **$20 + 10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment + coinsurance** **$20+10%**
- **Hospital (facility) coinsurance** **10%+$75**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.heretrust.com or call 1-844-411-0786. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-844-411-0786 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Providers: **$1,500** individual/$4,500 family; Non-Preferred Providers: **$2,500** individual / **$7,500** family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care by a Preferred Provider is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Preferred Providers $8,550 individual / $17,100 family; for Non-Preferred Providers $12,000 individual / $36,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, deductibles, copayments, health care this plan doesn't cover, prescription drugs, penalties for failure to obtain preauthorization, charges in excess of allowed amounts, physical, occupational or speech therapy, repair of teeth following accidental injury, and neurodevelopmental therapy.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind and select "Aetna Choice® POS II (Open Access)" network for a list of network providers. For vision providers visit www.eyemedvisioncare.com or call 1-866-289-0614.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/office visit plus 20% coinsurance	$20 copay/office visit plus 50% coinsurance	All services must be medically necessary. Prescription required for massage therapy.
	Specialist visit	$20 copay/office visit plus 20% coinsurance	$20 copay/office visit plus 50% coinsurance	
	Preventive care/screening/ immunization	No charge	Not Covered	No coverage for routine preventive care tests performed by a Non-Preferred Provider, except mammograms at 50% coinsurance. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.savrx.com** or by calling 800-228-3108	Generic drugs (Tier 1)	$12 copay/prescription (retail & mail order)	$12 copay/prescription (retail & mail order)	Covers up to a 34-day supply at a retail pharmacy or up to a 90-day supply through Walk-In-Mail or mail order. Brand drugs when a generic is available require you to pay the difference in cost between the generic and brand, plus the copay. If you fill your prescription at a non-network pharmacy, you must pay the full cost of prescription and file a claim for reimbursement with Sav-Rx. Contraceptive coverage provided for female member and female dependent children.
	Preferred brand drugs (Tier 2)			
	Non-preferred brand drugs (Tier 3)			
	Specialty drugs (Tier 4)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	All services must be medically necessary. Preauthorization is required for certain procedures. Failure to do so will result in a $250 benefit reduction (not to exceed $500) for
	Physician/surgeon fees	$20 copay/visit plus 20% coinsurance	$20 copay/visit plus 50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				all related expenses incurred in excess of the deductible for each surgery that is not preauthorized when required.
If you need immediate medical attention	Emergency room care	$75 copay/visit plus 20% coinsurance	$75 copay/visit plus 50% coinsurance	Copay waived if admitted to hospital. Emergency room physician requires $20 copay.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$20 copay/visit plus 20% coinsurance	$20 copay/visit plus 50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	All services must be medically necessary. Preauthorization is required. Failure to do so will result in a $250 benefit reduction (not to exceed $500) for all related expense incurred in excess of the deductible for each hospitalization that is not preauthorized.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit plus 20% coinsurance	$20 copay/visit plus 50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	All services must be medically necessary. Preauthorization is required. Failure to do so will result in a $250 benefit reduction (not to exceed $500) for all related expense incurred in excess of the deductible for each hospitalization that is not preauthorized.
If you are pregnant	Office visits	$20 copay/office visit plus 20% coinsurance	$20 copay/office visit plus 50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment /coinsurance may apply. No Coverage for a dependent or child of dependent child.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	$20 copay/visit plus 20% coinsurance	$20 copay/visit plus 50% coinsurance	Limited to 130 visits per calendar year.
	Rehabilitation services	20% coinsurance	50% coinsurance	All services must be medically necessary. Preauthorization is required for inpatient. If preauthorization is not obtained there will be a

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				$250 benefit reduction (not to exceed $500) for all related expenses incurred in excess of the deductible. Outpatient rehabilitation services require $20 copay/visit.
	Habilitation services	Not Covered	Not Covered	Neurodevelopmental therapy available to dependent children age 6 and under, $20 copay and PPO/Non-PPO coinsurance levels and deductible apply.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 90 days/year. Preauthorization is required, failure to do so will result in a $250 benefit reduction (not to exceed $500) for all related expense incurred in excess of the deductible.
	Durable medical equipment	20% coinsurance	50% coinsurance	Requires a prescription. Excludes equipment whose primary purpose is preventing illness or injury, for exercise, comfort, or hygiene. Special equipment and supplies 20% coinsurance.
	Hospice services	20% coinsurance	50% coinsurance	$20 copay applies to professional services. Inpatient care limited to 14 days within benefit period of 6 months.
If your child needs dental or eye care	Children's eye exam	No charge	Fees in excess of $72 and over UCR	Limited to one exam every 12 months.
	Children's glasses	No charge for single vision lenses and fees in excess of $120 for frames	Fees in excess of $60 for single vision lenses and fees in excess of $60 for frames	Lenses limited to one pair each 12 months. Frames are limited to once each 24 months.
	Children's dental check-up	Charges in excess of fee schedule	Charges in excess of fee schedule	Limited to 2 exams per calendar year. $2,000 annual maximum waived for children under age 18.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery (except to correct congenital anomalies or following mastectomy)
- Habilitation Services (except for treatment of neurodevelopmental conditions in children age 6 and under)
- Infertility treatment
- Long-term care
- Pregnancy for a dependent child
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limited to 12 visits/year)
- Chiropractic care (limited to 12 visits/year)
- Hearing Aids
- Non-emergency care when traveling outside the US.
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or contact the Administration Office at 1-844-411-0786.
Additionally, a consumer assistance program can help you file your appeal. Contact Washington Consumer Assistant Program at 1-800-562-6900 or www.insurance.wa.gov.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-844-411-0786.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment + coinsurance** **$20 + 20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$20
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,780**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment + coinsurance** **$20 + 20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment + coinsurance** **$20+20%**
- **Hospital (facility) coinsurance** **20%+$75**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

March 11, 2021

To: All Participants
UNITE HERE Northwest Health Trust

Re: Important Health Plan Changes Effective January 1, 2021

This is a summary of material modification describing benefit changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

IMPORTANT BENEFIT MODIFICATIONS

The Board of Trustees of the UNITE HERE Northwest Health Trust is extremely pleased to announce the following benefit change:

Decreased In-Network (PPO) Out-of-Pocket Maximum

Effective January 1, 2021 the In-Network (PPO) out-of-pocket maximum has been reduced from $5,000 per individual; $15,000 per family (co-payments not included) to $2,500 per individual; $7,500 per family (co-payments not included).

The Out-of-Network (non-PPO) out-of-pocket maximum will remain at $10,000 per individual; $30,000 per family (co-payments and deductibles not included).

If you have any questions regarding these changes, please contact the Administration Office using the phone numbers above.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

11 de marzo de 2021

A: todos los participantes
UNITE HERE Northwest Health Trust

Asunto: Cambios importantes al plan de seguro médico a partir del viernes, 1 de enero de 2021

Este es un resumen de una modificación importante que describe los cambios en los beneficios que la Junta de Fideicomisarios adoptó. Asegúrese de que usted y su familia lean detenidamente este documento y consérvelo con su documento de descripción resumida del plan.

MODIFICACIONES IMPORTANTES A LOS BENEFICIOS

Es un placer para la Junta de Fideicomisarios del fideicomiso UNITE HERE Northwest Health Trust anunciar el siguiente cambio a los beneficios:

Disminución del máximo de su bolsillo dentro de la red (PPO)

A partir del 1 de enero de 2021, el máximo de su bolsillo dentro de la red (PPO) disminuyó de $5,000 por individuo; $15,000 por familia (no incluye los copagos) a $2,500 por individuo y $7,500 por familia (no incluye los copagos).

El máximo de su bolsillo para gastos fuera de la red (que no son de un plan PPO) seguirá siendo $10,000 por individuo; $30,000 por familia (no incluye los copagos ni deducibles).

Si tiene preguntas con respecto a estos cambios, comuníquese con la Oficina de Administración llamando a los números de teléfono indicados arriba.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

Marso 11, 2021

Sa: Lahat ng mga Kalahok
UNITE HERE Northwest Health Trust

Tungkol sa: Mahalagang Pagbabago sa Health Plan, Magkakabisa sa Enero 1, 2021

Ito'y buod ng paglalarawan ng pagbabago sa benefit na inadopt ng Board of Trustees. Mangyaring siguraduhin na babasahin ninyo ito kasama ng inyong pamilya, at na itatago ninyo ito kasama ng inyong Summary Plan Description Booklet (Polyeto ng Buod ng Paglalarawan sa Plan).

MAHALAGANG PAGBABAGO SA BENEFIT

Lubos na ikinalulugod ng Board of Trustees ng UNITE HERE Northwest Health Trust na ianunsyo ang sumusunod na pagbabago sa benefit:

Binawasan ang In-Network (PPO) Out-of-Pocket Maximum

Simula Enero 1, 2021 ay mas mababâ na ang In-Network (PPO) out-of-pocket maximum; ang dating $5,000 para sa bawat indibidwal, $15,000 para sa bawat pamilya (hindi kasama ang co-payments) ay binawasan at ginawa na ngayong $2,500 para sa bawat indibidwal, $7,500 para sa bawat pamilya (hindi kasama ang co-payments).

Ang Out-of-Network (hindi-PPO) out-of-pocket maximum ay mananatiling $10,000 para sa bawat indibidwal, $30,000 para sa bawat pamilya (hindi kasama ang co-payments at deductibles).

Kung mayroon kayong anumang mga katanungan tungkol sa mga pagbabagong ito, mangyaring kontakin ang Administration Office sa mga numerong nasa itaas.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

Ngày 11 tháng 3, 2021

Gửi: Toàn thể hội viên
UNITE HERE Northwest Health Trust

Về việc: Thay đổi quan trọng của chương trình bảo hiểm sức khỏe, hiệu lực kể từ ngày 1 tháng 1, 2021

Đây là bản tóm tắt những điều chỉnh quan trọng đối với các thay đổi về quyền lợi đã được Hội đồng quản trị thông qua. Xin quý vị và gia đình nhớ đọc cẩn thận và giữ tài liệu này cùng với Tập tài liệu tóm tắt quyền lợi bảo hiểm.

ĐIỀU CHỈNH QUAN TRỌNG VỀ QUYỀN LỢI BẢO HIỂM

Hội đồng quản trị của Quỹ UNITE HERE Northwest Health Trust vô cùng hân hạnh thông báo cùng quý vị thay đổi quan trọng về quyền lợi sau đây:

Giảm tiền tự trả tối đa cho các dịch vụ trong hệ thống (PPO)

Hiệu lực kể từ ngày 1 tháng 1, 2021, số tiền tự trả tối đa cho các dịch vụ trong hệ thống (thuộc PPO) được giảm từ $5,000 cho cá nhân; $15,000 cho cả gia đình (không bao gồm tiền đồng thanh toán) xuống còn $2,500 cho cá nhân; $7,500 cho cả gia đình (không bao gồm tiền đồng thanh toán).

Số tiền tự trả tối đa cho các dịch vụ ngoài hệ thống (không thuộc PPO) vẫn còn ở mức $10,000 cho cá nhân; $30,000 cho cả gia đình (không bao gồm khoản khấu trừ và tiền đồng thanh toán).

Nếu quý vị có điều gì thắc mắc liên quan đến thay đổi này, vui lòng liên lạc với Văn phòng Quản trị theo những số điện thoại ghi trên.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

2021 年 3 月 11 日

收件人： 所有参加者
UNITE HERE 西北健康信托基金

事宜： 重要保健计划变更，2021 年 1 月 1 日生效

以下是重大修改摘要，描述董事会采纳的福利变更。请确保您和您的家人仔细阅读本文件，并将其与《计划摘要说明手册》保存在一起。

重要福利修改

UNITE HERE西北健康信托基金董事会非常高兴地宣布以下福利变更：

降低网络内（PPO）自付费用最高限额

从 2021 年 1 月 1 日开始生效，网络内（PPO）自付费用最高限额已经从每个个人 $5,000 和每个家庭 $15,000（不包括共同保费）降低至每个个人 $2,500 和每个家庭 $7,500（不包括共同保费）。

网络外（非 PPO）自付费用最高限额仍然是每个个人 $10,000 和每个家庭 $30,000（不包括共同保费和免赔额）。

如果您对这些变更有任何疑问，请拨打以上电话号码，与行政管理办公室联系。

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

መጋቢት 11, 2021

ለ፡- ሁሉም ተሳታፍዎች
UNITE HERE የሰሜን ምዕራብ የጤና ትራስት
መልስ፡- ከጥር 1 ቀን 2021 ጀምሮ የሚተገበር ጠቃሚ የጤና ዕቅድ ለውጦች

ይህ በባለአደራዎች ቦርድ ተቀባይነት ያገኘ የጥቅም ለውጦችን የሚገልጽ የሰነድ ማሻሻያ ማጠቃለያ ነው እባክዎን እርሰዎ እና ቤተሰብዎ በጥንቃቄ ማንበባችሁን እርግጠኛ ይሁኑ እና ይህን ሰነድ ከማጠቃለያ ዕቅድ መግለጫዎ ወረቀት(ቡክሌት) ጋር ያያይዙት።

አስፈላጊ የጥቅም ማሻሻያዎች

UNITE HERE የሰሜን ምዕራብ የጤና ትራስት የባለአደራዎች ቦርድ የሚከተሉትን የጥቅም ለውጦች በማወጁ የላቀ ደስታ ይሰማዋል፡-

በግል የሚከፈለው ከፍተኛ ወጪ በኔትወርክ ውስጥ (PPO) ቀንሷል

ከከጥር 1 ቀን 2021 ጀምሮ በግል የሚከፈል ከፍተኛ ወጪ በኔትወርክ ውስጥ (PPO) ለግለሰብ ከ $5,000 ወደ $2,500፣ ለቤተሰብ ደግሞ ከ $15,000 ወደ $7,500 (የኮፐይ ክፍያዎች አልተካተቱም) ቀንሷል።

ከኔትወርክ ውጭ(PPO ያልሆነ) የሆኑት በነበረበት የሚቆዩ ይሆናል ማለትም ለግለሰብ $10,000 እና ለቤተሰብ ደግሞ $30,000(ክፕፐይመንት እና ተቀናሾች አልተካተቱም)።

እነዚህን ለውጦች በተመለከተ ማንኛውም ጥያቄ ካለዎት እባክዎን ከላይ ያሉትን የስልክ ቁጥሮች በመጠቀም የአስተዳደር ቢሮን ያነጋግሩ።

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

October 22, 2020

To: All Participants
UNITE HERE Northwest Health Trust Fund

From: Erik Van Rossum, Chairman
Howard Cohen, Secretary

RE: Summary of Material Modification -
Important Information Regarding Changes to the Prescription Plan Effective January 1, 2021

This is a summary of material modification describing benefit changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

PRESCRIPTION DRUG PROVIDER CHANGE FROM OptumRx TO Sav-Rx

We are pleased to inform you that effective January 1, 2021, your prescription drug benefit program will be administered by Sav-Rx, replacing the program currently administered by OptumRx. This change is being made to better serve the participants while maintaining a cost effective program. New combination **Medical, Dental, Vision, and Prescription Drug Identification (ID) cards** reflecting this change will be mailed to eligible participants in mid-December. You will also be receiving a welcome kit from Sav-Rx which will include pertinent prescription benefit information. You will need to present this new ID card at the pharmacy on or after January 1, 2021.

Please note there are no changes to your Medical, Dental, Vision or Prescription benefits. The retail and mail order prescription copayments will remain at $12 for each prescription. Remember, if you purchase a brand-name prescription drug and a generic equivalent is available, you will be responsible for payment of the difference in cost between the two medications in addition to the copayment.

We strongly encourage you to get your prescriptions refilled prior to January 1st if at all possible. We anticipate a smooth transition but there is always a possibility that if you were to try to refill your prescription during the first several days of January, a system error could delay your ability to fill it (for example: the system incorrectly not recognizing eligibility, a refill may require prior authorization from your physician, etc.).

WHAT YOU NEED TO DO WHEN YOU RECEIVE YOUR NEW ID CARDS

- Make sure your name is listed correctly
- Place your new cards into your purse or wallet
- Destroy your old ID cards after January 1, 2021
- Carefully review the packet of materials included with your new ID cards
- Present your new ID card whenever visiting the doctor, hospital or when obtaining a prescription
- **Do not use your new card until January 1, 2021**

WHAT IF I DON'T RECEIVE MY ID CARD OR MY NAME IS MISSPELLED?

Please contact the Administration Office using the phone number above to order an ID card or to have your card corrected. You can also call the Administration Office to update your mailing address, verify eligibility and benefits.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

22 de octubre de 2020

A: Todos los participantes
Fondo Fiduciario de UNITE HERE Northwest Health

De: Erik Van Rossum, Presidente
Howard Cohen, Secretario

Asunto: Resumen de modificación sustancial -
Información importante sobre cambios en el plan de medicamentos con receta en vigencia a partir del 1º de enero de 2021

Este es un resumen de una modificación sustancial que describe los cambios en los beneficios que han sido adoptados por la Junta de Fideicomisarios. Asegúrese de que usted y su familia lean detenidamente este documento y consérvelo con su documento de descripción resumida del plan.

CAMBIO DE PROVEEDOR DE MEDICAMENTOS CON RECETA DE OptumRx A Sav-Rx

Es un placer informarle que a partir del 1º de enero de 2021, su programa de beneficios de medicamentos con receta será administrado por Sav-Rx, en reemplazo del programa actualmente administrado por OptumRx. Este cambio se hace para servir mejor a los participantes y a la vez contar con un programa económico. A mediados de diciembre se enviará por correo a los participantes elegibles nuevas **tarjetas de identificación (ID) combinadas para servicios médicos, dentales, de la vista y medicamentos con receta**. Usted también recibirá un paquete de bienvenida de Sav-Rx que incluirá información pertinente sobre los beneficios de medicamentos con receta. Será necesario que presente esta nueva tarjeta de identificación en la farmacia a partir del 1 de enero de 2021.

Tenga en cuenta no hay cambios en sus beneficios médicos, dentales, de la vista ni de medicamentos con receta. El copago de medicamentos con receta en farmacias y pedidos por correo seguirá siendo $12 por cada medicamento con receta. Recuerde, si compra un medicamento de marca y hay un equivalente genérico, usted será responsable, además del copago, del pago de la diferencia entre el costo de los dos medicamentos.

Le recomendamos enfáticamente que, si es posible, resurta sus medicamentos con receta antes del 1º de enero. Tenemos previsto que la transición se hará sin problemas, pero siempre existe la posibilidad de que si intentara resurtir su medicamento con receta en los primeros días de enero, un error del sistema podría interferir en el resurtido (por ejemplo: por error el sistema no reconoce su elegibilidad, un resurtido podría requerir la autorización previa de su médico, etc.).

QUÉ DEBE HACER CUANDO RECIBA SUS NUEVAS TARJETAS DE IDENTIFICACIÓN

- Revise que su nombre se indique correctamente
- Guarde sus nuevas tarjetas en su bolso o billetera
- Destruya sus tarjetas de identificación antiguas después del 1º de enero de 2021
- Revise cuidadosamente el paquete de materiales incluido con sus nuevas tarjetas de identificación.
- Presente su nueva tarjeta de identificación cada vez que acuda al médico, hospital o cuando vaya por un medicamento con receta
- **No use su nueva tarjeta antes del 1º de enero de 2021**

¿Y SI NO RECIBO MI TARJETA DE IDENTIFICACIÓN O MI NOMBRE ESTÁ MAL ESCRITO?

Llame a la Oficina de Administración al número de teléfono indicado arriba para pedir una tarjeta de identificación o para que la corrijan. También puede llamar a la Oficina de Administración para darles su nueva dirección postal, verificar la elegibilidad y los beneficios.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

Oktubre 22, 2020

Sa: Lahat ng mga Kalahok
UNITE HERE Northwest Health Trust Fund

Mula kay: Erik Van Rossum, Chairman
Howard Cohen, Sekretarya

TUNGKOL SA: Buod ng Pagbabago -
Mahalagang Impormasyon Tungkol sa mga Pagbabago sa Prescription Plan, na Magkakabisa sa Enero 1, 2021

Ito'y buod ng paglalarawan ng mga pagbabago sa benefits na inadopt ng Board of Trustees. Mangyaring siguraduhin na babasahin ninyo ito kasama ng inyong pamilya, at na itatago ninyo ito kasama ng inyong Summary Plan Description Booklet (Polyeto ng Buod ng Paglalarawan sa Plan).

ANG PRESCRIPTION DRUG PROVIDER AY ILILIPAT MULA OptumRx AT GAGAWING Sav-Rx

Natutuwa kaming ibalita sa inyo na simula Enero 1, 2021, ang inyong prescription drug benefit program ay pamamahalaan na ng Sav-Rx; ito'y magiging kapalit ng programang kasalukuyang pinamamahalaan ng OptumRx. Ang pagbabagong ito ay ginawa upang mas mainam na pagsilbihan ang mga kalahok, habang nagmimintina ng isang cost-effective na programa. Ang bagong pinagsamang **Medical, Dental, Vision, and Prescription Drug Identification (ID) cards** dahil sa pagbabagong ito ay ipapadala sa mail sa mga eligible na kalahok sa kalagitnaan ng Disyembre. Tatanggap din kayo ng isang welcome kit mula sa Sav-Rx; ito'y maglalaman ng mahalagang impormasyon tungkol sa prescription benefit. Simula sa o pagkatapos ng Enero 1, 2021, kailangan ninyo ipakita ang bagong ID card na ito sa botika.

Mangyaring tandaan na hindi magbabago ang inyong Medical, Dental, Vision, o Prescription benefits. Ang retail at mail order prescription copayments (mga kabahaging bayad) ay hindi magbabago at mananatili pa ring $12 para sa bawat prescription o reseta. Tandaan na kung bibili kayo ng brand-name na de-resetang gamot, at mayroon itong available na katumbas na generic, kayo ang magbabayad ng pagkakaiba sa gastos ng dalawang gamot, bukod pa sa copayment.

Lubos namin kayong hinihikayat na kunin ang mga refill ng inyong mga prescription (de-resetang gamot) bago mag-Enero 1, kung maaari. Bagama't inaasahan namin na hindi magkakaproblema sa transisyon na ito, may posibilidad na kung susubukan ninyong mag-refill ng inyong prescription sa unang bahagi ng Enero, maaring magka-system error na makakapag-delay sa pagkuha ninyo ng inyong refill (halimbawa, may error sa system at hindi nito tatanggapin ang inyong eligibility, o ang refill ay maaring mangailangan muna ng pahintulot mula sa inyong doktor, atbp.).

ANO ANG DAPAT NINYO GAWIN KAPAG NATANGGAP NINYO ANG INYONG MGA BAGONG ID CARD

- Siguraduhing tama ang pagkasulat ng inyong pangalan
- Ilagay ang inyong mga bagong card sa inyong bag o wallet
- Sirain ang inyong mga lumang ID card pagkatapos ng Enero 1, 2021
- Maingat na rebyuhin ang pakete ng mga materyales na ipinadala kasama ng inyong mga bagong ID card
- Ipakita ang inyong bagong ID card tuwing magpupunta kayo sa doktor, ospital, o kapag kumukuha ng de-resetang gamot
- **Huwag gamitin ang inyong bagong card bago mag-Enero 1, 2021**

PAANO KUNG HINDI KO NATANGGAP ANG AKING ID CARD, O KAYA'Y MALI ANG SPELLING NG AKING PANGALAN?

Mangyaring tawagan ang Administration Office sa numerong nakasulat sa itaas upang mag-order ng isang ID card, o upang ipawasto ang inyong card. Maari din ninyo tawagan ang Administration Office upang i-update ang inyong mailing address o upang i-verify ang inyong eligibility at benefits.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

Ngày 22 tháng 10, 2020

Gửi: Toàn thể hội viên
UNITE HERE Northwest Health Trust Fund

Từ: Erik Van Rossum, Chủ tịch
Howard Cohen, Tổng thư ký

Về: Tóm lược về những điều chỉnh quan trọng -
Thông tin quan trọng về những thay đổi đối với chương trình bảo hiểm thuốc theo toa có hiệu lực bắt đầu từ ngày 1 tháng 1, 2021

Đây là bản tóm tắt những điều chỉnh quan trọng đối với các thay đổi về quyền lợi đã được Hội đồng quản trị thông qua. Xin quý vị và gia đình nhớ đọc cẩn thận và giữ tài liệu này cùng với Tập tài liệu tóm tắt quyền lợi bảo hiểm.

CÔNG TY CUNG CẤP THUỐC THEO TOA SẼ ĐỔI TỪ OptumRx SANG Sav-Rx

Chúng tôi hân hạnh thông báo cùng quý vị là bắt đầu từ ngày 1 tháng 1, 2021, chương trình bảo hiểm thuốc theo toa của quý vị sẽ do công ty Sav-Rx điều hành, thay cho chương trình do công ty OptumRx điều hành hiện nay. Chúng tôi thực hiện sự thay đổi này nhằm phục vụ hội viên chương trình một cách hữu hiệu hơn đồng thời giữ được mức giá phải chăng. **Các thẻ ID tổng hợp dùng chung cho các chương trình bảo hiểm y tế, nha khoa, nhãn khoa và thuốc theo toa** phản ảnh sự thay đổi này sẽ được gửi đến cho các hội viên chương trình bảo hiểm hội đủ tiêu chuẩn trong giữa tháng 12. Sav-Rx cũng sẽ gửi cho quý vị một bộ tài liệu chào mừng tham gia chương trình trong đó có các thông tin về quyền lợi thuốc theo toa phù hợp. Quý vị sẽ phải xuất trình thẻ ID mới này tại nhà thuốc kể từ ngày 1 tháng 1 năm 2021 trở về sau.

Vui lòng lưu ý rằng quyền lợi bảo hiểm y tế, nha khoa, nhãn khoa và thuốc theo toa của quý vị sẽ không có gì thay đổi. Tiền đồng trả cho mỗi toa thuốc mua tại nhà thuốc hay qua bưu điện sẽ vẫn là $12. Xin nhớ, nếu quý vị muốn mua biệt dược thay vì thuốc gốc cùng loại, ngoài tiền đồng trả, quý vị có trách nhiệm trả phần chi phí chênh lệch giữa hai loại thuốc.

Chúng tôi khuyên quý vị, nếu có thể được, nên mua thêm tất cả các thuốc theo toa quý vị dùng trước ngày 1 tháng 1. Chúng tôi tiên đoán tiến trình đổi từ công ty cũ sang công ty mới sẽ suôn sẻ, tuy thế, vẫn có thể là trong vài ngày đầu của tháng 1, nếu quý vị cần mua thêm thuốc theo toa, những trục trặc về hệ thống có thể làm chậm việc mua thêm thuốc (thí dụ như, hệ thống không nhận ra đúng tình trạng hội đủ tiêu chuẩn, hay hệ thống xác định không đúng là quý vị phải được bác sĩ cho phép trước khi mua thêm thuốc, v.v.).

QUÝ VỊ CẦN LÀM GÌ KHI NHẬN ĐƯỢC CÁC THẺ ID MỚI

- Xem kỹ coi tên mình có đúng không
- Cất thẻ mới vào bóp
- Hủy bỏ thẻ ID cũ sau ngày 1 tháng 1, 2021
- Đọc kỹ bộ tài liệu gửi kèm theo các thẻ ID mới
- Trình thẻ ID mới mỗi khi đi khám bác sĩ, đến bệnh viện hoặc khi đi mua thuốc theo toa
- **Không được dùng thẻ mới trước ngày 1 tháng 1, 2021**

NẾU TÔI KHÔNG NHẬN ĐƯỢC THẺ ID HAY TÊN TÔI TRONG THẺ KHÔNG ĐÚNG THÌ SAO?

Vui lòng liên lạc với Văn phòng Quản trị theo số điện thoại ghi trên để yêu cầu được cấp thẻ ID hoặc xin sửa tên lại cho đúng. Quý vị cũng có thể liên lạc với Văn phòng Quản trị để cập nhật địa chỉ gửi thư, xác nhận tình trạng hội đủ tiêu chuẩn và quyền lợi.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

2020 年 10 月 22 日

收件人：全体会员
UNITE HERE 西北健康信托基金

发件人：Erik Van Rossum 董事长
Howard Cohen 秘书长

事宜： 重要修改总结 —
有关处方药计划变更的重要信息，2021 年 1 月 1 日生效

此为描述董事会采纳的福利变更的重要修改总结。请确保您和您的家人认真阅读本文件，并将本文件与您的总结计划说明手册存放在一起。

处方药服务提供者从 OptumRx 更改为 Sav-Rx

我们很高兴地通知您，从2021年1月1日开始，您的处方药福利计划将由Sav-Rx管理，取代目前由OptumRx管理的计划。作出此项更改是为了更好地为会员提供服务，同时保持具有成本效益的计划。反映此项更改的新组合**医疗、牙科、眼科和处方药身份（ID）证**将在十二月中旬邮寄给合格的会员。您还将收到Sav-Rx发出的欢迎资料，其中将包括相关的处方药福利信息。您需要从2021年1月1日开始在药房出示该新身份证。

请注意，您的医疗、牙科、眼科或处方药福利没有任何变化。零售和邮购处方药共付额仍然为每张处方12美元。请记住，如果您购买原厂处方药，但有等效的非专利药，则除了共付额外，您还要支付两种药物之间的费用差额。

我们极力建议您尽可能在1月1日之前续配处方药。 我们预计过渡会很顺利，但总是存在这样的可能性，如果您在一月份的头几天尝试续配处方药，系统错误可能会延迟您的配药能力（例如：系统错误地无法识别您的资格，续配处方药可能要求您的医生事先授权等）。

收到新身份证后，您需要做什么？

- 确认身份证上所列的您的姓名准确无误
- 将新身份证放入您的钱包或皮夹内
- 2021年1月1日后销毁您的旧身份证
- 仔细查阅随您的新身份证寄给您的资料
- 每当接受医生门诊、住院或配取处方药时，出示您的新身份证
- **等到2021年1月1日再开始使用您的新身份证**

如果我没有收到我的身份证或者我的姓名拼写错误，该怎么办？

请使用上方所列电话号码，与行政管理办公室联系，索取身份证，或者要求纠正身份证上的错误。您还可以打电话给行政管理办公室更新您的邮寄地址、确认资格和福利。

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

አክቶበር 22, 2020

ለ: ሁሉም ተሳታፊዎች
Unite Here ኖርዝ-ዌስት ሄልዝ ትረስት ፈንድ

ከ: Erik Van Rossum, ሊቀመንበር

Howard Cohen ፣ ጸሓፊ

ጉዳዩ: ማጠቃለያ ስለ ማወቅ ለሚገባዎ ማሻሻያ -
<u>በጃንዋሪ 1 ቀን 2021 ላይ ተግባራዊ የሚሆኑት የመድሐኒት ማዘዣ ዕቅድ ላይ የሚደረጉ ለውጦችን በተመለከተ አስፈላጊ መረጃ</u>

ይህ በአስተዳዳሪዎች ቦርድ ተግባራዊ የሆኑትን የጥቅም ለውጦች የሚገልፅ ማወቅ የሚገባዎ ማሻሻያ ማጠቃለያ ነው። እባክዎን እርስዎ እና ቤተሰብዎ በጥንቃቄ ማንበብዎን እና ይህን ሰነድ ከማጠቃለያ ዕቅድ መግለጫው ቡክሌት ጋር ማስቀመጥዎን እርግጠኛ ይሁኑ::

<u>በሐኪም ትዕዛዝ የሚሰጡ መድሃኒቶች አቅራቢ ከ OptumRx ወደ Sav-Rx ተቀይሯል</u>

የእርስዎ በሐኪም የታዘዙ መድሃኒቶች ድጋፍ ፕሮግራም በአሁኑ ጊዜ በ OptumRx የሚተገበረውን ፕሮግራም ከጃንዋሪ 1፣ 2021 ጀምሮ በ Sav-Rx በመተካት እንደሚሰጥ ስንገልጽልዎት በደስታ ነው። ይህ ለውጥ ተግባራዊ የሆነው ወጪ ቆጣቢ መርሃ ግብርን ጠብቆ ተሳታፊዎችን በተሻለ ለማገልገል ሲባል ነው ::: ይህን ለውጥ የሚያንፀባርቁ ልዩ ጥምረት ያላቸው **የሕክምና ፣ የጥርስ ፣ የአይን እና የሐኪም ማዘዣ መድኃኒት መታወቂያ** (ID) **ካርዶች** በዲሴምበር አጋማሽ ላይ ብቁ ለሆኑ ተሳታፊዎች በፖስታ ይላካሉ ::: እንዲሁም ከ Sav-Rx አግባብነት ያለው የመድኃኒት ማዘዣ ጥቅማጥቅም መረጃን የሚያካትት የእንኳን ደህና መጣችሁ ኪት ይቀበላሉ። ይህንን አዲስ መታወቂያ ካርድ ጃንዋሪ 1 ቀን 2021 ወይም ከዚያ በኋላ ለፋርማሲው ማቅረብ ይጠበቅብዎታል።

እባክዎን ያስተውሉ በእርስዎ የሕክምና ፣ የጥርስ ፣ የአይን ወይም የሐኪም ማዘዣ ጥቅማጥቅሞች ላይ ምንም አይነት ለውጥ አይደረግም::: በሐኪም ለሚታዘዙ መድሃኒቶች የችርቻሮ እና የፖስታ ትእዛዝ ክፍያዎች(copayment) ለእያንዳንዱ ማዘዣ $ 12 በመሆን የሚቀጥሉ ይሆናል። ያስታውሱ ፣ ብራንድ-ስም ያለው በሐኪም የሚታዘዝ መድሃኒት ከገዙ እና ሌላ እኩል መጠን ያለውም(generic equivalent) የቀረበ ከሆነ ፣ ከቅድመ-ቋሚ ክፍያው(copayment) በተጨማሪ በሁለቱ መድኃኒቶች መካከል ያለውን የዋጋ ልዩነት የመክፈል ሃላፊነት ይኖርብዎታል።

<u>የሚቻል ከሆነ ከጃንዋሪ 1 በፊት የመድኃኒት ማዘዣዎችዎን ደግመው እንዲያስሞሉ በጥብቅ እናበረታታዎታለን።</u> ምንም ችግር የሌለበት ሽግግር እንደሚሆን እንጠብቃለን ነገር ግን ሁልጊዜም ቢሆን በጃንዋሪ መጀመሪያዎቹ ቀናት ውስጥ የታዘዘልዎትን መድሃኒት እንደገና ለማስሞላት ከሞከሩ፣ የስርዓት(ሲስተም) ብልሽት በሚሞሉበት ጊዜ ሊያዘገይዎ የሚችልበት ሰፊ እድል ይኖራል (ለምሳሌ፡ ስርዓቱ በስህተት ብቁ መሆንዎን አለመለየት ፣ እንደገና ለመሙላት ከሐኪምዎ ቀድሞ ፈቃድ ማግኘት ያስፈልጋል ወዘተ) :::

<u>አዲሱን የመታወቂያ ካርድዎን ሲቀበሉ ምን ማድረግ ይጠበቅብዎታል</u>

- የእርስዎ ስም በትክክል ተገልፆ እንደሆነ ያረጋግጡ
- አዲሱን ካርድዎን በትንሽ ቦርሳዎ ወይም ዋሌት ውስጥ ያስቀምጡ
- ከጃንዋሪ ፣ 2021 በኋላ የቀድሞውን የመታወቂያ ካርድዎን ያስወግዱ
- ከእርስዎ አዲስ የመታወቂያ ካርድ ጋር የተካተቱትን የቁሳቁስ ፓኬቶችን በጥንቃቄ ይመልከቱ
- ሐኪም ጋር ፣ ሆስፒታል ሲሄዱ ወይም የሐኪም ማዘዣ ሲወስዱ አዲሱን መታወቂያ ካርድዎን ያቅርቡ
- **አዲሱን ካርድዎን እስከ ጃንዋሪ ፣ ቀን 2021 ድረስ አይጠቀሙ**

<u>መታወቂያ ካርዴን ካልተቀበልኩ ወይም ስሜ በትክክል ያልተፃፈ ከሆነስ?</u>

የመታወቂያ ካርድ ለማዘዝ ወይም ካርድዎ እንዲስተካከልልዎ እባክዎ ከላይ ያለውን ስልክ ቁጥር በመጠቀም የአስተዳደር ቢሮን ያነጋግሩ ። እንዲሁም የመልእክት አድራሻዎን ለማሻሻል ፣ ብቁነትዎን እና ጥቅማጥቅምዎን ለማረጋገጥ ለአስተዳደር ቢሮ መደወል ይችላሉ ።

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

July 3, 2020

To: All Participants
UNITE HERE Northwest Health Trust

From: Erik Van Rossum, Chairman
Howard Cohen, Secretary

Re: COVID-19 Response – COBRA Rate Subsidy

UNITE HERE Northwest Health Trust, your health fund, is taking care of you during these tough times!

The health and safety of all plan participants is a serious concern for the Trustees of the UNITE HERE Northwest Health Trust. In an ongoing effort to provide assistance during this difficult time, the Trustees took action to enact a temporary COBRA rate subsidy of 50% of the current cost effective for new COBRA enrollees who experienced any layoffs or loss of coverage as a result of COVID-19. The COBRA rate subsidy is effective for August 2020 through June 2021 coverage.

What this means to you:

If you had coverage in any month July 2020 through January 2021 under the Trust's **Extension of Coverage program,** you will be able to elect and purchase COBRA continuation coverage at the lower rate through June 2021.

When your extended coverage under the Trust ends, you will receive a COBRA notice and Election Form detailing the subsidized amount to continue coverage under the Trust. You must return the Election Form and make payment to continue coverage. Please see the subsidized rates below.

Coverage Tier	Washington Residents	Oregon Residents
Employee Only	$227.50	$207.00
Employee + Child(ren)	$387.00	$352.00
Employee + Spouse	$478.00	$435.00
Family	$728.50	$662.50

If you have questions about your health coverage or eligibility, please call the Administration Office using the phone numbers above.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

3 de julio de 2020

A: Todos los participantes
UNITE HERE Northwest Health Trust

De: Erik Van Rossum, Presidente
Howard Cohen, Secretario

Asunto: Respuesta a COVID-19 - Subsidio del costo de COBRA

UNITE HERE Northwest Health Trust, su fondo de salud, ¡lo está cuidando durante estos tiempos difíciles!

La salud y seguridad de todos los participantes del plan es una preocupación importante para los Fideicomisarios de UNITE HERE Northwest Health Trust. Con el fin de continuar prestando asistencia durante esta etapa difícil, los Fideicomisarios tomaron medidas para promulgar un subsidio temporal del 50% del costo actual efectivo de COBRA para los nuevos afiliados de COBRA que sufrieron despidos temporales o pérdida de cobertura como resultado de COVID-19. El subsidio del costo de COBRA tiene vigencia para la cobertura desde agosto de 2020 hasta junio de 2021.

Lo que esto significa para usted:

Si usted tuvo cobertura en cualquier mes de julio de 2020 a enero de 2021 en virtud del **programa de Extensión de la Cobertura** del Fideicomiso, podrá elegir y comprar la continuación de cobertura de COBRA a un costo más bajo hasta junio de 2021.

Cuando se termine la extensión de su cobertura a través del Fideicomiso, usted recibirá un aviso de COBRA y un formulario de elección que detalla la cantidad subsidiada para continuar la cobertura del Fideicomiso. Debe devolver el formulario de elección y hacer el pago para continuar con la cobertura. Consulte el costo subsidiado a continuación.

Nivel de cobertura	Residentes de Washington	Residentes de Oregon
Solo empleado	227.50$	207.00$
Empleado + Hijo(s)	387.00$	352.00$
Empleado + Cónyuge	478.00$	435.00$
Familia	728.50$	$662.50

Si tiene preguntas sobre su cobertura médica o su elegibilidad, llame a la Oficina de Administración a los números de teléfono indicados anteriormente.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

Ngày 3 tháng 7, 2020

Gởi: Toàn thể hội viên
UNITE HERE Northwest Health Trust

Từ: Erik Van Rossum, Chủ tịch
Howard Cohen, Tổng thư ký

Về việc: Đáp ứng nạn dịch COVID-19 – Mức trợ cấp COBRA

UNITE HERE Northwest Health Trust, quỹ bảo hiểm sức khỏe của quý vị, chăm lo cho quý vị trong giai đoạn khó khăn này!

Sức khỏe và sự an toàn của tất cả các hội viên tham gia chương trình bảo hiểm là những vấn đề Hội đồng quản trị Quỹ bảo hiểm UNITE HERE Northwest Health Trust chú ý và vô cùng quan tâm. Trong nỗ lực cố gắng hỗ trợ và giúp đỡ hội viên trong thời điểm khó khăn này, Hội đồng quản trị Quỹ bảo hiểm đã ban hành quyết định tạm thời trợ cấp 50% của lệ phí bảo hiểm COBRA hiện hành cho những hội viên vừa ghi danh vào chương trình COBRA vì bị sa thải hoặc mất bảo hiểm do COVID-19 gây ra. Mức trợ cấp lệ phí bảo hiểm COBRA có hiệu lực cho bảo hiểm từ tháng 8, 2020 đến hết tháng 6, 2021.

Đối với quý vị, điều này có nghĩa là:

Nếu quý vị có bảo hiểm trong bất cứ tháng nào từ tháng 7, 2020 đến hết tháng 1, 2021 qua **chương trình Gia hạn quyền lợi bảo hiểm** của Hội đồng quản trị Quỹ bảo hiểm, quý vị sẽ được chọn và mua bảo hiểm COBRA để được tiếp tục có bảo hiểm với giá thấp cho đến hết tháng 6, 2021.

Khi chương trình gia hạn quyền lợi bảo hiểm của quý vị do Hội đồng quản trị Quỹ bảo hiểm cấp chấm dứt, quý vị sẽ nhận được thông báo từ chương trình COBRA và Giấy chọn lựa chương trình bảo hiểm trong đó có trình bày chi tiết số tiền trợ cấp quý vị nhận được để tiếp tục có bảo hiểm qua Hội đồng quản trị Quỹ bảo hiểm. Quý vị phải điền và gửi lại Giấy chọn lựa chương trình bảo hiểm, cũng như đóng tiền để được tiếp tục có bảo hiểm. Vui lòng xem mức trợ cấp dưới đây.

Bậc quyền lợi bảo hiểm	Người dân Washington	Người dân Oregon
Chỉ một mình nhân viên	$227.50	$207.00
Nhân viên + con cái	$387.00	$352.00
Nhân viên + vợ, hay chồng	$478.00	$435.00
Gia đình	$728.50	$662.50

Nếu quý vị có điều gì thắc mắc liên quan đến quyền lợi bảo hiểm hay tình trạng hội đủ điều kiện hưởng quyền lợi bảo hiểm, vui lòng liên lạc với Văn phòng Quản trị theo những số điện thoại ghi trên.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

2020 年 7 月 3 日

收件人：全体会员
UNITE HERE 西北健康信托

发件人：Erik Van Rossum 董事长
Howard Cohen 秘书长

事宜： 新型冠状病毒（COVID-19）应对 — COBRA 费率补贴

您的健康基金 — UNITE HERE 西北健康信托
在目前的困难时期关照您！

所有计划会员的健康和安全是UNITE HERE西北健康信托受托人十分关心的问题。在目前的困难时期提供援助的持续努力中，受托人采取了措施，对因COVID-19遭受任何裁员或丧失承保的新COBRA参加者，实施了当前费用50%临时COBRA费率补贴政策。COBRA费率补贴有效期为2020年8月至2021年6月。

这对您意味着什么：

如果您在 2020 年 7 月至 2021 年 1 月之间的任何一个月参加了信托的**承保延长（Extension of Coverage）**计划，您将能够在 2021 年 6 月之前以较低的费率选择和购买 COBRA 续延承保计划。

当您在本信托的延长承保终止时，您将收到 COBRA 的通知和选择表格，其中会详细列出继续享受本信托承保的补贴金额。您必须送回选择表格并付款，才能继续享受承保。请参阅以下补贴费率。

承保层级	华盛顿州居民	俄勒冈州居民
仅限雇员	$227.50	$207.00
雇员 + 子女	$387.00	$352.00
雇员 + 配偶	$478.00	$435.00
家庭	$728.50	$662.50

如果您对您的健康承保或资格有疑问，请使用以上电话号码，打电话给行政管理办公室。

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

ጁላይ 3 ፣ 2020

ለ: ሁሉም ተሳታፊዎች
(UNITE HERE Northwest Health Trust)

ከ: ኤሪክ ቫን ሱም ሊቀመንበር
ሃዋርድ ኮን ፣ ጸሐፊ

ስለ: COVID-19 ምላሽ - የ COBRA የገንዘብ ድጎማ

‘UNITE HERE Northwest Health Trust’፣ የእርስዎ የጤና ፈንድ በእነዚህ አስቸጋሪ ጊዜያት የሚረዳዎት ይሆናል!

የሁሉንም የዕቅድ ተሳታፊዎች ጤና እና ደህንነት የ ‘UNITE HERE Northwest Health Trust’ ባለአደራዎች አሳሳቢ ጉዳይ ነው። በዚህ አስቸጋሪ ጊዜ ድጋፍ ለመስጠት በሚደረገው እርምጃ ውስጥ ባለአደራዎች በ COVID-19 ሳቢያ የሥራ ቅነሳ ወይም የገንዘብ ሽፋን ማጣት ላጋጠማቸው ለአዲሶቹ የ COBRA ተመዝጋቢዎች ስራ ላይ ከዋለው የአሁኑ ዋጋ 50% ጊዜያዊ የ COBRA የገንዘብ ድጎማ ለመተግበር እርምጃ ወስደዋል ። የ COBRA የገንዘብ ድጎማ ሽፋን ከኦገስት 2020 እስከ ጁን 2021 ድረስ ተግባራዊ ይሆናል።

ይህ ለእርስዎ ምን ማለት ነው:

በማንኛውም ወር ከጁላይ 2020 እስከ ጃንዋሪ 2021 በባለአደራዎቹ **የሽፋን ማራዘም መርሃግብር** ስር ሽፋን ያለዎት ከሆነ፣ እስከ ሰኔ 2021 ድረስ በዝቅተኛ መጠን COBRA የቀጣይነት ሽፋን መምረጥ እና መግዛት ይችላሉ።

በባለአደራዎቹ ስር የሚራዘመው ሽፋን ሲያበቃ ፣ በባለአደራነቱ ስር ለመቀጠል የተገኘውን የድጎማ ዝርዝር የሚገልጽ የ COBRA ማስታወቂያ እና የምርጫ ቅጽ ይደርስዎታል። የምርጫ ቅጹን መመለስ እና ሽፋኑን ለመቀጠል ክፍያ መፈጸም አለብዎት። እባክዎን ከዚህ በታች የድጎማ ክፈያችን ይመልከቱ ።

የሽፋኑ ደረጃ	የዋሽንግተን ነዋሪዎች	የኦሪገን ነዋሪዎች
ለሰራተኞች ብቻ	$227.50	$207.00
ሰራተኛ + ልጅ (ጆች)	$387.00	$352.00
ሰራተኛ + የትዳር ጓደኛ	$478.00	$435.00
ቤተሰብ	$728.50	$662.50

ስለ የእርስዎ የጤና ሽፋን ወይም ብቁነት ጥያቄ ያለዎት ከሆነ እባክዎን ከላይ ያሉትን የስልክ ቁጥሮች በመጠቀም ለአስተዳደር ቢሮ ይደውሉ ።

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

April 24, 2020

To: All Participants
UNITE HERE Northwest Health Trust

From: Erik Van Rossum, Chairman
Howard Cohen, Secretary

Re: Important Health Plan Changes Effective April 15, 2020

This is a summary of material modification describing benefit changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

IMPORTANT BENEFIT MODIFICATIONS

Effective immediately, the Trust will waive the 10% patient co-insurance on medical services received from a PPO provider from April 15, 2020 through July 31, 2020. Allowed charges will be paid at 100% after the applicable co-pay. Non-PPO providers will be covered at the regular non-PPO reimbursement percentage after applicable deductibles and copays.

Covid-19 testing, as well as office visits or other provider charges related to testing, for both PPO and non-PPO providers, is covered at 100% until further notice.

If you have any questions regarding these changes, please contact the Administration Office using the phone numbers above.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

24 de abril de 2020

A: Todos los participantes
UNITE HERE Northwest Health Trust

De: Erik Van Rossum, Presidente
Howard Cohen, Secretario

Asunto: Cambios importantes en el plan de seguro médico a partir del 15 de abril de 2020

Este es un resumen de la modificación importante que describe los cambios en los beneficios adoptados por el Consejo de Administración. Asegúrese de que usted y su familia lo lean detenidamente y conserve este documento con su folleto de descripción resumida del plan.

MODIFICACIONES IMPORTANTES A LOS BENEFICIOS

Con vigencia inmediata, el Fideicomiso eximirá el pago del coseguro del paciente del 10% en los servicios médicos recibidos de un proveedor de la PPO entre el 15 de abril de 2020 y el 31 de julio de 2020. Los cargos permitidos se pagarán al 100% después del copago correspondiente. Los proveedores que no forman parte de la PPO estarán cubiertos con el porcentaje de reembolso regular para proveedores que no forman parte de la PPO, después de los deducibles y copagos correspondientes.

La prueba de Covid-19, así como las citas en consultorio u otros cargos de proveedores relacionados con la prueba, tanto para proveedores de la PPO como los que no forman parte de la PPO, tienen cobertura del 100% hasta nuevo aviso.

Si tiene alguna pregunta con respecto a estos cambios, comuníquese con la Oficina de Administración llamando a los números de teléfono indicados arriba.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

Ngày 24 tháng 4, 2020

Gởi: Toàn thể hội viên
UNITE HERE Northwest Health Trust

Từ: Erik Van Rossum, Chủ tịch
Howard Cohen, Tổng thư ký

Về việc: Thay đổi quan trọng của chương trình bảo hiểm sức khỏe, hiệu lực kể từ ngày 15 tháng 4, 2020

Đây là bản tóm tắt những điều chỉnh quan trọng đối với các thay đổi về quyền lợi đã được Hội đồng quản trị thông qua. Xin quý vị và gia đình đọc cẩn thận và giữ tài liệu này cùng với Tập tài liệu tóm tắt quyền lợi bảo hiểm.

ĐIỀU CHỈNH QUAN TRỌNG VỀ QUYỀN LỢI BẢO HIỂM

Hiệu lực ngay lập tức, Quỹ bảo hiểm sẽ miễn phần 10% tiền đồng bảo hiểm bệnh nhân phải trả đối với những dịch vụ y khoa mà hội viên nhận được từ các nhà chăm sóc sức khỏe PPO kể từ ngày 15 tháng 4, 2020 đến hết ngày 31 tháng 7, 2020. Mọi chi phí được cho phép sẽ được đài thọ 100% sau khi hội viên đã trả phần tiền đồng trả phù hợp. Các dịch vụ do các nhà chăm sóc sức khỏe không phải là PPO sẽ được đài thọ và hoàn tiền theo tỉ lệ phần trăm bình thường dành cho các nhà chăm sóc sức khỏe không thuộc hình thức PPO sau khi hội viên đã trả phần khấu trừ và tiền đồng trả phù hợp.

Chi phí xét nghiệm Covid-19, cũng như chi phí khám tại văn phòng bác sĩ và những chi phí của các nhà chăm sóc sức khỏe PPO và không phải PPO liên quan đến xét nghiệm, sẽ được đài thọ 100% cho đến khi có quy định mới.

Nếu quý vị có điều gì thắc mắc liên quan đến những thay đổi này, vui lòng liên lạc với Văn phòng Quản trị theo những số điện thoại ghi trên.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

2020 年 4 月 24 日

收件人：所有会员
UNITE HERE Northwest Health Trust

发件人：Erik Van Rossum，董事长
Howard Cohen，秘书长

事宜： 重要保健计划**更**改，2020 年 4 月 15 日生效

此为重要修改摘要，描述董事会采纳的福利更改。您和您的家人务必仔细阅读本文件，并将其与《计划说明摘要》手册保存在一起。

重要福利修改

立即生效，本董事会将免除从 2020 年 4 月 15 日至 2020 年 7 月 31 日从 PPO 服务提供者处接受的医疗服务的 10% 患者共同保险。许可的收费将在支付适用的协同付款后按 100% 赔付。非 PPO 服务提供者将在支付适用的免赔额和协同付款后按普通非 PPO 偿付百分比赔付。

对于 PPO 和非 PPO 服务提供者，新型冠状病毒（Covid-19）测试以及门诊或与测试相关的其他服务提供者费用均按 100% 赔付，直至另行通知。

如果您对这些更改有任何疑问，请使用上面的电话号码与行政管理办公室联系。

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

ኤፕሪል 24, 2020

ለ: ሁሉም ተሳታፊዎች
(UNITE HERE Northwest Health Trust)

ከ: Erik Van Rossum, Chairman
Howard Cohen, Secretary

ስለ: ጠቃሚ የጤና ዕቅድ ለውጦች ከኤፕሪል 15 ቀን 2020 ጀምሮ ተግባራዊ ይሆናሉ።

ይህ በአስተዳዳሪ ቦርዱ የተቀበለቸውን ጥቅማ ጥቅሞችን የሚገልፅ ሊያውቋት የሚገባ ማሻሻያ አጠቃላይ ማብራሪያ ነው። እባክዎን እርስዎ እና ቤተሰብዎ በጥንቃቄ እንዳነበቡት እና ይህንን ሰነድ በማጠቃለያ ዕቅድ መግለጫ መጽሐፍዎ ውስጥ ማስቀመጥዎን እርግጠኛ ይሁኑ ።።

የአስፈላጊ ጥቅማ ጥቅሞች ማሻሻያ

ከኤፕሪል 15 ቀን 2020 እስከ ጁላይ 31 ቀን 2020 ድረስ ከፒ.ፒ.ኦ.(PPO) አቅራቢ ከተቀበሉት የህክምና አገልግሎቶች ላይ የ 10% የታካሚ-ኢንሹራንስ የሚተዉላቸዉ ክፍያ ወዲያውኑ ተፈጻሚ ይሆናል ።። ኮ-ፔይ (co-pay) ተግባራዊ ከሆነ በኃላ የተፈቀዱ ክፍያዎች 100% ተከፋይ ይሆናል ።። ፒ.ፒ.ኦ. ያልሆኑ አቅራቢዎች የሚሸፈኑት መደበኛ ያልሆነ ፒ.ፒ.ኦ. ተመላሽ ክፍያ በመቶኛ፣ የመደበኛ ተቀናሽ ሂሳብ እና ተቀናሽ ክፍያዎች (copays) ከተፈፀሙ በኃላ ነዉ።።

የኮቪድ -19 ምርመራ ፣ እንዲሁም ለቢሮ ጉብኝቶች ወይም ለሌላ ለፒ.ፒ.ኦ. እና ፒ.ፒ.ኦ. ላልሆኑ አቅራቢዎች ከምርመራ ጋር የተገናኙ ክፍያዎች ተጨማሪ ማስታወቂያ እስከሚወጣ ድረስ በ 100% ይሸፈናል ።።

እነዚህን ለውጦች በተመለከተ ማንኛቸውም ጥያቄዎች ካሉዎት እባክዎን ከዚህ በላይ ያሉትን የስልክ ቁጥሮች በመጠቀም የአስተዳደር ጽ / ቤቱን ያነጋግሩ።።

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

SAVE SOME MONEY AND THE DRIVE

Have Your Prescriptions Delivered to Your Door

Having your maintenance medications filled via mail can save you money on certain prescriptions, and you may even be able to get a larger supply at one time.

Mail Order Rx is convenient because:

- OptumRx home delivery is safe, reliable and includes free standard shipping.
- Prescriptions are shipped right to your door.
- You may pay less for your medication with a 90-day supply.
- An expert pharmacist is available to answer your questions 24/7.

Get Started

It's simple to set up a new prescription or transfer an existing one to OptumRx. When your doctor prescribes a maintenance medication, have the prescription written for a 90-day supply, as the mail-order program can only fill your prescription with the quantity your doctor indicates.

Your prescription can then be filled using the following methods:

e-Prescribe
Ask your doctor to send an electronic prescription to OptumRx.

Online
Visit www.optumrx.com and select "Get Started" or use the OptumRx app. From there, you can fill new prescriptions; transfer others to home delivery, and more.

Phone
Call 866-354-0090 (toll-free) to speak to a customer service representative.

Once OptumRx receives your complete order for a new prescription, your medication should arrive within 10 business days.

Need your medication right away?
Ask your doctor for a one-month supply that can be immediately filled at participating retail pharmacy.

Refills Are Easy

OptumRx makes ordering refills or checking how many refills you have available very easy. Once you register online, you will receive an e-mail reminder when it's time to refill your medication and most maintenance medications, will be sent automatically. You can also control when you receive your medication and cancel a prescription online at OptumRx or by calling Customer Service at 866-354-0090. Completed refill orders should arrive in about seven business days.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

AHORRE DINERO Y EL VIAJE A LA FARMACIA

Le pueden entregar sus medicamentos en la puerta

Surtir sus medicamentos de mantenimiento por correo puede ahorrarle dinero en ciertos medicamentos de receta y quizás hasta pueda pedir un suministro más grande a la vez.

Pedir medicamentos de receta por correo es conveniente porque:

- La entrega a domicilio a través de OptumRx es segura, fiable e incluye envío estándar gratuito.
- Los medicamentos de receta se entregan directamente a su puerta.
- Usted podría pagar menos por su medicamento al pedir un suministro para 90 días.
- Un farmacéutico experto está a sus órdenes para contestar sus preguntas las 24 horas del día, los 7 días de la semana.

Para empezar

Es fácil pedir un medicamento de receta nuevo o transferir a OptumRx un medicamento que ya está tomando. Cuando su médico le recete un medicamento de mantenimiento, pídale una receta para un suministro de 90 días, ya que el programa de pedidos por correo solo puede surtir la receta en la cantidad que su médico indique.

Con eso, pueden surtirle su medicamento usando los siguientes métodos:

e-Prescribe
Pídale a su médico que envíe una receta electrónica a OptumRx.

En línea
Visite www.optumrx.com y seleccione “Get Started” (Comenzar) o use la aplicación OptumRx. A partir de ese momento puede surtir sus medicamentos nuevos; transferir otros al servicio de entrega a domicilio, y más.

Teléfono
Llame al 866-354-0090 (sin cargo) para hablar con un representante de servicio al cliente.

Una vez que OptumRx reciba su pedido completo de un medicamento de receta nuevo, su medicamento le llegará en un plazo de 10 días hábiles.

¿Necesita su medicamento de inmediato?
Pídale a su médico una receta para un suministro de un mes que se pueda surtir de inmediato en una farmacia participante.

Es fácil resurtir sus medicamentos

Con OptumRx es muy fácil resurtir sus medicamentos o consultar cuántos resurtidos le quedan. Una vez que se registre en línea, recibirá un recordatorio por correo electrónico cuando llegue el momento de resurtir su medicamento y la mayoría de los medicamentos de mantenimiento se enviarán automáticamente. También puede controlar cuándo recibe su medicamento y cancelar una receta en línea en OptumRx o llamando a Servicio al Cliente al 866-354-0090. Los pedidos de resurtidos se entregan en aproximadamente siete días hábiles.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

TIẾT KIỆM THỜI GIỜ VÀ TIỀN BẠC

Đặt mua thuốc theo toa gửi đến tận nhà

Quý vị sẽ tiết kiệm được tiền khi đặt mua một số loại thuốc duy trì qua bưu điện và cùng lúc quý vị còn có thể nhận được số lượng thuốc cao hơn.

Đặt mua thuốc theo toa qua bưu điện thuận tiện vì:

- Thuốc gửi đến nhà qua OptumRx an toàn, tin tưởng và miễn phí giá gửi tiêu chuẩn.
- Thuốc theo toa được gửi đến tận nhà.
- Có thể quý vị sẽ phải trả ít tiền hơn cho lượng thuốc đủ dùng 90 ngày.
- Dược sĩ chuyên môn sẵn sàng trả lời mọi thắc mắc của quý vị 24/24.

Hãy bắt đầu

Gửi mua thuốc theo toa hay chuyển toa thuốc từ nhà thuốc khác qua OptumRx rất dễ. Khi bác sĩ cho toa thuốc duy trì, hãy yêu cầu bác sĩ viết cho quý vị một lượng thuốc đủ dùng 90 ngày, lý do là vì chương trình đặt mua thuốc qua bưu điện chỉ có thể gửi thuốc đúng số lượng bác sĩ chỉ định.

Sau đó, thuốc theo toa của quý vị sẽ được cấp theo những phương pháp sau đây:

e-Prescribe (Cho toa theo phương pháp điện tử)
Hỏi xin bác sĩ gửi toa thuốc qua phương pháp điện tử đến OptumRx.

Trên mạng
Vào trang www.optumrx.com và chọn “Get Started” ("Hãy bắt đầu") hoặc dùng ứng dụng OptumRx. Qua mạng hay ứng dụng này, quý vị có thể đặt mua thuốc theo toa mới, chuyển toa thuốc cũ gửi thẳng về nhà, và quý vị cũng có thể làm được nhiều điều khác.

Qua điện thoại
Gọi số 866-354-0090 (miễn phí) và nói chuyện với nhân viên phục vụ khách hàng.

Một khi OptumRx nhận được yêu cầu đặt mua toa thuốc mới đầy đủ của quý vị, quý vị sẽ nhận được thuốc trong vòng 10 ngày làm việc.

Nếu quý vị cần thuốc ngay lập tức
Xin bác sĩ cho quý vị toa thuốc đủ dùng cho một tháng. Quý vị sẽ mua được thuốc này ngay tại các nhà thuốc địa phương có tham gia trong chương trình bảo hiểm.

Mua thêm thuốc rất dễ

OptumRx giúp quý vị mua thêm thuốc, hay xem mình còn bao nhiêu lần mua thêm thuốc, một cách dễ dàng. Sau khi quý vị đã đăng ký trên mạng, đến lúc cần mua thêm thuốc, quý vị sẽ nhận được email nhắc quý vị, và đối với phần lớn các loại thuốc duy trì, chương trình sẽ tự động gửi thuốc cho quý vị. Quý vị cũng có thể quyết định khi nào quý vị muốn nhận thuốc và bỏ toa thuốc, trên mạng tại OptumRx, hoặc gọi Ban Phục vụ khách hàng tại số 866-354-0090. Sau khi quý vị hoàn tất thủ tục đặt mua thêm thuốc, quý vị sẽ nhận được thuốc trong khoảng 7 ngày làm việc.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

省钱省油

将处方药寄到家中

通过邮购配取您的维持性药物可为您节省一些处方药费用，您甚至可以一次配取较多的药量。

邮购处方药很方便，因为：

- OptumRx 家中递送安全可靠，并包括免费标准邮寄。
- 处方药会直接寄到您的家中。
- 一次配取 90 天的药量可支付较少的费用。
- 专业药剂师可每周七天、每天二十四小时回答您的问题。

开始设置

配取新处方或将现有处方转到 OptumRx 很简单。当医生为您开具维持性药物处方时，请让医生开 90 天的药量，因为邮购程序只能按照您的医生指示的药量为您配处方药。

然后，您可以使用以下方法配处方药：

e-Prescribe
请您的医生将电子处方发送至 OptumRx。

在线
访问网站 www.optumrx.com，并选择“Get Started”（开始设置），或使用 OptumRx 应用程序。您可以从那里配新处方药、将其他处方药转为家中递送等。

打电话
请拨打电话号码 866-354-0090（免费电话），与客户服务部代表交谈。

一旦 OptumRx 收到您填写的新处方药订单，您就会在 10 个工作日内收到您的药物。

立即需要药物？
请您的医生开一个月的药量，您可以在参加计划的零售药房立即配取药物。

续配药很便利

OptumRx 使续配药或查看续配药次数非常容易。在线注册后，当您需要续配药时，您会收到一封电子邮件提醒通知，会自动寄送大多数维持性药物。您还可以通过 OptumRx 以在线方式或打电话给客户服务部（电话号码 866-354-0090）控制何时收到药物和取消处方。完成的续配药订单应在大约七个工作日内送达。

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

የተወሰነ ገንዘብን እና ጉዞዎን ይቆጥቡ

(SAVE SOME MONEY AND THE DRIVE)

ማዘዣዎችዎ ወደ ቤትዎ እንዲላኩ ያድርጉ

ለረጅም ጊዜ የሚወሰዱ መድሃኒቶች (maintenance medications) በፖስታ በኩል በመሙላትዎ(መዛዝዎ) በተወሰኑ መድሃኒቶች ማዘዣ ገንዘብዎን ይቆጥባል ፣ እናም በአንድ ጊዜ ትልቅ አቅርቦት ሊያገኙ ይችላሉ ።

የደብዳቤ ትዕዛዝ Rx ምቹ ነው ምክንያቱም:

- የ OptumRx ቤት ማድረስ ደህንነቱ የተጠበቀ ፣ አስተማማኝ እና ነፃ መላኪያንም ያካትታል ።
- የታዘዙ መድኃኒቶች በቀጥታ ወደ ቤትዎ ይላካሉ ።
- ለመድሃኒትዎ አነስተኛ ክፍያ፣ ከ90 ቀናት አቅርቦት ጋር ሊያገኙ ይችላሉ።
- ጥያቄዎችዎን ለመመለስ ባለሙያ ፋርማሲስት ለ24/7 ይገኛል ።

መጀመር

አዲስ የታዘዘ ማዘዣን ማዘጋጀት ወይም የነበረውን ወደ OptumRx ማስተላለፍ ቀላል ነው። በፖስታ መድኃኒት ማዘዣ መርሃ ግብር ሐኪምዎ ባዘዘው መጠን ብቻ ሊሞላ ስለሚችል ዶክተርዎ የሚወሰዱ መድሃኒቶች በሚሰጥበት ጊዜ ለ 90 ቀናት የሚበቃ እንዲጽፍልዎት ያድርጉ ።

ከዚያም የሐኪም ማዘዣዎ የሚከተሉትን ዘዴዎችን በመጠቀም ሊሞላ ይችላል፡

ኢ-ፕሬስክራይብ/ e-Prescribe
ሐኪምዎ የኤሌክትሮኒክ ማዘዣን ወደ OptumRx እንዲልክ ይጠይቁ።

ኦንላይን/Online
www.optumrx.com ይጎብኙ እና “Get Started”ን ይምረጡ ወይም የ OptumRx መተግበሪያውን ይጠቀሙ። ከዚያ አዳዲስ መድኃኒቶችን መሙላት፣ ወደ ቤት እንድመጣልዎ ማድረግ፣ ማስተላለፍ እና ሌሎችም ።

ስልክ
ለደንበኞች አገልግሎት ተወካይ ለማነጋገር 866-354-0090 (በነጻ) ይደውሉ።

OptumRx ለአዲስ ማዘዣ የተሟላ ትዕዛዝዎን አንዴ ከተቀበለ ፣ መድሃኒትዎ በ 10 የሥራ ቀናት ውስጥ የሚደርስ ይሆናል።

መድሃኒትዎን ወዲያውኑ ይፈልጋሉ?
በተሳታፊ የቸርቻሮ ፋርማሲ ውስጥ ወዲያውኑ ሊሞላ የሚችል የአንድ ወር አቅርቦት ለማግኘት ሃኪምዎን ይጠይቁ

መልሶ ማስሞላት ቀላል ነው

OptumRx የምስሞያ ማዘዣዎቹን ያዘጋጃልል ወይም የምን ያህ.ል ጊዜ ማስሞያ እንዳለዎት በቀላሉ ይፈትሻል። አንዴ በአንላይን ከተመዘገቡ በኋላ መድሃኒትዎን ለመጣራት እና አብዛኛዎቹ የታዘዙ መድሃኒቶች ወዲያዉኑ የሚላኩ የኢ-ሜል ማስታወሻ ይደርስዎታል ። እንዲሁም መድሃኒትዎን ሲቀበሉ መቆጣጠር እና በአንላይን ማዘዣ (OptumRx) በመጠቀም ወይንም በደንበኞች አገልግሎት በስልክ ቁጥር 866-354-0090 ላይ በመደወል መሰረዝ ይችላሉ ። የተሞሉ ትዕዛዞች በሰባት የሥራ ቀናት ውስጥ የሚደርስ ይሆናል።

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

April 8, 2020

To: All Participants
UNITE HERE Northwest Health Trust

From: Erik Van Rossum, Chairman
Howard Cohen, Secretary

Re: COVID-19 Response – Extension of Benefits

UNITE HERE Northwest Health Trust, your health fund, is taking care of you during these tough times!

The situation with COVID-19 (Coronavirus) continues to evolve quickly. The Trustees of the UNITE HERE Northwest Health Trust know that those in our industry are affected the most through reduction in hours, layoffs and closures; which impact you and your family. But we are here to help and are working to appropriately respond to support your health coverage needs. To assist you during this unprecedented time, the Trustees have implemented an Extension for Those Who Lose Coverage During the COVID-19 Crisis.

What this means to you:

If you had coverage in any month February through April, the **Extension of Coverage** will allow you to keep your coverage through at least July at no cost to you. The extension would be effective for terminations, lay off and reductions beginning in March 2020.

If you don't work enough hours in…	Will we cover your Monthly Payment, including any Employee contribution?	So that you and any covered dependents can keep your coverage in…
March	**YES**	**May**
April	**YES**	**June**
May	**YES**	**July**

If you have questions about your health coverage or eligibility, please call the Administration Office using the phone numbers above.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

8 de abril de 2020

A: todos los participantes
UNITE HERE Northwest Health Trust

De: Erik Van Rossum, Presidente
Howard Cohen, Secretario

Asunto: Respuesta ante COVID-19 - Extensión de beneficios

¡UNITE HERE Northwest Health Trust, su fondo de salud, **lo está cuidando** durante estos tiempos difíciles!

La situación con COVID-19 (Coronavirus) continúa evolucionando rápidamente. Los fideicomisarios de UNITE HERE Northwest Health Trust saben que en nuestra industria nos hemos visto muy afectados por el recorte de horas, despidos y cierres, cuyas medidas afectan a usted y a su familia. Pero estamos aquí para ayudarle y estamos tomando medidas para responder debidamente y apoyar sus necesidades de cobertura de seguro médico. Para ayudarle durante este suceso sin precedentes, los fideicomisarios han implementado una extensión para quienes pierdan cobertura durante la crisis de COVID-19.

Lo que esto significa para usted:

Si tuvo cobertura en cualquier mes entre febrero y abril, la **extensión de cobertura** le permitirá conservar su cobertura por lo menos hasta julio sin costo alguno para usted. La extensión tendrá efecto en los casos de despido, paro forzoso y recortes de personal a partir de marzo de 2020.

Si no trabaja suficientes horas en ...	**¿cubriremos su pago mensual, incluida la contribución del empleado?**	**para que usted y sus dependientes cubiertos puedan conservar su cobertura en...**
Marzo	**SÍ**	**Mayo**
Abril	**SÍ**	**Junio**
Mayo	**SÍ**	**Julio**

Si tiene preguntas sobre su cobertura médica o su elegibilidad, llame a la Oficina de Administración a los números de teléfono indicados anteriormente.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

Ngày 8 tháng 4, 2020

Gửi: Tất cả các hội viên
UNITE HERE Northwest Health Trust Fund

Từ: Erik Van Rossum, Chủ tịch
Howard Cohen, Tổng thư ký

Về việc:Đáp ứng với tình trạng COVID-19 – Gia hạn quyền lợi bảo hiểm

UNITE HERE Northwest Health Trust,
quỹ bảo hiểm sức khỏe của quý vị,
sẽ **chăm lo cho quý vị** trong giai đoạn khó khăn này!

Tình trạng bệnh COVID-19 (Coronavirus) hiện nay tiếp tục thay đổi nhanh chóng. Hội đồng quản trị Quỹ bảo hiểm UNITE HERE Northwest Health Trust hiểu rằng tất cả mọi người trong ngành công nghiệp của chúng ta bị ảnh hưởng nặng nề nhất bởi tình trạng giảm giờ làm việc, sa thải và hãng sở đóng cửa, và điều đó ảnh hưởng đến quý vị và gia đình. Nhưng xin quý vị luôn nhớ rằng, chúng tôi có mặt nơi đây để hỗ trợ quý vị và chúng tôi đang tận lực cố gắng đáp ứng các nhu cầu bảo hiểm sức khỏe của quý vị. Nhằm mục đích giúp đỡ quý vị trong giai đoạn khó khăn chưa từng có này, Hội đồng quản trị đã thành lập và đang thực thi chương trình Gia hạn cho những người bị mất quyền lợi bảo hiểm trong cơn khủng hoảng COVID-19.

Đối với quý vị, điều này có nghĩa là:

Nếu quý vị có bảo hiểm trong bất cứ tháng nào giữa tháng 2 và tháng 4, chương trình **Gia hạn quyền lợi bảo hiểm** sẽ cho phép quý vị được có bảo hiểm tối thiểu là cho đến hết tháng 7, miễn phí cho quý vị. Chương trình gia hạn này sẽ có hiệu lực cho các trường hợp bị nghỉ việc, sa thải và giảm giờ làm việc bắt đầu từ tháng 3, 2020.

Nếu quý vị không làm đủ giờ trong...	Chương trình có đài thọ Lệ phí hàng tháng của quý vị, kể cả phần Nhân viên đóng góp không?	Để giúp quý vị và tất cả người phụ thuộc của quý vị hiện có bảo hiểm được đài thọ trong...
tháng 3	**CÓ**	**tháng 5**
tháng 4	**CÓ**	**tháng 6**
tháng 5	**CÓ**	**tháng 7**

Nếu quý vị có điều gì thắc mắc liên quan đến quyền lợi bảo hiểm hay tình trạng hội đủ điều kiện hưởng quyền lợi bảo hiểm, vui lòng liên lạc với Văn phòng Quản trị theo những số điện thoại ghi trên.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

2020 年 4 月 8 日

收件人：所有参加者
UNITE HERE Northwest Health Trust

发件人：Erik Van Rossum，董事长
Howard Cohen，秘书长

事宜： COVID-19 回应 – 福利延期

您的保健基金 UNITE HERE Northwest Health Trust
在这些困难时期关照您！

COVID-19（新型冠状病毒）疫情继续迅速变化。UNITE HERE Northwest Health Trust董事会知道，本行业雇员因减少工时、裁员和停产受到的影响最大；并对您和您的家人产生影响。但是我们可以向您提供帮助，我们正在努力作出适当回应，对您的健康保险需求提供支持。为了在这个前所未有的时期向您提供帮助，董事会实施了一项措施，为COVID-19危机期间失去保险的人延期福利。

这对您意味着什么：

如果您在二月到四月的任何一个月有保险，**承保延期**将允许您至少到七月可保持该保险，无需支付任何费用。延期将从 2020 年 3 月开始对被解聘和裁员的员工有效。

如果您在以下月份没有足够的工时……	我们将支付您的月费（包括任何雇员出资）吗？	以便您和任何享受保险的家属能够在以下月份有保险……
三月	是	五月
四月	是	六月
五月	是	七月

如果您对医疗保险或资格有疑问，请用以上电话号码打电话给行政管理办公室。

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

ሚያዝያ 8 ቀን 2020

ለ፡ ሁሉም ተሳታፊዎች
UNITE HERE Northwest Health Trust (ዩናይት ሂር ኖርዝወስት የጤና ባለአደራ)

ከ፡ Erik Van Rossum, ሊቀመንበር
Howard Cohen, ጸሀፊ

የኮቪድ-19 ምላሽ - የጥቅሞች ማራዘም

በእነዚህ አስቸጋሪ ጊዜያት ውስጥ የጤና ፈንድዎ UNITE HERE Northwest Health Trust (ዩናይትሂር ኖርዝወስት የጤና ባለአደራ) እየተንከባከበዎት ነው !

ከኮቪድ -19 (Coronavirus) ጋር ያለው ሁኔታ በፍጥነት መቀያየሩን ቀጥሏል። የUNITE HERE Northwest Health Trust (ዩናይት ሂር ኖርዝወስት የጤና ባለአደራ) ባለአደራዎች በሰዓት ቅነሳ፣ በ ከስራ መባረር እና በመዘጋት በኩል በጣም የሚጎዱት በኢንዱስትሪያችን ውስጥ ያሉት መሆናቸውን ያውቃሉ፤ ይህም እርስዎ እና ቤተሰብዎ ላይ ተጽዕኖ ያሳድራል። ነገር ግን ለመርዳት እዚህ አለን እናም ለጤና ሽፋን ፍላጎቶችዎ ለመደገፍ ተገቢውን ምላሽ ለመስጠት እየሰራን ነው። ከዚህ በፊት ታይቶ በማይታወቅ በዚህ ጊዜ እርስዎን ለማገዝ ባለአደራዎች በኮቪድ-19 ቀውስ ወቅት ሽፋን ለሚያጡ ሰዎች ማራዘምን ተግባራዊ አድርገዋል።

ይህ ለእርስዎ ምን ማለት ነው፡

ከየካቲት እስከ ሚያዝያ ባለው በማንኛውም ወር ወስጥ ሽፋን ከነበርዎት የሽፋን ማራዘሙ ቢያንስ እስከ ሀምሌ መጨረሻ ድረስ ለእርሶ ያለ ምንም ወጪ ሽፋንዎን እንዲያቆዩ ያስችልዎታል። ማራዘሙ ከመጋቢት 2020 ጀምሮ ለማቋረጦች፣ ማቆሞች እና ቅነሳዎች ስራ ላይ ይውላል።

በሚከተለው ውስጥ በቂ ሰዓታት የማይሰሩ ከሆነ	<u>ማንኛውንም የሰራተኛ መዋጮን ጨምሮ</u> ወርሃዊ ክፍያዎን እንሸፍናለን?	ስለዚህም እርስዎ <u>እና ማንኛውም የተሸፈኑ ጥገኞች</u> ሽፋንዎን በሚከተለው ውስጥ ማቆየት እንዲችሉ...
መጋቢት	አዎ	ግንቦት
ሚያዝያ	አዎ	ሰኔ
ግንቦት	አዎ	ሀምሌ

ስለ የጤና ሽፋንዎ ወይም ብቁነትዎ ጥያቄዎች ካለዎት እባክዎን ከዚህ በላይ ያሉትን የስልክ ቁጥሮች በመጠቀም ለአስተዳደሩ ጽ/ቤት ይደውሉ።

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

March 19, 2020

To: All Participants
UNITE HERE Northwest Health Trust

Re: Important Health Plan Changes Effective March 1, 2020

This is a summary of material modification describing benefit changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

TELEHEALTH/TELEMEDICINE SERVICES

Effective March 1, 2020, the UNITE HERE Northwest Health Fund will cover "Telehealth/Telemedicine" services. Under this coverage the Trust will pay for two-way, real-time audiovisual interactive audio and visual communication between the patient and the healthcare provider. This interaction does not involve direct, face-to-face or hands-on patient contact. Benefits for these visits will be covered the same as for any other office visit at 90% after $20 copay if an Aetna preferred provider is used and at 60% after a $20 copay if a non-preferred provider is used. These benefits are not subject to the deductible.

IMPORTANT BENEFIT MODIFICATIONS - COVID-19

Coverage for novel (new) coronavirus (COVID 19) has been modified until further notice as follows:

COVID-19 Testing

- The Trust will waive any out-of-pocket costs associated with testing for COVID-19 for both PPO and non-PPO providers. This would include the cost of the test as well as office visits or other provider charges related to testing.
- The Trust will suspend any prior authorization requirement for testing of COVID-19.

Prescription Refills – Retail and Mail Order

- The Trust will allow a one-time early refill on prescriptions drugs. (The early refill allowance would not apply to certain controlled substances.)

Extension of Time Loss Benefits

- The Trust will extend time loss benefits to participants who do not otherwise qualify for unemployment insurance who are required to quarantine on a physician's orders, self-quarantine due to exposure or who are immune-compromised and advised to self-quarantine. Contact the Administration Office to obtain the appropriate application for this benefit.

If you have any questions regarding these changes, please contact the Administration Office using the phone numbers above.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

19 de marzo de 2020

A: todos los participantes
UNITE HERE Northwest Health Trust

Asunto: Cambios importantes en el plan de seguro médico a partir del 1 de marzo de 2020

Este es un resumen de la modificación importante que describe los cambios en los beneficios adoptados por el consejo de administración. Asegúrese de que usted y su familia lo lean detenidamente y conserve este documento con su folleto de descripción resumida del plan.

SERVICIOS DE TELESALUD/TELEMEDICINA

A partir del 1 de marzo de 2020, UNITE HERE Northwest Health Fund cubrirá los servicios de "telesalud/telemedicina". En virtud de esta cobertura, el Fideicomiso pagará la comunicación audiovisual interactiva en tiempo real entre el paciente y el proveedor de atención médica. Esta interacción no es contacto directo, presencial o en persona con el paciente. Los beneficios para estas consultas estarán cubiertos de la misma manera que para cualquier otra cita en el consultorio al 90% después de un copago de $20 si se usa un proveedor preferido de Aetna y al 60% después de un copago de $20 si se usa un proveedor no preferido. Estos beneficios no están sujetos al deducible.

MODIFICACIONES IMPORTANTES A LOS BENEFICIOS - COVID-19

La cobertura para el nuevo coronavirus (COVID 19) se ha modificado hasta nuevo aviso de la siguiente manera:

Pruebas de COVID-19

- El Fideicomiso anulará los gastos de bolsillo asociados con las pruebas de COVID-19 para proveedores PPO y no PPO. Esto incluiría el costo de la prueba, así como las citas en el consultorio u otros cargos del proveedor relacionados con la prueba.
- El Fideicomiso suspenderá el requisito de autorización previa para la prueba del COVID-19)

Resurtidos de recetas - Farmacias y pedidos por correo

- El Fideicomiso permitirá el resurtido temprano una sola vez de medicamentos recetados. (La autorización para resurtido temprano no se aplica a ciertas sustancias controladas).

Extensión de beneficios por pérdida de tiempo

- El Fideicomiso extenderá los beneficios por pérdida de tiempo a los participantes que de otro modo no califican para el seguro de desempleo que están obligados a cuarentena por orden de un médico, se ponen en cuarentena debido a la exposición o que están inmunocomprometidos y se les recomienda ponerse en cuarentena. Comuníquese con la Oficina de Administración para obtener la solicitud adecuada para este beneficio.

Si tiene alguna pregunta con respecto a estos cambios, comuníquese con la Oficina de Administración llamando a los números de teléfono indicados arriba.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

Ngày 19 tháng 3, 2020

Gửi: Tất cả các hội viên
UNITE HERE Northwest Health Trust Funds

Về việc: Thay đổi quan trọng của chương trình bảo hiểm sức khỏe, hiệu lực kể từ ngày 1 tháng 3, 2020

Đây là bản tóm tắt những điều chỉnh quan trọng đối với các thay đổi về quyền lợi bảo hiểm đã được Hội đồng quản trị thông qua. Xin các bạn và gia đình nhớ đọc cẩn thận và giữ tài liệu này cùng với Tập tài liệu tóm tắt quyền lợi bảo hiểm.

DỊCH VỤ CHĂM SÓC SỨC KHỎE TỪ XA/DỊCH VỤ ĐIỀU TRỊ Y KHOA TỪ XA

Hiệu lực kể từ ngày 1 tháng 3, 2020, Quỹ bảo hiểm UNITE HERE Northwest Health Trust Funds sẽ đài thọ cho các dịch vụ "Chăm sóc sức khỏe từ xa/Điều trị y khoa từ xa". Qua quyền lợi đài thọ này, Quỹ bảo hiểm sẽ đài thọ cho phương pháp giao tiếp bằng âm thanh và hình ảnh, nghe nhìn hai chiều, trong thời gian thực, giữa bệnh nhân và nhà cung cấp dịch vụ chăm sóc sức khỏe. Sự giao tiếp này sẽ không là việc tiếp xúc trực tiếp, gặp tận mặt, hoặc làm việc trực tiếp với bệnh nhân. Quyền lợi bảo hiểm cho những lần khám như thế này sẽ được đài thọ giống như những buổi khám tại văn phòng, ở mức 90% sau khi trả $20 tiền đồng trả, nếu hội viên dùng nhà cung cấp dịch vụ chăm sóc sức khỏe ưu tiên của Aetna, và ở mức 60% sau khi trả $20 tiền đồng trả, nếu hội viên không dùng nhà cung cấp dịch vụ chăm sóc sức khỏe ưu tiên. Những quyền lợi bảo hiểm này không ảnh hưởng bởi khoản tiền khấu trừ.

SỬA ĐỔI QUAN TRỌNG VỀ QUYỀN LỢI - COVID-19

Quyền lợi bảo hiểm cho trường hợpvirus corona mới (COVID 19) được sửa đổi như sau cho đến khi có thông báo mới:

Thử nghiệm COVID-19

- Quỹ bảo hiểm sẽ miễn mọi chi phí tự trả liên quan đến việc thử nghiệm COVID-19 qua cả hai thành phần nhà cung cấp dịch vụ chăm sóc sức khỏe PPO và không phải PPO. Các chi phí được miễn bao gồm chi phí thử nghiệm cũng như những lần đi khám tại văn phòng, hoặc những chi phí khác mà nhà cung cấp dịch vụ chăm sóc sức khỏe tính liên quan đến thử nghiệm.
- Quỹ bảo hiểm sẽ tạm ngưng áp dụng điều kiện phải được chấp thuận trước khi làm thử nghiệm COVID-19.

Mua thêm thuốc theo toa – Mua thuốc tại nhà thuốc bán lẻ hay đặt mua qua bưu điện

- Quỹ bảo hiểm sẽ cho phép mua thêm thuốc theo toa sớm một lần. (Việc được mua thêm thuốc theo toa sớm này sẽ không áp dụng cho những loại thuốc bị kiểm soát.)

Gia hạn quyền lợi bảo hiểm trong thời gian không được làm việc

- Quỹ bảo hiểm sẽ gia hạn quyền lợi bảo hiểm trong thời gian không được làm việc cho những hội viên không đủ điều kiện được lãnh bảo hiểm thất nghiệp mà bị bắt buộc phải cách ly theo lệnh bác sĩ, phải tự cách ly vì có tiếp xúc với nguồn bệnh, hoặc là những người có hệ miễn dịch suy yếu và được khuyên nên tự cách ly. Vui lòng liên lạc với Văn phòng Quản trị để xin đơn ghi danh dành riêng cho quyền lợi này.

Nếu quý vị có điều gì thắc mắc liên quan đến những thay đổi này, vui lòng liên lạc với Văn phòng Quản trị theo những số điện thoại ghi trên.

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

2020 年 3 月 19 日

收件人：所有参加者
UNITE HERE Northwest Health Trust

事宜： 重要保健计划更改，2020 年 3 月 1 日生效

此为重大修改摘要，描述董事会通过的福利变更。请确保您和您的家人仔细阅读本文件，并将其与《摘要计划说明》手册一起保存。

远程健康/远程医疗服务

从2020年3月1日开始生效，UNITE HERE Northwest Health Fund将提供“远程健康/远程医疗”服务。根据本保险计划，Trust将支付患者与医疗保健提供者之间的双向实时交互式音频和视觉通信。这种交互不涉及直接或面对面的患者接触或亲手检查。如果使用Aetna首选服务提供者，这些门诊的福利承保将与其他任何前往医院的门诊一样，在支付20美元共付费后为90%的费用提供承保，如果使用非首选服务提供者，则在支付20美元共付费后为60%的费用提供承保。这些福利不受免赔额的限制。

重要福利修改 — 2019 年新型冠状病毒（COVID-19）

已经对新型冠状病毒（COVID-19）的承保作出以下修改，直至发出进一步通知：

COVID-19 检测

- Trust 将免除与 PPO 和非 PPO 服务提供者提供的 COVID-19 检测相关的所有自付费。这包括检测费用以及门诊费用或与检测相关的其他服务提供者收费。
- Trust 将暂时中止 COVID-19 检测的任何预先授权要求。

处方药续配 — 零售和邮购

- Trust 将允许一次提早续配处方药。（提早续配许可不适用于某些受控物质。）

延长时间损失福利

- Trust 将为没有资格获得失业保险、需要根据医生的命令进行检疫隔离、由于接触病毒或免疫功能低下被建议进行自我检疫隔离的参加者延长时间损失福利。请与行政办公室联系，获取有关此项福利的相关申请表。

如果您对这些变更有任何疑问，请使用以上电话号码与行政办公室联系。

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

ማርች 19፣ 2020

ለ፡ ሁሉም ተሳታፊዎች
UNITE HERE Northwest Health Trust

Re: ከማርች 1 2020 ጀምሮ ስራ ላይ የሚውል አስፈላጊ የጤና ዕቅድ ለውጦች

ይህ ባለአደራ ቦርዱ የተቀበላቸውን የጥቅማጥቅሞችን ለውጥ የሚያብራራ አዳጎስ ያለ ማሻሻያ ማጠቃለያ ነው። እባክዎን እርስዎ እና ቤተሰብዎ በጥንቃቄ እንዳነበቡት እርግጠኛ ይሁኑ እና ይህንን ሰነድ ማጠቃለያ ዕቅድ መግለጫ መጽሐፍዎ ጋር ያስቀምጡት።

የቴሌ ጤና / የቴሌ ህክምና አገልግሎቶች

ከማርች 1 ቀን 2020 ጀምሮ ከ UNITE HERE Northwest Health Fund የ "ቴሌ ጤና/ ቴሌ ህክምና" አገልግሎቶችን ይሸፍናል። በዚህ ሽፋን ስር ባለአደራው በታካሚው እና በጤና ጥበቃ አቅራቢው መካከል ላለ የሁለት መንገድ፣ ቅጽበታዊ የኦዲዮቪዥዋል መስተጋብራዊ የድምፅ እና የእይታ ግንኙነት ይከፍላል። ይህ መስተጋብር ከታካሚ ጋር ቀጥተኛ፣ ፊት-ለፊት ወይም የእጅ ግንኙነትን አያካትትም። የእነዚህ ጉብኝቶች ጥቅማጥቅሞች የ Aetna (አትና) ተመራጭ አገልግሎት አቅራቢ ጥቅም ላይ ከዋለ እንደ ለማንኛውም የቢሮ ጉብኝት ከ$20 የክፍያ መጋራት በኋላ በ90% እና ተመራጭ ያልሆነ አቅራቢ ጥቅም ላይ ከዋለ ከ$20 የክፍያ መጋራት በኋላ በ60% ይሸፍናል። እነዚህ ጥቅማጥቅሞች ተቀናሽ አይደሉም።

አስፈላጊ የጥቅም ለውጦች - COVID-19

ተጨማሪ ማስታወቂያ እስኪወጣ ድረስ ለኖቬል (አዲስ) Coronavirus (ኮቪድ 19) ሽፋን እንደሚከተለው ተስተካክሏል፡

COVID-19 **ምርመራ**

- ባለአደራው ማንኛውንም COVID-19 ምርመራ ጋር የተያያዘ የኪስ ወጪዎች ለPPO እና PPO-ላልሆኑም አቅራቢዎች ይተዋል። ይህ የምርመራውን ወጪ እንዲሁም የቢሮ ጉብኝቶችን ወይም ከምርመራው ጋር የተዛመዱ ሌሎች የአቅራቢ ክፍያዎችን ያካትታል።
- ባለአደራው COVID-19 ለመመርመራ ማንኛውንም ቅድመ-ፈቃድ የመጠየቅ ሁኔታን ያግዳል።

የታዘዙ መድኃኒቶች ድጋሚ ማስሞላት - የቸርቻሮ እና የፖስታ ትዕዛዝ

- ባለአደራው በሀኪም በታዘዙ መድሃኒቶች ላይ የአንድ ጊዜ ቀደም ብሎ መሙላት ይፈቅዳል። (የቀደም ብሎ መሙላት ፈቃድ ለተወሰኑ ቁጥጥር በተደረገባቸው ንጥረ ነገሮች ላይ ተፈፃሚ አይሆንም።)

የጊዜ መጥፋት ጥቅሞች ማራዘም

- ባለአደራው በሀኪም ትእዛዝ እንዲገለሉ የተጠየቁ፣ በመጋለጥ ምክንያት ራስን በማግለል ወይም በሽታን በመቋቋም ችሎታቸው የደከመ የሆኑ እና እራሳቸውን እንዲያገሉ የተመከሩ እና ለስራ አጥነት ዋስትና ብቁ ላልሆኑ ተሳታፊዎችን የጊዜ ኪሳራ ጥቅማጥቅሞችን ያደርሳል። ለዚህ ጥቅም ተገቢውን ማመልከቻ ለማግኘት የአስተዳደሩ ጽህፈት ቤት ያነጋግሩ።

እነዚህን ለውጦች በተመለከተ ማንኛቸውም ጥያቄዎች ካሉዎት እባክዎን ከዚህ በላይ ያሉትን የስልክ ቁጥሮች በመጠቀም የአስተዳደር ጽ/ቤቱን ያነጋግሩ።

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

February 28, 2020

To: All Participants
UNITE HERE Northwest Health Trust

Re: Weekly Disability Benefit Update

This is a summary of material modification describing benefit changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

The Board of Trustees is pleased to announce that effective January 1, 2020 the weekly disability benefit was increased from $225 per week to $400 per week, with an additional increase of $10 per week effective on January 1st of each subsequent year until further notice.

The increases apply only to participants who are eligible under Rule A. The Rule B benefit will remain at the current benefit level.

The Trustees also directed that weekly disability benefits be offset by any benefits received under the Washington Paid Family and Medical Leave program.

If you have any questions regarding these changes, please contact the Administration Office using the phone numbers above.

Board of Trustees

UNITE HERE Northwest Health Trust

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

September 2018

IMPORTANT NOTICE: PLEASE KEEP WITH PLAN MATERIALS

TO: Participants and Beneficiaries of the UNITE HERE Northwest Health and Pension Trust Funds

FROM: Board of Trustees

RE: **ADMINISTRATIVE OFFICE CHANGE EFFECTIVE OCTOBER 1, 2018**

We have a very important announcement to make regarding a change in administration of the UniteHERE Northwest Trust Funds **effective October 1, 2018**.

What this change means to you:

- ✓ **NEW ID Cards**
  New ID cards will be issued to all UNITE HERE Northwest Health Trust Fund Participants before October 1, 2018. In the meantime, please continue to use your current ID card when obtaining any medical, prescription drug, dental and/or vision services covered under the Trust. **Please watch your mail for the new cards and begin presenting them for services received on or after October 1, 2018.** If you find errors on your newly issued ID cards or do not receive your cards prior to October 1, 2018, please contact Northwest Administrators, Inc. immediately.

- ✓ **NEW Customer Service Telephone Numbers**
  The Funds' toll free customer service telephone numbers will change effective October 1, 2018.

  - Phone: **(206) 753-1097 or toll-free at (844) 411-0786**

- ✓ **NEW Fund Administrative Office and Address - Northwest Administrators (NWA)**
  NWA has offices in Seattle, Washington and Portland, Oregon.

Seattle	Portland
2323 Eastlake Avenue E	700 NE Multnomah Street, Suite 350
Seattle, WA 98102-3305	Portland, OR 97232-4197

NOTE: The addresses shown above should only be used on and after October 1, 2018. Until then, please continue to use the current address.

This change does not affect your medical, dental, prescription, vision, life, AD&D or pension benefits. All other contact information is staying the same – review the chart at the bottom of the page for a comprehensive list of benefit contacts.

Following careful consideration, the Board of Trustees has decided to change the Fund administration from Welfare & Pension Administration Service, Inc. (WPAS) to Northwest Administrators, Inc. (NWA). This change was made to provide you with improved administrative services at a better cost. As of October 1, 2018, NWA will take over all administrative functions currently provided by WPAS, including the payment of health and welfare claims, maintaining Participant eligibility for all benefits provided by the Funds, processing pension applications, and issuing pension benefits.

NWA is headquartered in Seattle, Washington and has offices throughout the West, including in Portland, Oregon. NWA has been providing employee benefit plan administration and benefit claim processing services since 1958. NWA's integrated eligibility and claims system is highly secure and accessible throughout a network of regional offices, ensuring that dedicated customer service staff is always available to serve UNITE HERE Participants at the highest levels. Additionally, multilingual support is available both via phone and in-person at the Seattle and Portland offices.

WPAS and NWA staffs are working closely with the Trustees to make the transition as smooth as possible in order to avoid any inconvenience to Fund Participants. We ask for your patience during the transition process as we work toward this long term improvement for participants in the Fund. Thank you.

Trust Health Plan Contact Information:

Trust Office	Northwest Administrators, Inc.	**(206) 753-1097 or toll-free at (844) 411-0786**
Medical	Aetna	www.aetna.com
Prescription Drugs	Optum Rx	**(888) 354-0090** www.optumrx.com
Dental	Cigna	**(800) 797-3381** www.cignadentalsa.com
Vision	EyeMed	**(866)289-0614** www.eyemedvisioncare.com

DE/ea

cc: Board of Trustees
Trust Counsel
Trust Consultant
Participating Employers
Fund Administrative Office Staff

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

Septiembre 2018

AVISO IMPORTANTE: CONSERVAR CON LOS MATERIALES DEL PLAN

PARA: Participantes y beneficiarios del UNITE HERE Northwest Health and Pension Trust Funds

DEL: Consejo Directivo

ASUNTO: **CAMBIO DE LA OFICINA ADMINISTRATIVA DESDE EL 1 DE OCTUBRE DE 2018**

Tenemos un anuncio muy importante sobre un cambio en la administración del UNITE HERE Northwest Trust Funds que entrará **en vigencia el 1 de octubre de 2018.**

Qué representa este cambio para usted:

- ✓ **NUEVAS tarjetas de identificación**
  Se emitirán nuevas tarjetas de identificación a todos los participantes en el Fondo Fiduciario UNITE HERE Northwest Health antes del 1 de octubre de 2018. Mientras tanto, continúe usando su tarjeta actual de identificación cuando obtenga algún servicio médico, de medicamentos recetados, dentales y/o de visión con cobertura del Fondo. **Revise su correo para recibir las nuevas tarjetas y comience a presentarlas para los servicios que se le proporcionen a partir del 1 de octubre de 2018.** Si encuentra algún error en las nuevas tarjetas de identificación o no recibe sus tarjetas antes del 1 de octubre de 2018, comuníquese de inmediato con Northwest Administrators, Inc.

- ✓ **NUEVOS números de teléfono de servicio al cliente**
  Los números de teléfono gratuitos de servicio al cliente del Fondo cambiarán a partir del 1 de octubre de 2018.

  - Teléfono: **(206) 753-1097 o la línea gratuita (844) 411-0786**

- ✓ **NUEVA oficina administrativa del fondo y NUEVA dirección - Northwest Administrators, Inc. (NWA)**
  NWA tiene oficinas en Seattle, Washington y Portland, Oregon.

Seattle	Portland
2323 Eastlake Avenue E	700 NE Multnomah Street, Suite 350
Seattle, WA 98102-3305	Portland, OR 97232-4197

  NOTA: Las direcciones anteriores deben usarse solamente a partir del 1 de octubre de 2018. Hasta esa fecha, continúe usando la dirección actual.

Este cambio no afecta sus beneficios médicos, dentales ni de recetas médicas, visión, vida, muerte accidental y discapacidad o pensión. El resto de la información de contacto permanece igual. Revise el cuadro en la parte inferior de la página para ver la lista completa de los contactos de beneficios.

Después de una cuidadosa evaluación, el Consejo Directivo ha decidido transferir la administración del Fondo de Welfare & Pension Administration Service, Inc. (WPAS) a Northwest Administrators, Inc. (NWA). Se efectuó este cambio para ofrecerle mejores servicios administrativos a un menor costo. A partir del 1 de octubre de 2018, NWA asumirá las funciones administrativas que actualmente proporciona WPAS, incluido el pago de las reclamaciones de salud y bienestar, el mantenimiento de la elegibilidad de los participantes para todos los beneficios que proporcionan los Fondos, el procesamiento de solicitudes de pensiones y la emisión de los beneficios de pensiones.

La sede de NWA se encuentra en Seattle, Washington y cuenta con oficinas en todo el oeste, incluso en Portland, Oregon. Desde 1958, NWA ha ofrecido servicios de administración de planes de beneficios para empleados y de procesamiento de reclamaciones de servicios. La elegibilidad integrada y el sistema de reclamaciones de NWA tiene un alto grado de seguridad y accesibilidad a través de una red de oficinas regionales. De esta manera, se asegura que personal especializado en servicio al cliente siempre esté disponible para atender a los participantes de UNITE HERE con la mejor calidad. Además, se ofrece apoyo en varios idiomas tanto por teléfono como en persona en las oficinas de Seattle y Portland.

El personal de WPAS y el de NWA están trabajando conjuntamente con los Fideicomisores para facilitar en lo posible la transición, a fin de evitar inconvenientes para los participantes en el Fondo. Le pedimos paciencia durante el proceso de transición mientras trabajamos para lograr esta mejora a largo plazo para los participantes en el Fondo. Gracias.

Información de Contacto del Plan Médico del Fondo:

Oficina del Fondo	Northwest Administrators, Inc.	**(206) 753-1097 o la línea gratuita (844) 411-0786**
Médicos	Aetna	www.aetna.com
Medicamentos recetados	Optum Rx	**(888) 354-0090** www.optumrx.com
Dentales	Cigna	**(800) 797-3381** www.cignadentalsa.com
Visión	EyeMed	**(866)289-0614** www.eyemedvisioncare.com

DE/ea

cc: Consejo Directivo
Abogado del fideicomiso
Asesor del fideicomiso
Empleadores participantes
Personal de la oficina administrativa del Fondo

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

2018 年 9 月

重要通知：请与计划材料一同保存

收件人： UNITE HERE Northwest Health and Pension Trust Funds（美国工会联盟西北部健康和养老金信托基金会）的参加者和受益人

发件人： 受托委员会

回复： **行政管理办公室变更自 2018 年 10 月 1 日起生效**

关于将在 **2018 年 10 月 1 日**生效的 UNITE HERE Northwest Trust Funds 管理变更，我们发布了一项非常重要的公告。

此次变更意味着您将获得：

- ✓ **新身份证**
  新身份证将在 2018 年 10 月 1 日之前发放给所有 UNITE HERE Northwest Health Trust Fund 的参加者。在此期间，请在接受本信托涵盖的任何医疗、处方药、牙科和/或视力服务时继续使用您现有的身份证。 **请查看您的邮件获取新身份证，并请在 2018 年 10 月 1 日或之后接受服务时出示该新身份证。** 如果您发现新签发的身份证上信息有误或在 2018 年 10 月 1 日之前未收到新身份证，请立即联系 Northwest Administrators, Inc.。

- ✓ **新客户服务电话号码**
  本基金会的免费客户服务电话号码变更将于 2018 年 10 月 1 日起生效。

  - 电话： **(206) 753-1097 或免费电话 (844) 411-0786**

- ✓ **新基金会行政管理办公室及地址 — Northwest Administrators (NWA)**

  NWA 在华盛顿州西雅图市和俄勒冈州波特兰市设有办事处。

  西雅图
  2323 Eastlake Avenue E
  Seattle, WA 98102-3305

  波特兰
  700 NE Multnomah Street, Suite 350
  Portland, OR 97232-4197

注意： 上述地址仅应在 2018 年 10 月 1 日及之后使用。 在此之前，请继续使用当前地址。

UNITE HERE Northwest Trust Funds 参加者
2018 年 9 月
第 2 □

此变更不会影响您的医疗、牙科、处方药、视力、人寿、意外事故死亡或养老金福利。所有其他联系信息保持不变 — 请查看本页底部的图表，以获取完整的福利联系人名单。

经过慎重考虑后，受托委员会决定将基金管理机构由 Welfare & Pension Administration Service, Inc.(WPAS) 更改为 Northwest Administrators, Inc.(NWA)。 此变更旨在以更低的成本为您提供改进的管理服务。 自 2018 年 10 月 1 日起，NWA 将接管 WPAS 目前提供的所有行政管理职能，包括支付健康和福利索赔、维持参加者获得基金会提供的所有福利的资格、处理养老金申请和发放养老金福利。

NWA 总部位于华盛顿州西雅图市，并在西部各地设有多个办事处，包括俄勒冈州波特兰市。 自 1958 年以来，NWA 一直致力于提供员工福利计划管理和福利索赔处理服务。 NWA 拥有非常安全且可通过区域办事处网络访问的综合资格评定和索赔处理系统，确保专业的客户服务人员能够随时为 UNITE HERE 参加者提供最优质的服务。 此外，西雅图和波特兰办事处还提供电话和现场多语言支持。

WPAS 和 NWA 工作人员正在与受托人密切合作，使过渡尽可能顺利完成，以避免给基金会参加者带来任何不便。 在此过渡期间，我们恳请您耐心等待，我们将通过此变更努力为基金会参加者带来长期的服务改善。 谢谢！

信托健康计划联系信息：

信托办公室	Northwest Administrators, Inc.	**(206) 753-1097 或免费电话 (844) 411-0786**
医疗	Aetna	www.aetna.com
处方药	Optum Rx	**(888) 354-0090** www.optumrx.com
牙科	Cigna	**(800) 797-3381** www.cignadentalsa.com
视力	EyeMed	**(866)289-0614** www.eyemedvisioncare.com

DE/ea

抄送： 受托委员会
信托法律顾问
信托顾问
参与雇主
基金会行政办公室人员

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

Сентябрь 2018 г.

ВАЖНОЕ УВЕДОМЛЕНИЕ: ПОЖАЛУЙСТА, СОХРАНИТЕ ВМЕСТЕ С ПЛАНОВЫМИ МАТЕРИАЛАМИ

КОМУ: Участникам и выгодоприобретателям UNITE HERE Northwest Health and Pension Trust Funds

ОТ КОГО: Совет попечителей

ТЕМА: **ИЗМЕНЕНИЕ АДМИНИСТРАТИВНОГО ОФИСА НАЧИНАЯ С 1 ОКТЯБРЯ 2018 Г.**

Мы собираемся сделать важное объявление об изменении администрирования UNITE HERE Northwest Trust Funds, **которое вступит в силу с 1 октября 2018 г**.

Что это изменение означает для вас:

- ✓ **НОВЫЕ идентификационные карты**
  Новые идентификационные карты будут выданы всем участникам UNITE HERE Northwest Health Trust Fund до 1 октября 2018 г. Пока что продолжайте использовать вашу нынешнюю идентификационную карту при получении любых лекарств по рецепту, медицинских, стоматологических и/или оптических услуг, покрываемых Трастовым фондом. **Вы получите новые карты по почте и сможете предъявлять их при получении услуг начиная с 1 октября 2018 г.** Если вы обнаружите ошибки в ваших новых идентификационных картах или не получите свои карты до 1 октября 2018 г., немедленно обратитесь в Northwest Administrators, Inc.

- ✓ **НОВЫЕ телефонные номера службы поддержки клиентов**
  Бесплатные телефонные номера службы поддержки клиентов Фондов изменятся начиная с 1 октября 2018 г.

  - Телефон: **(206) 753-1097 или для бесплатных звонков (844) 411-0786**

- ✓ **НОВЫЙ административный офис Фонда и его адреса - Northwest Administrators (NWA)**

  Офисы NWA расположены в Сиэтле, штат Вашингтон, и Портленде, штат Орегон.

  Сиэтл
  2323 Eastlake Avenue E
  Seattle, WA 98102-3305

  Портленд
  700 NE Multnomah Street, Suite 350
  Portland, OR 97232-4197

  ПРИМЕЧАНИЕ: Вышеуказанные адреса будут использоваться только начиная с 1 октября 2018 г. До тех пор, пожалуйста, продолжайте использовать нынешний адрес.

Это изменение не повлияет на ваше медицинское, стоматологическое, рецептурное, оптическое или пенсионное обеспечение, а также страхование жизни и на случай смерти и увечья в результате несчастного случая. Вся прочая контактная информация остается без изменений – ознакомьтесь с таблицей в нижней части страницы, содержащей полный список контактных данных по предоставляемым услугам.

После тщательного рассмотрения Совет попечителей решил заменить управление Фондом с Welfare & Pension Administration Service, Inc. (WPAS) на Northwest Administrators, Inc. (NWA). Это изменение было сделано, чтобы предоставить вам улучшенное административное обслуживание по более привлекательной цене. Начиная с 1 октября 2018 г. организация NWA примет на себя все административные функции, ныне осуществляемые WPAS, включая оплату по заявкам на услуги здравоохранения и социального обеспечения, сохраняя права участника на получение всех пособий и льгот, предоставляемых Фондами, обработкой пенсионных заявлений и предоставлением пенсионного обеспечения.

Главное управление NWA расположено в г. Сиэтле, штат Вашингтон, и имеет филиалы на западе США, включая Портленд, штат Орегон. С 1958 г. организация NWA занимается администрированием планов пособий и льгот для работников и обработкой заявок на пособия и льготы. Комплексная система соответствия требованиям и заявок NWA обеспечивает высокую безопасность и доступность с помощью сети региональных офисов, благодаря чему преданные своему делу сотрудники службы поддержки клиентов всегда готовы обслужить участников UNITE HERE на высочайшем уровне. Кроме того, существует многоязычная поддержка как по телефону, так и лично в офисах в Сиэтле и Портленде.

Сотрудники WPAS и NWA тесно сотрудничают с попечителями, чтобы обеспечить наиболее плавный переход и избежать любых неудобств для участников Фонда. Просим вас проявить терпение во время переходного процесса, поскольку мы работаем над длительным улучшением для участников Фонда. Спасибо!

Контактная информация по трастовому медицинскому плану:

Офис Трастового фонда	Northwest Administrators	**(206) 753-1097 или для бесплатных звонков (844) 411-0786**
Медицинская помощь	Aetna	www.aetna.com
Лекарства по рецепту	Optum Rx	**(888) 354-0090** www.optumrx.com
Стоматология	Cigna	**(800) 797-3381** www.cignadentalsa.com
Оптика	EyeMed	**(866)289-0614** www.eyemedvisioncare.com

DE/ea

копия: Совет попечителей
Совет Трастового фонда
Трастовый консультант
Участвующие работники
Сотрудники административного офиса Фонда

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

Setyembre 2018

MAHALAGANG PAUNAWA: PAKITAGO ITO KASAMA NG MGA MATERYALES NG PLANO

PARA SA: Mga Kalahok at Benepisyaryo ng UNITE HERE Northwest Health and Pension Trust Funds

MULA SA: Konseho ng mga Tagapangalaga

TUNGKOL SA: **PAGBABAGO SA TANGGAPANG PAMPANGASIWAAN NA MAGKAKAROON NG BISA SA OKTUBRE 1, 2018**

Mayroon kaming napakahalagang paunawa na may kinalaman sa isang pagbabago sa pangangasiwa sa UNITE HERE Northwest Trust Funds na **magkakaroon ng bisa sa Oktubre 1, 2018.**

Ano ang kahulugan ng pagbabagong ito sa iyo:

- ✓ **Mga BAGONG ID Card**
  Bibigyan ng mga bagong ID card ang lahat ng Kalahok sa UNITE HERE Northwest Health Trust Fund bago ang Oktubre 1, 2018. Samantala, mangyaring ipagpatuloy na gamitin ang iyong kasalukuyang ID card kapag kumukuha ka ng anumang serbisyong medikal, de-resetang gamot, serbisyo sa ngipin at/o paningin na saklaw sa ilalim ng Trust. **Mangyaring abangan sa koreo ang iyong mga bagong card at simulang gamitin ang mga ito para sa mga serbisyong matatanggap sa araw ng o makalipas ang Oktubre 1, 2018.** Kung may makita kang mga mali sa iyong mga bagong ID card o hindi mo matanggap ang iyong mga card bago dumating ang Oktubre 1, 2018, mangyaring makipag-ugnayan kaagad sa Northwest Administrators, Inc.

- ✓ **Mga BAGONG Numero ng Telepono ng Serbisyo sa Kostumer**
  Magbabago ang mga numero ng toll free na telepono ng serbisyo sa kostumer ng Fund simula Oktubre 1, 2018.

  - Telepono: **(206) 753-1097 o toll-free sa (844) 411-0786**

- ✓ **BAGONG Address at Tanggapang Pampangasiwaan ng Fund - Northwest Administrators (NWA)**

  May mga tanggapan ang NWA sa Seattle, Washington at Portland, Oregon.

  Seattle
  2323 Eastlake Avenue E
  Seattle, WA 98102-3305

  Portland
  700 NE Multnomah Street, Suite 350
  Portland, OR 97232-4197

  TANDAAN: Dapat lamang gamitin ang mga address na ipinapakita sa taas sa araw ng at makalipas ang Oktubre 1, 2018. Sa ngayon, mangyaring ipagpatuloy na gamitin ang kasalukuyang address.

Hindi inaapektuhan ng pagbabagong ito ang iyong mga benepisyong medikal, benepisyo sa ngipin, reseta, paningin, buhay, aksidenteng pagkamatay at pagkaputol ng parte ng katawan (AD&D) o pension. Mananatiling pareho ang lahat ng iba pang impormasyon sa pakikipag-ugnayan – tingnan ang talaan sa ibabang bahagi ng pahina para sa mas kumpletong listahan ng mga makakaugnayan tungkol sa benepisyo.

Matapos ang masusing pagsasaalang-alang, nagpasiya ang Konseho ng mga Tagapangalaga na ilipat ang pangangasiwa sa Fund mula sa Welfare & Pension Administration Service, Inc. (WPAS) tungo sa Northwest Administrators, Inc. (NWA). Ginawa ang pagbabagong ito para bigyan ka ng pinahusay na mga serbisyong pangangasiwa sa mas mabuting halaga. Simula Oktubre 1, 2018, hahawakan ng NWA ang lahat ng pampangasiwaang tungkulin na kasalukuyang ipinagkakaloob ng WPAS, kabilang ang pagbabayad ng mga claim sa kalusugan at welfare, pagpapanatili ng pagiging karapat-dapat ng Kalahok para sa lahat ng benepisyong ipinagkakaloob ng Funds, pagproseso ng mga aplikasyon para sa pension, at pagbibigay ng mga benepisyo sa pension.

Nasa Seattle, Washington ang punong tanggapan ng NWA at may mga tanggapin sa buong West, kabilang sa Portland, Oregon. Mula pa noong 1958, nagkakaloob na ang NWA ng pangangasiwa ng plano ng benepisyo ng empleyado at mga serbisyo sa pagproseso ng claim ng benepisyo. Mataas ang seguridad at madaling gamitin sa kabuuan ng network ng mga panrehiyong tanggapan ang pinagsama-samang sistema ng NWA sa pagiging karapat-dapat at claims, na tumitiyak na palaging nakahandang maglingkod ang nakalaang mga tauhan ng serbisyo sa kostumer sa mga Kalahok sa UNITED HERE sa pinakamatataas na antas. Dagdag pa, may magagamit na suporta sa maraming wika sa kapwa telepono at nang harapan sa mga tanggapan sa Seattle at Portland.

Nakikipagtulungang mabuti ang mga tauhan ng WPAS at NWA sa mga Tagapangalaga upang ang paglipat ay maging kasing-ayos nang maaari para maiwasan ang anumang pagkaabala ng mga Kalahok sa Fund. Hinihingi namin ang iyong pag-unawa sa panahon ng proseso ng paglipat habang nagsisikap kami tungo sa pangmatagalang pagpapahusay para sa mga kalahok sa Fund. Salamat.

Impormasyon sa Pakikipag-ugnayan sa Trust Health Plan:

Tanggapan ng Trust	Northwest Administrators, Inc.	**(206) 753-1097 o toll-free sa (844) 411-0786**
Medikal	Aetna	www.aetna.com
Mga De-resetang Gamot	Optum Rx	**(888) 354-0090** www.optumrx.com
Ngipin	Cigna	**(800) 797-3381** www.cignadentalsa.com
Paningin	EyeMed	**(866)289-0614** www.eyemedvisioncare.com

DE/ea

cc: Konseho ng mga Tagapangalaga
Abogado ng Trust
Sanggunian ng Trust
Mga Nakikilahok na Employer
Mga Tauhan sa Tanggapang Pampangasiwaan ng Fund

UNITE HERE
NORTHWEST TRUST FUNDS
2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

tháng 9, 2018

THÔNG BÁO QUAN TRỌNG: VUI LÒNG GIỮ TRONG HỒ SƠ CHƯƠNG TRÌNH BẢO HIỂM CỦA QUÝ VỊ

KÍNH GỬI: Tất cả hội viên và người hưởng quyền lợi của Quỹ Tín thác UNITE HERE Northwest Health and Pension Trust Funds

TỪ: Hội đồng Quản trị

VỀ VIỆC: **THÔNG BÁO VỀ THAY ĐỔI HÀNH CHÁNH CÓ HIỆU LỰC TỪ NGÀY 1 THÁNG 10, 2018**

Chúng tôi xin gửi đến quý vị thông báo rất quan trọng về một sự thay đổi về hành chánh của Quỹ Tín thác UNITE HERE Northwest Trust Funds **có hiệu lực từ ngày 1 tháng 10, 2918**.

Sự thay đổi này sẽ ảnh hưởng gì đến quý vị:

- ✓ **Thẻ ID MỚI**
  Tất cả các hội viên tham gia Quỹ Tín thác UNITE HERE Northwest Health Trust Fund sẽ được cấp thẻ ID mới trước ngày 1 tháng 10, 2018. Trong khi chờ đợi, xin quý vị tiếp tục dùng thẻ ID quý vị đang có khi quý vị cần được chăm sóc y tế, thuốc theo toa, dịch vụ nha khoa và/hoặc nhãn khoa được đài thọ qua Quỹ Tín thác này. **Vui lòng chú ý xem trong thư gửi đến cho quý vị qua bưu điện để tìm thẻ ID mới và bắt đầu trình thẻ này khi cần được cung cấp dịch vụ bắt đầu từ ngày 1 tháng 10, 2018 trở đi.** Nếu quý vị thấy có gì sai trong thẻ ID mới của quý vị, hoặc nếu quý vị không nhận được thẻ mới trước ngày 1 tháng 10, 2018, vui lòng liên lạc với văn phòng Northwest Administrators, Inc. ngay.

- ✓ **Số điện thoại MỚI của ban Dịch vụ hội viên**
  Số điện thoại miễn phí của ban dịch vụ hội viên của Quỹ Tín thác sẽ đổi kể từ ngày 1 tháng 10, 2018.

  - Điện thoại: **(206) 753-1097 hoặc số điện thoại miễn phí (844) 411-0786**

- ✓ **Văn phòng hành chánh của Quỹ Tín thác và địa chỉ MỚI - Northwest Administrators (NWA)**
  NWA cò văn phòng tại Seattle, Washington và Portland, Oregon.

  Seattle
  2323 Eastlake Avenue E
  Seattle, WA 98102-3305

  Portland
  700 NE Multnomah Street, Suite 350
  Portland, OR 97232-4197

  CHÚ Ý: Chỉ dùng những địa chỉ bên trên bắt đầu từ ngày 1 tháng 10, 2018 trở về sau. Từ nay cho đến ngày đó, vui lòng dùng địa chỉ quý vị hiện có.

Sự thay đổi này không ảnh hưởng gì đến quyền lợi bảo hiểm sức khỏe, nha khoa, thuốc theo toa, nhãn khoa, bảo hiểm nhân thọ, tử vong hoặc mất chi do tai nạn (AD&D) hay quyền lợi hưu bỗng của quý vị. Tất cả những thông tin liên lạc khác sẽ không thay đổi – vui lòng xem danh sách đầy đủ của thông tin liên lạc về quyền lợi trong bảng ở cuối trang.

Sau khi đã cân nhắc cẩn thận, Hội đồng quản trị đã quyết định đổi tên Quỹ Tín thác từ Welfare & Pension Administration Service, Inc. (WPAS) sang Northwest Administrators, Inc. (NWA). Sự thay đổi này được thực hiện nhằm mục đích cải tiến các dịch vụ hành chánh với chi phí thấp hơn. Kể từ ngày 1 tháng 10, 2018, NWA sẽ đảm nhiệm mọi hoạt động hành chánh mà WPAS đang thực hiện, kể cả việc thanh toán các yêu cầu thanh toán về quyền lợi y tế và phúc lợi, xem xét tình trạng hội viên hội đủ điều kiện tham gia cho tất cả các quyền lợi do Quỹ cung cấp, cứu xét đơn xin hưởng hưu bỗng và cấp quyền lợi hưu bỗng.

Trụ sở của NWA được đặt tại Seattle, Washington và NWA có văn phòng chi nhánh trong toàn khu vực miền Tây, kể cả tại Portland, Oregon. NWA có kinh nghiệm quản lý các chương trình quyền lợi của nhân viên và chương trình cứu xét yêu cầu thanh toán dịch vụ quyền lợi kể từ năm 1958. Hệ thống phối hợp cứu xét yêu cầu thanh toán và tình trạng hội đủ điều kiện của NWA rất an toàn và có thể được sử dụng trong toàn hệ thống các văn phòng khu vực, bảo đảm là các ban nhân viên chuyên phụ trách dịch vụ hội viên sẽ luôn sẵn sàng phục vụ hội viên của UNITE HERE một cách hoàn hảo nhất. Ngoài ra, các văn phòng tại Seattle và Portland cũng có dịch vụ đa ngôn ngữ qua điện thoại và trực tiếp.

Ban nhân viên WPAS và NWA làm việc chặt chẽ với các Ủy viên hội đồng nhằm giúp cho tiến trình chuyển tiếp được suôn sẻ và tránh mọi bất tiện cho hội viên Quỹ Tín thác. Chúng tôi xin quý vị kiên nhẫn cùng chúng tôi trong tiến trình chuyển tiếp này trong lúc chúng tôi nỗ lực làm việc để mang lại sự cải tiến lâu dài cho tất cả hội viên của Quỹ Tín thác. Thành thật cám ơn quý vị.

Thông tin liên lạc Chương trình bảo hiểm sức khỏe của Quỹ Tín thác:

Văn phòng Quỹ Tín thác	Northwest Administrators, Inc.	**(206) 753-1097 hoặc số điện thoại miễn phí (844) 411-0786**
Y tế	Aetna	www.aetna.com
Thuốc theo toa	Optum Rx	**(888) 354-0090** www.optumrx.com
Nha khoa	Cigna	**(800) 797-3381** www.cignadentalsa.com
Nhãn khoa	EyeMed	**(866)289-0614** www.eyemedvisioncare.com

DE/ea

bản sao gửi cho:
Hội đồng Quản trị
Luật sư của Quỹ Tín thác
Cố vấn của Quỹ Tín thác
Hãng sở tham gia chương trình
Ban nhân viên văn phòng hành chánh Quỹ Tín thác

UNITE HERE Northwest Trust Funds

7525 SE 24th Street, Suite 200 • Mercer Island, Washington 98040 • P.O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website www.heretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

September 19, 2018

TO: All Participants of the UNITE HERE Northwest Health Trust

RE: Plan Benefit Changes

This is a summary of material modification describing benefit changes adopted by the Board of Trustees.
Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

The Trustees took recent action to make the following changes to the Plan:

Coverage of Transgender Healthcare Services

Effective **July 1, 2018**, the Plan will cover medically necessary transgender healthcare services for Gender Dysphoria (also called Gender Identity Disorder), as generally described below. ***For more information on coverage requirements for transgender healthcare services, please contact the Administration Office at (800) 331-6158, option 0. You and/or your service provider(s) should submit information to the Plan for a coverage determination prior to beginning treatment. Certain services are subject to the Health Management Program provisions of the Plan.***

Services covered by the Plan include:

- Counseling
- Hormone Therapy
- Gender reassignment surgery
- Services typically associated with one sex, which may continue to be required after transition
- Prescription drugs (as covered under the Prescription Drug Program of this Plan)

To be eligible for coverage you must:

- Be 18 years of age or older,
- Have a well-documented diagnosis of Gender Dysphoria or Gender Identity Disorder meeting the diagnostic criteria of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) made by a qualified mental health professional,
- Agree to coordination of care through the Trust's designated Case Management Program, and
- In the event of gender reassignment surgery or hormone therapy, have no medical contraindications and complete specific evaluation and recommendation requirements.

The Plan does not cover services that are considered cosmetic, not medically necessary and/or are otherwise excluded under the Plan. This includes, but is not limited to:

- Rhinoplasty or nose implants
- Face-lifts
- Lip enhancement or reduction

(over)

- Facial bone reduction or enhancement
- Blepharoplasty (eyelid surgery)
- Breast Augmentation
- Liposuction
- Reduction thyroid chondroplasty (Adam 's Apple reduction)
- Hair removal
- Voice modification surgery or training
- Skin resurfacing
- Travel expenses

Please keep this important notice with your Plan Document/Summary Plan Description for easy reference to all Plan provisions. If you have any questions about these changes, please contact the Administration Office at (800) 331-6158, option 0. For additional Plan information and forms visit the Trust's website at http://www.uniteherenwtrusts.com/.

NOTE: Beginning October 1, 2018, if you have questions regarding these benefits, please contact Northwest Administrators (NWA) as follows:

Phone: **(206) 753-1097 or toll free at (844) 411-0786**

Seattle	Portland
2323 Eastlake Avenue E	700 NE Multnomah Street, Suite 350
Seattle, WA 98102-3305	Portland, OR 97232-4197

Sincerely,

Board of Trustees
UNITE HERE Northwest Health Trust

GG/Srw/afj/adg opeiu#8
S:\Mailings\Individual Trust Fund Mailings (SMM, Benefit Changes, etc.)\F19\F19-02 - Mailing - 2018 - 09.19 - SMM - Transgender Healthcare Services Effective 07.01.2018.docx

UNITE HERE Northwest Trust Funds

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website www.heretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

July 18, 2017

To: All Plan Participants
UNITE HERE Northwest Health Trust Fund

Re: Summary of Material Modification
New Vision Carrier – Effective August 1, 2017

This is a Summary of Material Modification describing recent benefit changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

New Vision Carrier

The Board of Trustees of the UNITE HERE Northwest Health Trust Fund (the "Trust") has elected EyeMed to replace National Vision as the Trust's vision benefit administrator effective **August 1, 2017.**

The enclosed Benefit Highlights flyer summarizes the benefits available under the EyeMed Access Network. For maximum benefits, it is to your advantage to see an EyeMed member doctor. However, should you go out-of-network, you will be reimbursed up to the scheduled amounts listed on the Benefit Highlights flyer. If you use an out-of-network provider, you must pay for the services at the time you receive them and then file a claim with EyeMed.

How do I locate an EyeMed doctor?

1. Visit www.eyemedvisioncare.com
   a. Select **Find a Provider**
   b. Input your zip code and select the **Access** network

   or

2. Call EyeMed Customer Service at (866) 289-0614

New Identification (ID) Cards

New medical, prescription drug and vision combination ID cards recognizing you as a member of the EyeMed network, will be mailed to you mid-August. Be sure to present your new ID card to providers for services received on or after August 1, 2017. If you have a vision appointment before you receive your new ID card, you may receive care by giving the provider your name, date of birth and social security number or member identification number or contact EyeMed customer care at (866) 289-0614.

If you have any questions regarding the contents of this notice, please contact the Administration Office at (206) 441-7574 or toll free at (800) 732-1121, option 4.

Board of Trustees
UNITE HERE Northwest Health Trust Fund

This 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 this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administration Office at 206-441-7574, option 0 or toll free at 800-33-6158, option 0. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Getting Help in Other Languages

This complete notice is also available in Spanish, Tagalog, Vietnamese, Chinese, and Russian. If you require a translated version of this notice, please visit www.heretrust.com or contact the Administration Office at (206) 441-7574.

Ayuda en otros idiomas (Spanish)

Todo este aviso también se encuentra disponible en español, tagalo, vietnamita, chino y ruso. Si necesita una versión traducida de este aviso, sírvase visitar www.heretrust.com o llame a la Oficina de Administración al (206) 441-7574.

Paghingi ng Tulong sa Ibang Wika (Tagalog)

Makukuha rin ang kumpletong abisong ito sa wikang Spanish, Tagalog, Vietnamese, Chinese, at Russian. Kung kailangan mo ng isinaling bersyon ng abisong ito, pakibisita ang www.heretrust.com o makipag-ugnayan sa Administration Office sa (206) 441-7574.

Nhận Trợ giúp bằng Ngôn ngữ khác (Vietnamese)

Thông báo đầy đủ này hiện có sẵn bằng tiếng Tây Ban Nha, tiếng Tagalog, tiếng Việt, tiếng Trung Quốc, và tiếng Nga. Nếu quý vị cần một bản dịch của thông báo này, vui lòng ghé thăm www.heretrust.com hoặc liên hệ với Văn phòng Hành chính theo số điện thoại (206) 441-7574.

获取其他语种的帮助信息 (Chinese)

本完整通知还提供西班牙语、他加禄语、越南语、中文和俄语版本。如果您需要本通知的翻译版本，请访问 www.heretrust.com **或致**电 (206) 441-7574 联系管理办公室。

Как получить информацию на других языках (Russian)

Полный текст данного уведомления доступен также на испанском, тагальском, вьетнамском, китайском и русском языках. Если Вам нужна переводная версия данного уведомления, посетите веб-сайт www.heretrust.com или свяжитесь с административным отделом по телефону (206) 441-7574.

UNITE HERE!

Ameritas

Vision Plan Summary

Effective Date: 8/1/2017

	EyeMed Access Network	Out of Network
Deductibles		
	$0 Exam $0 Eye Glass Lenses	No deductible
Annual Eye Exam	Covered in full	Up to $72
Lenses (per pair)		
Single Vision	Covered in full	Up to $60
Bifocal	Covered in full	Up to $96
Trifocal	Covered in full	Up to $120
Lenticular	20% discount	No benefit
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams		
Standard	Standard: Member cost up to $55	No benefit
Premium (Allowance)	Premium: 10% off of retail	No benefit
Elective	Up to $120	Up to $120
Medically Necessary	Covered in full	Up to $120
Frames	$120	Up to $60
Frequencies (months)		
Exam/Lens/Frame	12/12/24 Based on date of service	12/12/24 Based on date of service

Eye Care Plan Member Service

ViewPointe eye care from Ameritas Group features the money-saving eye care network of **EyeMed Vision Care**. Customer service is available to plan members through **EyeMed's** well-trained and helpful service representatives. Call or go online to locate the nearest **EyeMed Access network** provider, view plan benefit information and more.

EyeMed Customer Care Center: 1-866-289-0614

- Service representative hours: 8 a.m. to 11 p.m. ET Monday through Saturday, 11 a.m. to 8 p.m. ET Sunday
- Interactive Voice Response available 24/7

Locate an EyeMed provider at: www.eyemedvisioncare.com
View plan benefit information at www.ameritas.com/group/olbc/UNITEhere

Lens Options (member cost)

	EyeMed Access Network	Out of Network
Progressive Lenses		No benefit
Standard **Premium**	Standard: $65 + lens deductible Premium: lens cost - 20% discount - $120 allowance + Standard Progressive cost	
Std. Polycarbonate	$40	No benefit
Tint (solid and gradient)	$15	No benefit
Scratch Resistant Coating	$15	No benefit
Anti-Reflective Coating	$45	No benefit
Ultraviolet Coating	$15	No benefit
Lasik or PRK	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers.	No benefit

UNITE HERE!

Ameritas

Additional ViewPointe® H Features

EyeMed In-Network Secondary Purchase Plan	Members receive a 40% discount on a complete pair of glasses once the funded benefit has been exhausted. Members receive a 15% discount off the retail price on conventional contact lenses once the funded benefit has been exhausted. Discount applies to materials only.
Contact Lens Replacement by Mail Program	After exhausting the contact lens benefit, replacement lenses may be obtained at significant discounts on-line. Visit EyeMedvisioncare.com for details.

eCard

Once you are enrolled in the plan, your plan member ID card is provided electronically. Access your eCard online by creating a Secure Member Account – it's fast, easy and secure. Go to ameritas.com, click on account access (at top right), select Dental/Vision/Hearing, then Secure Member Account.

Enrolled members may receive care without the card just by giving the provider their name, date of birth, and social security number/member identification number.

Rx Savings

Our valued plan members and their covered dependents can save on prescription medications at over 60,000 pharmacies across the nation including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

To receive this Rx discount, Ameritas plan members just need to visit us at ameritas.com and sign into (or create) a secure member account where they can access and print an online-only Rx discount savings ID card.

Worldwide Support

When our members travel abroad, they'll have peace of mind knowing that should a dental or vision need arise, help is just a phone call away. Through AXA Assistance, Ameritas offers its dental and vision plan members 24-hour access to dental or vision provider referrals when traveling outside the U.S.

Immediately after a call is made to AXA, an assistance coordinator assesses the situation, provides credible provider referrals and can even assist with making the appointment. Within 48 hours following the appointment, the coordinator calls the member to find out if additional assistance is needed. If all is well, the case is closed. Then, the plan member may submit a claim to Ameritas for reimbursement consideration based on applicable plan benefits. Contact AXA Assistance USA toll free by calling 866-662-2731, or call collect from anywhere in the world by dialing 1-312-935-3727.

Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

UNITE HERE Northwest Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website www.heretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

December 30, 2016

TO: All Eligible Participants
UNITE HERE Northwest Health Trust Fund

RE: Prescription Drug Benefit Changes Effective January 1, 2017

This is a Summary of Material Modification describing changes adopted by the Board of Trustees. Please be sure that you and your family read this information carefully and keep it with your Plan Booklet.

Usted puede solicitar ayuda de traducción en español llamando a la Oficina de Administración al número telefónico que aparece arriba.
Maaari kang humiling ng pagsasalin ng tulong mula sa Admistration Office sa Tagalog sa pamamagitan ng pagtawag sa numero ng telepono na nakalista si itaas.
Bạn có thể yêu cầu hỗ trợ dịch tiếng Việt từ Văn phòng Cục Quản lý bằng cách gọi số điện thoại được liệt kê ở trên.
你可以通过调用行政办公室在上面列出的电话号码，请求帮助中国的翻译。
Вы можете обратиться за помощью в переводе на русский язык по телефону Управления Администрации по номеру телефона , указанному выше.

This notice is to inform participants in the UNITE HERE Northwest Health Trust Fund ("the Trust") of changes to the Prescription Drug benefit effective **January 1, 2017.**

Flu Vaccines
Effective January 1, 2017, the Trust will cover Flu Vaccinations at the pharmacy with $0 copay.

Before you visit the pharmacy:

- Make sure the pharmacy you use is part of OptumRx participating pharmacy network. If you are not sure, please log on to www.optumrx.com/myCatamaranRx or you may call OptumRx Member Services at (888) 354-0090.
- Call the pharmacy to verify they provide flu vaccinations, availability and age restrictions.
- Present your combination medical and prescription ID card to the pharmacy.

Should you have questions regarding participating pharmacies or any of these updates within your prescription drug benefit, please contact OptumRx Customer Service Help Desk at (888) 354-0090. The OptumRx Help Desk will assist you with prescription questions 24 hours a day, 7 days a week. You may also contact the Administration Office for any additional questions at (800) 331-6158, option 0.

Board of Trustees
UNITE HERE Northwest Health Trust Fund

UNITE HERE Northwest Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website www.heretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

November 18, 2016

TO: **All Eligible Participants**
UNITE HERE Northwest Health Trust Fund

RE: **Summary of Material Modification – Benefit Changes Effective January 1, 2017**

This is a summary of material modifications describing recent benefit changes adopted by the Board of Trustees. Please be sure you and your family read it carefully and keep it with your plan booklet.

Usted puede solicitar ayuda de traducción en español llamando a la Oficina de Administración al número telefónico que aparece arriba.
Maaari kang humiling ng pagsasalin ng tulong mula sa Admistration Office sa Tagalog sa pamamagitan ng pagtawag sa numero ng telepono na nakalista si itaas.
Bạn có thể yêu cầu hỗ trợ dịch tiếng Việt từ Văn phòng Cục Quản lý bằng cách gọi số điện thoại được liệt kê ở trên.
你可以通过调用行政办公室在上面列出的电话号码，请求帮助中国的翻译。
Вы можете обратиться за помощью в переводе на русский язык по телефону Управления Администрации по номеру телефона , указанному выше.

The Board of Trustees is pleased to inform you of important benefit improvements made to the UNITE HERE Northwest Health Trust Fund that will go into effect **January 1, 2017**.

Traditional Dental Plan Fee Schedule
The HERE Traditional dental plan covers preventive services and services necessary for the diagnosis and treatment of dental disease. You may visit the dentist of your choice; however, benefits are only paid up to the amounts listed on the Schedule of Dental Benefits. Effective January 1, 2017, the fee schedule has been increased, an updated schedule is enclosed.

The Trust has an agreement with Pacific Dental Alliance (or Access Dental Alliance for Oregon participants). The Pacific Dental Alliance/Access Dental Alliance providers will accept the Trust's dental plan allowance as payment in full. This means that eligible participants will pay nothing for covered dental care up to the annual Plan maximum except for copays.

As a reminder, the Trust also has Cigna as a Dental Preferred Provider Organization (DPPO) in addition to Pacific Dental Alliance. Under the Cigna arrangement, contract providers offer dental services and supplies at a discounted fee to you and your eligible dependents.

It is important to note, if you are enrolled in the Willamette Dental Group option the updated dental fee schedule and dental providers mentioned above do not apply to you.

over

Vision Benefit Schedule
If you and your dependents are eligible for vision coverage, Vision Care Benefits will be paid up to the amounts listed on the Vision Schedule. Effective January 1, 2017, the fee schedule has been increased, an updated schedule is enclosed.

National Vision Care Centers are the Preferred Optical Provider. National Vision Care providers will accept the Trust's Vision Schedule amounts as payment in full.

To determine if you are eligible for vision benefits contact the Administration Office at the number listed below.

Neurodevelopmental Benefits
The Trust is expanding its neurodevelopmental benefits to broaden coverage for developmental delays in speech, language and gross motor skills, typically called Applied Behavioral Analysis (ABA) Therapy, and includes coverages for common diagnoses of autism, dyslexia and Attention Deficit Disorder (ADD). All procedures, services and treatment must meet certain criteria and be considered medically necessary. For additional information regarding these benefits, contact the Administration Office at the number below.

Please read these documents carefully and keep this letter with your Health Plan Booklet and other important Trust documents so you can refer to them when necessary.

If you have any questions regarding these new benefit changes, please contact the Administration Office at 1-800-331-6158, option 0.

For easy access to Trust information and forms, visit the website at www.heretrust.com.

Trust Administration Office
UNITE HERE Northwest Health Trust Fund

CJ\AG:lmm opeiu#8
S:\Mailings\Individual Trust Fund Mailings (SMM, Benefit Changes, etc.)\F19\F19-00 - Mailings - 2016 - 11.18 - Benefit Changes - Eff. 2017-01-01.doc

UNITE HERE Northwest Health Trust Fund

SCHEDULE OF DENTAL BENEFITS EFFECTIVE JANUARY 1, 2017
PACIFIC DENTAL ALLIANCE

Procedure Code	Procedure Description	Benefit Allowance	
		Current Rate	Rate Effective January 1, 2017
Diagnostic			
210	X-ray – Complete Series	$75	$90
Preventive			
1110	Prophylaxis – Adult	$90	$100
1120	Prophylaxis – Child	$42	$50
Restorative			
2330	Resin – 1 Sur. Anterior	$125	$150
2331	Resin – 2 Sur. Anterior	$150	$175
2332	Resin – 3 Sur. Anterior	$175	$225
2391	Comp Resin – 1 Sur. Post	$125	$150
2392	Comp Resin – 2 Sur. Post	$150	$175
2393	Comp Resin – 3 Sur. Post	$180	$225
Crowns			
2740	Porcelain	$500	$600
2750	Porcelain w/ High Nob. Mlt	$575	$625
2451	Porcelain w Base metal	$400	$600
2950	Crown Buildup	$126	$150
Endodontics			
3310	Root Canal Therapy -1	$500	$600
3320	Root Canal Therapy - 2	$600	$700
3330	Root Canal Therapy - 3	$700	$800
Periodontics			
4341	Perio. Scaling and R.P.	$125	$150
4910	Periodontal Maintenance	$125	$150

SCHEDULE OF VISION BENEFITS EFFECTIVE JANUARY 1, 2017
NATIONAL VISION

Code	Description	Benefit Allowance	
		Current Rate	Rate Effective January 1, 2017
401	Eye exam with refraction	$60	$72
512	Two lenses, single vision	$50	$60
522	Two lenses, bifocal	$80	$96
532	Two lenses, trifocal	$100	$120
602	Two contact lenses	$100	$120
603	Disposable contact lenses	$100	$120
800	Frames	$50	$60

UNITE HERE Northwest Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website www.heretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

September 30, 2016

TO: All Eligible Participants
UNITE HERE Northwest Health Trust Fund

RE: Prescription Drug Benefit Changes Effective December 1, 2016

This is a Summary of Material Modification describing changes adopted by the Board of Trustees. Please be sure that you and your family read this information carefully and keep it with your Plan Booklet.

This notice is to inform participants in the UNITE HERE Northwest Health Trust Fund ("the Trust") of changes to the Prescription Drug benefit effective **December 1, 2016.**

The following prescription drug clinical programs have been adopted by the Trust and will be implemented effective December 1, 2016:

Me Too Drug Exclusion
"Me Too" drugs are chemically similar compounds that share the same mechanism of action to an existing, approved chemical entity and offer no significant clinical benefit.

The Trust will exclude products that meet the following:

- Approved for same indication as another FDA approved product
- Similar mechanism of action as an existing molecular entity
- Same route of administration as an existing product approved by the FDA.
- Similar efficacy and safety outcome with no significant clinical benefit over an existing product for the majority of users.
- If combination product, it's already available as single-ingredient products.

Non Essential Drug Exclusion List
The drugs in this list have been excluded to address the increasing number of non-FDA approved products in the marketplace that are leading to potential health risks and contributing to significant prescription costs.

Drugs that will be excluded from the prescription drug benefit include high cost, non-FDA approved pain patches and creams containing menthol and lidocaine. Some examples of these medications include Synvexia, Qroxin and Relyyt.

SECURE Compound Strategy
Compound medications are "made from scratch" prescriptions and individual ingredients are mixed together in the exact strength and dosage form required by the patient.

All compound medications over $300 will require a clinical prior authorization to ensure the compound prescription meets the FDA approved indication for use. The Trust will not cover the billing of compound kits and bulk chemicals.

This new exclusion will not affect the hormone therapies that are currently covered and fall within the coverage guidelines of the Plan document.

Clinical Prior Authorization
Certain non-specialty medications will require prior authorization. This program will ensure appropriate utilization and dosing as recommended by the FDA and patient safety of non-specialty medications.

Quantity Level Limit Program
This program manages drug costs by aligning the dispensed quantity of medication with FDA approved dosage guidelines.

Step Therapy Program

What is a Step Therapy Program?
The Step Therapy program is designed specifically for patients with certain conditions that require taking non-specialty medications regularly. This program promotes the safe and effective use of a less expensive, yet clinically effective therapeutic alternative medication. It is the practice of beginning medication therapy for a medical condition with the most cost-effective medication (generic) and progressing to other costlier medication(s) should the initial medication not provide adequate therapeutic benefit. The step therapy approach to care is a way to provide you with savings without compromising your quality of care.

How does the Step Therapy Program work?
In step therapy, medications are grouped into two categories.

- Step 1: First Line medications – medications proven safe, effective, and affordable (generic).
- Step 2: Second Line medications – mostly higher costing brand name medications.

You will first be required to try a recognized First Line medication (Step 1) before approval of a more costly and complex therapy is approved (Step 2). If the Step 1 therapy does not provide you with the therapeutic benefit desired, your physician may write a prescription for a Step 2 medication.

Am I subject to the Step Therapy Program?
Step Therapy Program will apply for new prescriptions on or after December 1, 2016. If you are currently preauthorized for the use of a prescription drug in the Second Line medication and quantity limit, you are not required to go through the Step Therapy Process and you may continue to take your current medication. Step Therapy will only apply to new prescriptions for non-specialty prescription drugs.

Jublia
Jublia will be excluded from the prescription benefit program. Jublia is a nail lacquer used to treat nail fungus.

If you are affected by any of the clinical programs outlined above, OptumRx will mail you a letter with additional information. Please watch your mail.

Should you have questions regarding participating pharmacies or any of these updates within your prescription drug benefit, please contact OptumRx Customer Service Help Desk at (888) 354-0090. The OptumRx Help Desk will assist you with prescription questions 24 hours a day, 7 days a week. You may also contact the Administration Office for any additional questions at (800) 331-6158.

Board of Trustees
UNITE HERE Northwest Health Trust Fund

UNITE HERE Northwest Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website www.heretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

May 17, 2016

TO: All Participants
UNITE HERE Northwest Health Trust Fund

Dear Participant:

You recently received materials regarding changes to your Health Trust coverage. The change to Aetna's Preferred Provider Organization (PPO) is being made to improve service, to expand access to doctors, and to make payment procedures more efficient. **At the request of the Union and Employer Trustees of the Fund, the change to Aetna's PPO for your health care coverage is being delayed until further notice.**

The extra time will allow us to provide additional materials and to have some items translated into multiple languages. When the Trust changes to the Aetna PPO you will receive a new health identification card, **but you will be able to continue to use it for the same services you have always used.**

Included in the previous materials was a notice regarding your Dental Plan options. If you want to change your current Dental Plan status, please follow the instructions outlined in those materials.

If you have questions regarding this notice or your Dental Plan options, please contact the Trust Administration Office at (800)732-1121, option 4.

Sincerely,

Eric Van Rossum
Chairman

Howard Cohen
Secretary

PARA: Todos los participantes
UNITE HERE Northwest Health Trust Fund

Estimado participante:

Hace poco tiempo recibió materiales sobre cambios en su cobertura de Health Trust. El cambio a la Organización de Proveedores Preferidos (PPO, por sus siglas en inglés) de Aetna

está realizándose para mejorar el servicio, ampliar el acceso a médicos y hacer que los procedimientos de pago sean más eficientes. **A pedido de los Síndicos del Fondo, tanto del sindicato como empleadores, el cambio a la PPO de Aetna relacionado con su cobertura de asistencia médica se postergará hasta nuevo aviso.**

El tiempo adicional nos permitirá proporcionarle más materiales y traducir algunos textos a varios idiomas. Cuando la empresa fiduciaria cambie a la PPO de Aetna, usted recibirá nuevas tarjetas de identificación de salud, **pero en el momento de hacer uso de los servicios en la fecha de entrada en vigencia de Aetna o con posterioridad, podrá seguir usándolas para los mismos servicios que siempre ha utilizado.**

Los materiales anteriores incluyeron un aviso sobre sus opciones de Plan Dental. Si desea cambiar su estado actual respecto del Plan Dental, sírvase seguir las instrucciones descritas en esos materiales.

Si tiene preguntas sobre este aviso o sus opciones de Plan Dental, llame a la Oficina de Administración de la Empresa Fideicomisaria al (800)732-1121, opción 4.

PARA SA: Lahat ng Mga Kalahok
UNITE HERE Northwest Health Trust Fund

Mahal na Kalahok:

Kamakailan lang ay nakatanggap kayo ng mga materyal hinggil sa mga pagbabago sa inyong pagkakasakop sa Health Trust. Ginagawa ang mga pagbabago sa Preferred Provider Organization (PPO) ng Aetna para mapahusay ang mga serbisyo, mapalawak ang access sa mga doktor, at para gawing mas episyente ang mga pamamaraan sa pagbabayad. **Sa kahilingan ng Unyon at Employer Trustees ng Fund, naantala ang mga pagbabago sa PPO ng Aetna para sa inyong pagkakasakop sa pangangalagang pangkalusugan hanggang sa susunod na abiso tungkol dito.**

Ang dagdag na panahon ay makakapagpahintulot sa amin na makapagkaloob sa inyo ng karagdagang mga materyal at para mapasalin-wika sa maramihang mga wika ang ilang mga bagay-bagay. Kapag nagbago ang Trust sa Aetna PPO ay makakatanggap kayo ng bagong mga ID card na pangkalusugan, **ngunit patuloy ninyong magagamit ang mga ito para sa parehong mga serbisyo na dati na ninyong nagagamit kapag ang mga serbisyo ay natamo sa o makalipas ang petsa ng bisa ng Aetna.**

Kasama sa mga dating materyal ay isang abiso hinggil sa inyong mga opsyon para sa Planong Dental. Kung nais ninyong baguhin ang inyong kasalukuyang katayuan para sa Planong Dental, mangyari lang sundin ang mga tagubilin na nakabalangkas sa mga materyal na iyon.

Kung mayroon kayong mga tanong hinggil sa abisong ito o sa inyong mga opsyon sa Planong Dental, mangyari lang makipag-ugnayan sa Tanggapan ng Trust Administration sa (800)732-1121, piliin ang opsyon 4.

GỬI: Mọi Người Tham Gia
UNITE HERE Northwest Health Trust Fund

Kính gửi Người Tham Gia:

Gần đây quý vị đã nhận được các tài liệu về những thay đổi cho phạm vi bảo hiểm của Health Trust. Thay đổi đối với Preferred Provider Organization (PPO) của Aeta được thực hiện để nâng cao dịch vụ, để mở rộng việc tiếp cận đến các bác sĩ, và để quy trình thanh toán được hiệu quả hơn. **Theo yêu cầu của Union and Employer Trustees of the Fund, thay đổi đối với PPO của Aetna về phạm vi bảo hiểm sức khỏe của quý vị được lùi lại cho tới khi có thông báo thêm.**

Thời gian kéo dài thêm cho phép chúng tôi cung cấp cho quý vị thêm các tài liệu và dịch được một số mục sang nhiều ngôn ngữ. Khi quỹ Trust đưa ra các thay đổi đối với PPO Aetna, quý vị sẽ nhận được các thẻ nhận dạng y tế mới, **nhưng quý vị sẽ có thể tiếp tục sử dụng chúng cho các dịch vụ tương tự mà quý vị đã sử dụng khi dịch vụ được cung cấp vào hoặc sau ngày hiệu lực của Aetna.**

Bao gồm trong các tài liệu trước đây là một thông báo về các lựa chọn cho Dental Plan của quý vị. Nếu quý vị muốn thay đổi trạng thái Dental Plan, hãy làm theo các hướng dẫn có trong các tài liệu này.

Nếu quý vị có thắc mắc liên quan đến thông báo này hoặc tùy chọn Dental Plan, xin vui lòng liên hệ với văn phòng Trust Administration theo số (800)732-1121, lựa chọn 4.

КОМУ: Всем участникам
НАША СИЛА В ЕДИНСТВЕ Северо-западный целевой фонд общественного здравоохранения (Northwest Health Trust Fund)

Уважаемый участник!

Недавно Вы получили материалы с информацией об изменениях в Вашем плане медицинского страхования, предоставляемом Фондом общественного здравоохранения Health Trust. В целях повышения качества медицинского обслуживания, расширения доступа к медицинским работникам и оптимизации процедуры оплаты услуг, в Организации предпочитаемых поставщиков медицинских услуг компании Aetna (Aetna's Preferred Provider Organization, PPO) проводятся некоторые изменения. **По настоянию членов правления Фонда, внесение вышеупомянутых изменений в PPO компании Aetna относительно плана Вашего медицинского страхования откладывается до дальнейшего уведомления.**

За это время мы сможем предоставить Вам дополнительные материалы и перевести некоторые документы на другие языки. После того, как инициированные Фондом изменения в PPO вступят в силу, Вы получите новые страховые идентификационные карточки, **и сможете пользоваться ими для получения тех же медицинских услуг, что и всегда, даже после истечения срока действия плана компании Aetna.**

Ранее Вы получили уведомление о вариантах условий Вашего страхового плана для покрытия расходов на услуги стоматолога (Dental Plan). Если Вы хотите изменить свой статус в Dental Plan, следуйте инструкциям, приведенным в вышеупомянутом письме.

Если у Вас есть какие-либо вопросы в отношении этого уведомления или вариантов условий Dental Plan, свяжитесь с Управлением Администрации Фонда по телефону (800)732-1121, доб. 4.

致： **所有参与者**
团结起来西北医疗信托基金（UNITE HERE Northwest Health Trust Fund）

亲爱的参与者：

您最近收到了有关您的健康信托支付范围变动的材料。安泰的首选提供商组织（PPO）**有了一些**变化，以便改善服务，让更多的医生向病人开放，并使支付程序更加高效。**在工会和基金的雇主受托人的要求下，安泰PPO有关您的健康医疗保险支付范围的变动被推迟了，我们会另行通知。**

这将给我们一点额外的时间，为您提供额外的材料，并把某些项目翻译成多种语言。信托对安泰PPO**作出**变动时，**您将收到新的健康保**险身份证，**但是，您可以继续使用该身份证，在安泰生效日当天或以后接受您已经接受的同样的服务。**

以前的材料中包括关于您的牙科计划选项的通知。如果您想改变您目前的牙科计划，请按照这些材料中列出的说明进行。

如果您对本通知或您的牙科计划的选项问题，请联系信托管理办公室，号码：（800）732-1121，选择4。

UNITE HERE Northwest Trust Funds

2815 SECOND AVENUE • SUITE 300 • P.O. BOX 34203 • SEATTLE, WASHINGTON 98124
TELEPHONE (206) 441-7574 • TOLL-FREE (800) 732-1121 • FAX (206) 505-WPAS (9727) • www.heretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

May 2, 2016

TO: All Plan Participants
UNITE HERE Northwest Health Trust Fund

RE: New Preferred Provider Organization (PPO) Effective June 1, 2016

This is a Summary of Material Modification describing changes adopted by the Board of Trustees. Please be sure that you and your family read this information carefully and keep it with your Plan Booklet.

Usted puede solicitar ayuda de traducción en español llamando a la Oficina de Administración al número telefónico que aparece arriba.
Maaari kang humiling ng pagsasalin ng tulong mula sa Admistration Office sa Tagalog sa pamamagitan ng pagtawag sa numero ng telepono na nakalista si itaas.
Bạn có thể yêu cầu hỗ trợ dịch tiếng Việt từ Văn phòng Cục Quản lý bằng cách gọi số điện thoại được liệt kê ở trên.
你可以通过调用行政办公室在上面列出的电话号码，请求帮助中国的翻译。
Вы можете обратиться за помощью в переводе на русский язык по телефону Управления Администрации по номеру телефона , указанному выше.

Preferred Provider Organization
The Trustees of the UNITE HERE Northwest Health Trust Fund ("the Trust") have selected Aetna to replace First Choice Health Network and Providence Preferred as the Preferred Provider organization (PPO) effective **June 1, 2016**. Aetna will also replace First Choice Health Network and Providence Preferred for Medical Review, Utilization Review and Individual Case Management. The Administration Office will continue to process your health claims.

Aetna is a nationwide insurance carrier with participating providers in all areas. The out-of-area provision of the plan will no longer apply. All services received by a Non-Preferred Provider on or after June 1, 2016 will be paid after deductible according to the out-of-network allowed amount at a reduced coinsurance level for covered services.

Aetna Navigator Website
You can access PPO provider directories and all of the online tools available on the Aetna Navigator website, by registering online after June 1, 2016. Until then, if you wish to review Aetna's provider network, you may search for providers at **www.Aetna.com/docfind**. Select the "Aetna Choice® POS II (Open Access)" network.

Aetna-contracted providers have agreed to provide services and supplies at a discounted fee to you and your eligible dependents covered by the Trust, which in turn helps the Trust control costs and reduces your out-of-pocket costs. While you may select any provider or hospital for services and care, non-PPO services will result in a lesser payment by the Trust; as a result, you will be responsible for a greater share of the cost of the claim.

over

New Identification (ID) Cards

New ID cards identifying you as an Aetna network member will be mailed to you by May 31, 2016. Your new ID cards will contain information for Medical, Dental, Vision and Prescription Drug benefits. **Please watch your mail for the new cards and begin presenting them for services received on or after June 1, 2016.** If you find errors on your newly issued ID cards or do not receive your cards prior to June 1, 2016, please contact the Administration Office immediately.

If you have any question regarding the information outlined in this notice, please contact the Administration Office at (206) 441-7574 or (800) 331-6158, option 0.

Administration Office
UNITE HERE Northwest Health Trust Fund

This 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 this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 800-331-6158, option 0. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

UNITE HERE Northwest Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website www.heretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

March 29, 2016

TO: All Participants Eligible for Dental Benefits
UNITE HERE Northwest Health Trust Fund

RE: New Dental Identification Cards

Temporary Dental ID Cards.
As per notice dated February 1, 2016, Cigna will become an additional Dental Preferred Provider Network. Here is your new temporary dental identification (ID) card. This ID card identifies you as a member of the *Cigna Dental Shared Administration –Dental PPO Plus* network beginning **April 1, 2016**.

Please review the ID card below and make sure your name and member ID are listed correctly. Report any errors to the Administration Office at (206) 441-7574, option 4.

Present this new ID card to your dental providers for services received on or after **April 1, 2016**. Keep in mind that your dental benefits are not changing and that you may continue to select the dental provider of your choice. However, because Cigna's contracted providers have agreed to discounted fees, your out-of-pocket costs will typically be lower when you use a Cigna dentist.

To confirm whether or not your dental provider is part of the Cigna network, please complete any of the following: Call (800) 797-3381, or visit www.cignadentalsa.com and select the *Cigna Dental Shared Administration - Dental PPO Plus* option.

As a reminder, the Trust also has an agreement with Pacific Dental Alliance (or Access Dental Alliance for Oregon participants) which will remain. The Pacific Dental Alliance/Access Dental Alliance providers will accept the Trust's dental plan allowance as payment in full. This means that eligible participants will pay nothing for covered dental care up to the annual Plan maximum except for copays.

Permanent Dental ID Cards --You will receive permanent plastic ID cards by May 31, 2016.

TEMPORARY ID CARD

Front

Dental Shared Administration - Dental PPO Plus
UNITE HERE Northwest Health Trust

Cigna.

Participant Name:

Participant Number:

Plan ID: 3339713

WPAS

To locate a network dentist go to:
www.cignadentalsa.com or call 1.800.797.3381
Customer Service for Providers: 1.800.735.7053
Customer Service for Members: 1.800.331.6158

Mail Claims to: UNITE HERE, PO Box 34355, Seattle, WA 98124
Electronic Claims to: Emdeon Group F19 – Payer ID 91136
Do not send claims to Cigna; send to address above.

Back

Visit an in-network dentist for reimbursement or coverage at a discounted rate and you will have less out-of-pocket expenses. Or visit an out-of-network dentist for reimbursement or coverage at the out-of-network level.

You will pay less money out-of-pocket if you visit a network dentist.

Dental Shared Administration is a dental network access program offered by Cigna Dental to Taft-Hartley Funds and their contracted third party administrators. These funds have elected to self-fund and administer members' dental benefits, including processing and paying claims. Members of these Funds will have access to a subset of the Cigna Dental PPO network of participating providers. Dental Shared Administration is not an insurance program.

The card does not guarantee coverage. You must comply with all terms and conditions of the plan. Willful misuse of this card is considered fraud. Cigna Dental refers to the following operating subsidiaries of Cigna Corporation:

Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company and Cigna Dental Health, Inc., and its operating subsidiaries and affiliates.

If you have questions regarding the information contained in this notice, please contact the Administration Office at (206) 441-7574 or (800) 331-6158, option 4.

UNITE HERE Northwest Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website www.heretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

February 1, 2016

TO: All Eligible Plan Participants
UNITE HERE Northwest Health Trust

RE: Benefit Changes Effective April 1, 2016

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your 2009 Edition Summary Plan Description Booklet.

This notice is to inform participants in the UNITE HERE Northwest Health Trust of the following:

- BriovaRx will be the Trust's exclusive specialty pharmacy effective April 1, 2016.
- Cigna will be added as a Dental Preferred Provider Organization (DPPO) to the Trust's Traditional Dental Plan effective April 1, 2016. Your dental benefits are not changing. **This dental benefit change does not apply to participants currently enrolled in the Willamette Dental option.**

BriovaRx Specialty Drugs Preferred Pharmacy Provider
Effective **April 1, 2016** BriovaRx will be the exclusive provider for Specialty Drugs. Plan participants will require preauthorization from BriovaRx for all new Specialty Drug prescriptions. If you are currently preauthorized for the use of a Specialty Drug and quantity limit you do not require preauthorization through BriovaRx.

What are Specialty Drugs?
Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions, such as cancer, multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.

Who is BriovaRx?
BriovaRx is a pharmacy that is focused on providing you with the best possible care while you undergo specialty medication treatment.

What do I need to do?
If you are currently taking a Specialty Drug medication, you will receive a notice from BriovaRx or you can call them at 1-855-4BRIOVA (1-855-427-4682) to enroll right away. A Patient Care Coordinator can get you started by coordinating your order with your doctor.

Cigna Dental Preferred Provider Organization (DPPO)
Effective **April 1, 2016,** Cigna will be added as a Dental Preferred Provider Organization (DPPO) for the Trust in addition to Pacific Dental Alliance. Under this DPPO arrangement, Cigna contracted providers will provide dental services and supplies at a discounted fee to you and your eligible dependents covered by the Plan. **Your dental benefits are not changing.**

Your claims will continue to be processed by the Administration Office. All claims will continue to be paid up to the amount listed on the Plan's Schedule of Dental Benefits. You are responsible for the difference between what your dentist charges and what the Plan pays.

The Trust also has an agreement with Pacific Dental Alliance (or Access Dental Alliance for Oregon participants) which will remain unchanged. The Pacific Dental Alliance/Access Dental Alliance providers will accept the Trust's dental plan allowance as payment in full. This means that eligible participants will pay nothing for covered dental care up to the annual Plan maximum except for copays.

Dental benefits--other than orthodontic--are payable up to the dental annual maximum of $2,000 during each calendar year for you and each of your eligible adult dependents. Eligible dependents under the age of 18 are not subject to the annual Plan maximum. The lifetime maximum for dental expenses in connection with orthodontics is $635 for you and each of your eligible dependents. In order to receive the maximum plan benefits you must use a Pacific Dental Alliance or Cigna provider.

You may continue to select the dental provider of your choice. However, because Cigna's contracted providers have agreed to discounted fees, your out-of-pocket costs will typically be lower when you use a Cigna dentist. This will save both you and the Trust money.

Cigna Preferred Provider Directory
The Trust encourages you to verify that your dental provider is part of the Cigna network in one of the following ways:

- By calling (800) 797-3381, or
- By visiting www.cignadentalsa.com and selecting the "Cigna Dental Shared Administration - Dental PPO Plus" option.

Willamette Dental Group Option
Eligible participants will continue to have the option to choose the Willamette Dental Group option. Benefits under the Willamette Dental Group will remain the same.

IMPORTANT: If you are enrolled in Willamette Dental Group, you are required to remain on that plan until the next open enrollment period.

New Identification (ID) Card
New identification cards, identifying you as a member of the Cigna Dental Shared Administration - Dental PPO Plus network, will be mailed to you. Be sure to present your new ID card to your dental provider for services received on or after April 1. If you do not receive your new ID cards by April 1, please contact the Administration Office at one of the numbers below.

If you have any questions regarding the information outlined in this notice, please contact the Administration Office at (206) 441-7574 or (800) 732-1121, option 4.

Board of Trustees
UNITE HERE Northwest Health Trust

CJ:lmm opeiu#8
S:\Mailings\Individual Trust Fund Mailings (SMM, Benefit Changes, etc.)\F19\F19-02 - Mailings - SMM - 2016-02.01 - BriovaRx and Cigna DPPO - Effect 2016 - 04.01.docx

Hotel Employees Restaurant Employees Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website www.heretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

June 25, 2014

TO: All Participating Employees
Hotel Employees Restaurant Employees Health Trust

RE: Affordable Care Act – Changes to Trust Provisions Related to "Initial Eligibility" Requirements and Benefit Change Clarification

Important Information – *This is a summary of material modifications describing recent changes adopted by the Board of Trustees. Please be sure you and your family read it carefully. Keep this important notice with your HERE Health Plan Booklet.*

The Board of Trustees took recent action with regards to certain eligibility provisions in an effort to comply with the Affordable Care Act (ACA). Currently, "Initial Eligibility" is earned after the employer has made three consecutive months of contributions; followed by a lag month; with the Initial Eligibility recognized on the first day of the 5th month.

As a result of the Trustees action, the Initial Eligibility provisions have been changed. The new provisions are stated below:

Employees may receive benefits on the first day of the month following 59 days of employment, if the employer has made at least two monthly contributions.

These new provisions apply to both Eligibility Rule A and B and will go into effect beginning with **June 2014 employment hours**. The new eligibility provisions do not change the requirements for continuing eligibility.

Please contact the Administration Office at (206) 441-7574 or (800) 732-1121, option 4, if you have questions regarding eligibility requirements.

Clarification of June 1, 2014 Benefit Changes - On May 1st, the Administration Office mailed you a benefit change notice and a Summary of Benefits and Coverage.

Emergency Services – Effective with services obtained on and after June 1, 2014, pre-authorization for Emergency Services will no longer be required. The Plan covers certain emergency services provided in hospital emergency rooms when you are suffering from an emergency medical condition. You do not have to obtain pre-authorization before seeking emergency services in a hospital emergency room. The Plan will charge you the same copay and coinsurance whether you obtain those services from a PPO hospital or from a non-PPO hospital. However, if you obtain those services from an Out-of-Network hospital, that hospital may bill you the difference between what the hospital charges and the Plan's Usual, Customary and Reasonable allowance.

Preventive Care Benefits – Effective June 1, 2014, the Trust has added preventive care benefits with no cost sharing to your plan of benefits. These changes were included in the Summary of Benefits but were not outlined on the notice itself.

The Plan will pay 100% of the costs incurred for certain preventive services when those services are provided by a network preferred provider. This means that these services will not be subject to any deductible, and you will not have to pay any cost sharing (in other words, you will not have to pay coinsurance for these services) as long as services are provided by a network preferred provider. Preventive services obtained at a non-PPO provider are not covered.

The preventive services to which this new rule applies are those that are mandated by the Affordable Care Act. The required services include services that are highly recommended by the U.S. Preventive Services Task Force (for example, screening mammography every 1-2 years for women age 40 and older and colorectal cancer screening at specified intervals for adults age 50 to 75). In addition, certain pediatric preventive services such as well baby and well child care visits will be covered at specified intervals. You will also have coverage for immunizations for infants, children, adolescents, and adults as recommended by the Federal Centers for Disease Control and Prevention. A complete list can be reviewed at www.uspreventiveservicestaskforce.org.

The Preventive Care Services Benefit also includes a limited number of over-the-counter pharmaceuticals, paid at 100% when prescribed by your physician and purchased through the Plan's pharmacy network. These include:

- aspirin (325 mg and 81 mg) for cardiovascular disease
- fluoride supplementation for children age 6 and younger
- folic acid (0.4 mg and 0.8 mg) supplements for women of childbearing age
- iron supplements for infants less than a year old
- smoking cessation drugs and products are covered at 100% when you enroll in the Quit For Life® Program through Alere*. .For more information on this program visit www.quitnow.net or call 1-866-QUIT-4-LIFE (1-866-784-8454)

Please check with the Administration Office or Catamaran (the Pharmacy Benefit Manager) for limitations that may apply.

Preventive Care Services for Women – Effective June 1, 2014, the Plan will cover these preventive care services for women without any cost-sharing when they are provided by a PPO provider and in accordance with applicable recommendations and guidelines, a complete list can be reviewed at http://www.hrsa.gov/womensguidelines/:

- Well-woman visits
- Gestational diabetes screening
- Human papillomavirus DNA testing, every three years for women age 30 or older
- Sexually transmitted infections counseling for sexually-active women
- Human immunodeficiency virus (HIV) screening and counseling for sexually active women
- Access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- Breastfeeding support, supplies, and counseling
- Interpersonal and domestic violence screening and counseling

Please check with the Administration Office or Catamaran (the Pharmacy Benefit Manager) for limitations that may apply.

Eligible Dependents - Effective June 1, 2014, the plan will no longer exclude dependent children between the ages of 19 and 26 who have their own employer-based coverage. All dependent children under age 26 are now eligible to enroll regardless of whether they have their own employer-based coverage. ***Should you wish to enroll an eligible dependent that now qualifies for eligibility, please contact the Administration Office at (206) 441-7574 or (800) 732-1121, option 4.***

Trust Website – All Trust forms and plan booklets are available for review and download on the Trust's website at: **www.heretrust.com**. We encourage you to visit the website whenever you have questions regarding your benefits.

This 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 this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 800-331-6158, option 0. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Board of Trustees
Hotel Employees Restaurant Employees Health Trust

CJ:lmm opeiu#8
S:\Mailings\Individual Trust Fund Mailings (SMM, Benefit Changes, etc.)\F19\F19-02 - Mailings - 2014 - 06.25 - Eligibility Provision Change - ACA - Employees.docx

Hotel Employees Restaurant Employees Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website www.heretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

May 1, 2014

To: All Participants
Hotel Employees Restaurant Employees Health Trust

Re: Benefit Changes Effective June 1, 2014

Important Information – *Please be sure that you and your family read this notice carefully and keep it with your benefit booklet or important insurance papers for future reference.*

Effective June 1, 2014, the Plan is being amended to reflect changes required pursuant to the Affordable Care Act. The changes are summarized below. This notice should be considered an insert to your Summary Plan Description and Plan Document (Health Plan Booklet).

Eligible Dependents – Effective June 1, 2014, the plan will no longer exclude dependent children between the ages of 19 and 26 who have their own employer-based coverage. All dependent children under age 26 are now eligible to enroll regardless of whether they have their own employer-based coverage.

Annual Maximum Benefit – For services incurred on and after June 1, 2014, the $2 million annual maximum benefit on Essential Medical Benefits will be removed. Essential Medical Benefits are defined in accordance with Federal Regulations.

Elimination of Pre-existing Conditions Limitations – Effective June 1, 2014, the Plan's pre-existing conditions limitations no longer apply to any participant regardless of age.

Summary of Benefits and Coverage (SBC) – In accordance with the Patient Protection and Affordable Care Act as amended, the Trust is required to provide a SBC to all participants and beneficiaries. The enclosed SBC is for the plan option in which you are currently enrolled. *Please note, the SBC furnished to the participant will be considered provided to dependents unless the Plan has been advised of a different address for dependents.*

A **Uniform Glossary of Terms** has also been published by the government. This document is intended to describe terms commonly used in health insurance coverage, such as "deductible" and "copayment." Both the SBC and the Uniform Glossary of Terms have been posted to the Trust's website at **www.heretrust.com** or you can call the Administration Office at the number below.

This 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 this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 800-331-6158, option 0. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Please keep this important notice with your Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions or need any additional information, please contact the Administration Office.

Receipt of this notice does not constitute a determination of benefits or your eligibility. If you wish to verify benefits or eligibility, please contact the Administration Office at (800) 331-6158, option 0.

Board of Trustees
Hotel Employees Restaurant Employees Health Trust

Cj:lmm opeiu#8
S:\Mailings\Individual Trust Fund Mailings (SMM, Benefit Changes, etc.)\F19\F19-02 - Mailing - 2014 - 05-02 - Benefit Changes Eff 2014-06-01.docx

Hotel Employees Restaurant Employees Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website www.heretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

May 28, 2013

TO: All Participants of the Hotel Employees Restaurant Employees Health Trust

RE: New Benefit

Long-term Disability Insurance Coverage

This is a summary of material modifications describing recent benefit changes adopted by the Board of Trustees. Please be sure you and your family read it carefully. Keep this important notice with your June 1, 2004 HERE Health Plan Booklet.

The purpose of this notice is to inform you of a new benefit program that will go into effect under the Health Trust effective June 1, 2013.

Monthly Benefit – Under the new provisions, you may be eligible for a benefit of up to 60% of your monthly covered earnings — to a maximum of $1,000 per month if you sustain a long-term disability.

Definition of Disability – Disability means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation and you are unable to earn 80% or more of your earnings from working in your regular occupation. After benefits have been payable for 12 months, you are considered disabled if solely due to your injury or sickness, you are unable to perform the material duties of any occupation for which you are (or may reasonably become) qualified by education, training or experience, and you are unable to earn 60% or more of your earnings. The insurance company who will pay these benefits may require proof of other earnings you may have during the period of disability; as well as medical verification of your disability.

Covered Earnings – Covered earnings means your wages or salary, not including bonuses, commissions and other extra compensation.

Elimination Period – You must be disabled for 120 days before benefits may be payable.

Benefit Duration – Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit period shown below, or until you no longer qualify for benefits, whichever occurs first.

Your benefit period begins on the first day after you complete your elimination period. And, should you remain disabled, your benefits continue according to the following schedule, depending on your age at the time you become disabled.

Age at Disability	Age 62 or younger	63	64	65	66	67	68	69+
Duration of Payments (months)	5 years or the date the 42nd monthly benefit is payable, if later	36	30	24	21	18	15	12

The full details of the new benefit coverage are summarized in a separate document, which can be accessed on the Trust website, **www.heretrust.com**, or obtained from the Administration Office.

If you have any questions regarding these new benefit changes, please contact Maria Cossio, Trust Coordinator as follows:

Toll Free: 1-800-253-4373
(206) 728-2326, Ext 2981
maria@unitehere8.org

Or, you can call the Administration Office at 1-800-331-6158.

Trust Administration Office
Hotel Employees Restaurant Employees Health Trust

GG:lmm opeiu#8
S:\SHARE SEC\Mailings\SMM\F19-02 - 2013 - 05.21 - HERE Health Trust Benefit Summary - LTD - Eff 06.01.13.doc

Hotel Employees Restaurant Employees

Hotel Employees Restaurant Employees Trust Funds

2815 SECOND AVENUE • SUITE 300 • P.O. BOX 34203 • SEATTLE, WASHINGTON 98124
TELEPHONE (206) 441-7574 • TOLL-FREE 1-800-732-1121 • FAX (206) 505-WPAS (9727)

Administered by
Welfare & Pension Administration Service, Inc.

April 23, 2013

To: **All Participants**
Hotel Employees Restaurant Employees Health Trust

Subject: **Summary of Material Modification and Summary of Benefits and Coverage**

This is a summary of material modifications describing recent benefit changes adopted by the Board of Trustees. Please be sure you and your family read it carefully. Keep this important notice with your June 1, 2004 HERE Health Plan Booklet.

Annual Open Enrollment – Enclosed are the annual open enrollment materials for your dental coverage. The deadline to change your dental plan election is **May 17, 2013.**

Annual Maximum Benefit for 2013 – The Plan's annual maximum benefit will increase to $2,000,000. The annual limit shall apply to the greater of $2,000,000 in claims for all medical benefits or $2,000,000 in claims for Essential Medical Benefits incurred from June 1, 2013 through May 31, 2014.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) – MHPAEA requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance abuse disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

MHPAEA will become effective for this Plan on June 1, 2013. Therefore, effective with dates of service on or after June 1, 2013, treatment for mental health or substance abuse disorders will be paid as any other medical condition and are subject to medical necessity provisions. The specific Plan changes are as follows:

Mental Disorders

- The visit limits for outpatient services will be removed.
- The inpatient day limits will be removed.

Summary of Benefits and Coverage – In accordance with the Patient Protection and Affordable Care Act as amended; the Trust is required to provide a **Summary of Benefits and Coverage** (SBC) to all participants and beneficiaries. There are two SBCs enclosed, one for eligibility Rule A, Family Coverage and one for eligibility Rule B, Employee Only Coverage. *Please note, the SBC furnished to the participant will be considered provided to dependents unless the Plan has been advised of a different address for dependents.*

It is important to note that the SBC is only a **summary** and does not replace the Summary Plan Description (plan booklet). Included in the SBC are "coverage examples", which estimate what the plan

benefit would be under two common medical situations. If you are eligible or enrolled in Medicare or have primary coverage through another group health plan, this plan's benefits will be coordinated with that other plan and differ from what's indicated in the SBC, and the coverage examples. **The SBC is not intended to be a cost estimator and should not be used to estimate your actual costs.**

A **Uniform Glossary of Terms** has also been published by the government. This document is intended to describe terms commonly used in health insurance coverage, such as "deductible" and "copayment" Both the SBC and the Uniform Glossary of Terms have been posted to the Trust's website at **www.heretrust.com** or you can call the **Administration Office at (800) 331-6158, option 0**.

Grandfather Status – This 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 this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administration Office at 800-544-5085, option 0. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This 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 this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administration Office at 800-331-6158, option 0. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Board of Trustees
Hotel Employees Restaurant Employees Health Trust

CJ:lmm opeiu#8
S:\SHARED SEC\Mailings\SBC\F19-02 - 2013- 04.19 - SBC Cover Ltr - Plan A - Eff 06.01.2013.docx

Enclosure

Hotel Employees Restaurant Employees Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website www.heretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

December 28, 2012

Important Notice

TO: All Participants
Hotel Employees Restaurant Employees Health Trust

Re: Summary of Material Modification – Important Information Regarding Changes to the Weekly Disability Benefit

This is a summary of material modifications describing recent benefit changes adopted by the Board of Trustees. Please be sure you and your family read it carefully. Keep this important notice with your June 1, 2004 HERE Health Plan Booklet.

WEEKLY DISABILITY BENEFITS

Effective January 1, 2013, the weekly disability benefit will increase from $220 to $225 for participants receiving benefits under eligibility Rule A (Rule A eligibility applies to any participant who works a minimum of 65 or 80 hours per month, depending on the number of hours established under your collective bargaining agreement). For individuals who are receiving weekly disability benefits for a qualifying disability that began prior to December 31, 2012 and that continues on or after January 1, 2013, the 2013 portion of the qualifying disability period will reflect the new benefit.

Individuals who are receiving Trust Benefits under "Subrogation Provisions" may be eligible for weekly disability benefits effective with claims incurred on or after January 1, 2013. Previously, these benefits were not recognized as eligible benefits for subrogation (third-party liability) claims.

If you have any questions regarding these changes, please contact the Claims Department at (800) 331-6158, option 0.

Sincerely,

Board of Trustees
Hotel Employees Restaurant Employees Health Trust

GG:lmm opeiu#8
S:\Mailings\F19\F19-02 - 2012 - 12.28 - Weekly Disability SMM - Eff 01.01.2013.docx

Hotel Employees Restaurant Employees Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

September 6, 2012

To: **All Participants and Employers**
Hotel Employees Restaurant Employees Health Trust

Subject: **Summary of Material Modification**
Benefit Changes

PARTICIPANT NOTICE OF BENEFIT MODIFICATIONS
Please be sure you and your family read this notice carefully.
Keep this important notice with your June 1, 2004 HERE Health Trust Plan Booklet.

The Board of Trustees has approved the following benefit changes to your Plan:

Effective August 1, 2012

Domestic Partner Life Insurance: A domestic partner of a participant will be recognized as a dependent spouse for Trust life insurance benefits.

Effective October 1, 2012

Spinal Manipulation benefits: Services provided for manipulation of the spine and the spine's supporting structures. Benefits increase from 10 visits to 12 visits per calendar year. Benefits for Spinal Manipulation will be paid at 90% of Covered Expenses with no deductible when treatment is provided by a Preferred Provider and 60% of Covered Expenses with a $500 deductible when treatment is provided by a non-Preferred Provider.

Please keep this Notice with your summary plan description. Receipt of this notice does not constitute a determination of benefits or your eligibility. If you have any questions regarding your eligibility or benefits, please call the Administration Office at (800) 331-6158, option 0.

Sincerely,

Board of Trustees
Hotel Employees Restaurant Employees Health Trust

GG: lmm/ekl opeiu #8
S:\Docs\F19\F19-00 - 2012 - 09.05 - SMM.docx

Hotel Employees Restaurant Employees

Hotel Employees Restaurant Employees Trust Funds

2815 SECOND AVENUE • SUITE 300 • P.O. BOX 34203 • SEATTLE, WASHINGTON 98124
TELEPHONE (206) 441-7574 • TOLL-FREE 1-800-732-1121 • FAX (206) 505-WPAS (9727)

Administered by
Welfare & Pension Administration Service, Inc.

May 15, 2012

TO: All Participants
Hotel Employees Restaurant Employees Health Trust

RE: Summary of Material Modification – Benefit Changes Effective June 1, 2012

This is a summary of material modifications describing recent benefit changes adopted by the Board of Trustees. Please be sure you and your family read it carefully. Keep this important notice with your June 1, 2004 HERE Health Plan Booklet.

This notice is to inform you of important changes to your health plan benefits that will go into effect June 1, 2012. Included are the following benefit updates to your June 1, 2004 Health Plan Booklet:

- New Schedule of Dental Benefits, effective June 1, 2012
- New Pacific Dental Alliance Provider Listing
- New Vision Benefits Schedule , effective June 1, 2012
- National Vision Network Provider Listing

Please read these documents carefully and keep this letter with your Health Plan Booklet and other important Trust documents so you can refer to them when necessary.

If you have any questions regarding these new benefit changes, please contact the Administration Office at 1-800-331-6158.

Trust Administration Office
Hotel Employees Restaurant Employees Health Trust

CJ:\lmm opeiu#8
S:\SHARED SEC\Mailings\Individual Mailings\F19\F19-02 - Dental-Vision - SMM - 06-01-2012.doc

HOTEL EMPLOYEES RESTAURANT EMPLOYEES HEALTH TRUST

SCHEDULE OF DENTAL BENEFITS EFFECTIVE JUNE 1, 2012

Procedure Code	Description	Revised Effective 06/1/12
Diagnostic		
150	Comprehensive Oral Evaluation	$50
272	Bitewings - Two Films	$25
274	Bitewings - Four Films	$40
Restorative		
2330	Resin - One Surface, Anterior	$125
2331	Resin - Two Surface, Anterior	$150
2332	Resin - Three Surface, Anterior	$175
2335	Resin - Four or More Surface, Anterior	$200
Restorative II		
2391	Comp Resin - One Surface - Posterior	$125
2392	Comp Resin- Two Surface - Posterior	$150
Crowns		
2752	Porcelain w/ Noble Metal Crown	$550
Endodontics		
3310	Root Canal Therapy - Anterior	$500
3320	Root Canal Therapy - Bicuspid	$600
3330	Root Canal Therapy - Molar	$700
Prosthodontics		
5213	Max. Partial Denture	$800
5214	Mand. Partial Denture	$800
Oral Surgery		
7140	Extraction eruped tooth or root	$150
7210	Surgical Extraction - Erupted	$250

PacificDentalAlliance

Your union dental provider

Date: May 2012

To: All HERE Dental Plan Participants

Re: No Out-of-Pocket Dental Care

Pacific Dental Alliance affiliated offices will continue to accept the HERE Trust Scheduled Dental Plan as payment-in-full.

This means members covered by the HERE Trust Dental Plan will have no out-of-pocket costs up to the maximum annual allowance of the plan*

If you are looking for quality dental care at a significant savings, you may want to try one of the offices listed on the back of this letter.

A few examples of your savings		
Procedure	Your cost at another provider**	**Your cost at the offices listed on the back of this letter**
Exam (comprehensive)	$77	**$0**
Cleaning (adult)	$50	**$0**
Filling (two-surface composite)	$143	**$0**
Crown (porcelain w/ noble metal)	$768	**$0**
Root canal (molar)	$968	**$0**

See other side for locations

Washington Locations

Arlington (360) 659-8777 Avenue Dental Care 3402 173rd Pl. NE Ste. 204	**Bellevue/Factoria** (425) 401-5000 Affordable Dental Care 4122 Factoria Blvd. SE Ste. 301	**Bremerton** (360) 792-0300 Avenue Dental Care 2741 Wheaton Way Ste. B	**Burien** (206) 988-0500 Affordable Dental Care 15726 1st Ave. S.
Edmonds (425) 778-6333 Avenue Dental Care 23805 Highway 99 Ste. 100	**Everett** (425) 438-8584 Avenue Dental Care 8625 Evergreen Way Ste. 212	**Federal Way** (253) 946-3895 Sterling Dental Care 30620 Pacific Hwy S. Ste. 111	**Kent/Covington** (253) 630-3500 Affordable Dental Care 16720 SE 271st St. Ste. 211
Mt. Vernon (360) 424-7921 Patel Dental Care 120 S. 15th St. Ste. A	**Olympia/Tumwater** (360) 943-5420 Affordable Dental Care 6015 Capitol Blvd. SW	**Puyallup** (253) 435-5656 Avenue Dental Care 10317 122nd St. E. Ste. D	**Renton** (425) 264-0044 Affordable Dental Care 3900 East Valley Road Ste. 203
Tacoma (253) 471-2655 Affordable Dental Care 3402 South 18th St.	**Spokane** (509) 467-8000 Avenue Dental Care 755 E. Holland Ave.	**Spokane Valley** (509) 926-1500 Avenue Dental Care 20 N. Evergreen Rd. Ste 101	Dentists: Steven Paige, Bob Virk, Danlu Lee, Wendy Yeung, Katherine Kim, Rattan Bains, Arpita Sharma, Andrea Doan, Michael Nguyen, Ram Patel, Gabor Klade, LeRoy Horton, Varun Sharma, Francisco Juson, Kenza Houki, , Adam Ford, , Mona Khan, David Myaskovsky, Dong Kim, Brian Radkey, Lauren Semerad, Jason Bressler

Oregon Locations

Clackamas (503) 786-3000 Downtown Dental Care 10001 SE Sunnyside Rd., Suite 250	**Gresham** (503) 465-0005 Soft Touch Dental 1388 E. Powell Blvd.	**Portland** (503) 228-4122 Downtown Dental Care 511 SW 10th Ave. Suite 1114	**Portland** (503) 249-1100 Soft Touch Dental 1301 NE Broadway
Tualatin (503) 692-9280 Soft Touch Dental 18773 SW Martinazzi Ave., Suite 100	**Woodburn** (503) 981-6133 Soft Touch Dental 980 N. Cascade Drive		Dentists: Danny Sadakah and Lance Bailey

*This offer applies to members covered by the HERE Trust Traditional Fee Scheduled Dental Plan. This offer is valid through March 2013. Implants, implant crowns, crowns with gold, crowns/onlays/inlays that are all porcelain, and specialty services performed in or out of these offices are not included.

**Source: 2010 *Ingenix Dental Fee Analyzer*, Seattle area 75th percentile.

Hotel Employees Restaurant Employees Health Trust
Self Insured Vision

Benefit Summary

Vision Care Benefits*	National Vision Network Providers	Non-Network Providers
Exam – once each calendar year**	100%	$ 60
Lenses – one pair each calendar year***		
Single	100%	$ 50
Bifocal	100%	$ 80
Trifocal	100%	$100
Contact (elective)	100%	$100
Disposable Contact Lenses	100%	$100
Frames – one each 2 calendar years	Preferred Frames 100%	$ 50
	(Other Frames $50)	

*No deductible is required

**Children under age 18 are subject to usual, reasonable and customary allowance (UCR) rather than $60.00 limit (effective June 1, 2011)

*** For standard plastic or clear glass

GD:lmm opeiu#8
S:\SharedSec\Mailings\Individual\F19\F19-02 – SMM – Vision Benefit Summary – 06.01.2012

HOTEL EMPLOYEES RESTAURANT EMPLOYEES HEALTH TRUST

VISION BENEFIT LOCATIONS

This is a representative list of locations available. Please visit **nationalvision.com** for the location of additional network providers:

Auburn
The Optical Shoppe
Inside Fred Meyer
801 Auburn Way N
253-735-4732

Bellevue
The Optical Shoppe
Inside Fred Meyer
2041 148th NE
425-644-4226

Bonney Lake
The Optical Shoppe
Inside Fred Meyer
20901 Hwy 410
253-863-9798

Covington
The Optical Shoppe
Inside Fred Meyer
16735 SE 272nd ST
253-639-4077

Everett
The Optical Shoppe
Inside Fred Meyer
8530 Evergreen Way
425-353-2750

Federal Way
Americas Best
1810 S 320th St STE A
253-237-5031

Kennewick
The Optical Shoppe
Inside Fred Meyer
2811 W 10th Ave
509-734-2511

Lacey
The Optical Shoppe
Inside Fred Meyer
700 Sleater-Kiney Rd
360-491-8440

Lacey
Americas Best
1350 Galaxy Dr, STE D
360-918-0449

Lynnwood
The Optical Shoppe
Inside Fred Meyer
4615 196th St SW
425-778-2611

Americas Best
3333 184th St SW, STE P
Phone: (425) 744-1177

Marysville
The Optical Shoppe
Inside Fred Meyer
9925 State Ave
360-653-3498

Monroe
The Optical Shoppe
Inside Fred Meyer
18805 State Rt #2
360-805-9323

Puyallup
The Optical Shoppe
Inside Fred Meyer
1100 N Meridian St
253-848-9600

Renton
The Optical Shoppe
Inside Fred Meyer
365 Renton Center Way SW
425-255-4630

The Optical Shoppe
Inside Fred Meyer
17801 108th Ave SE
425-271-9211

Seattle
The Optical Shoppe
Inside Fred Meyer
915 NW 45th St
206-789-8694

Spokane
EyeGlass World
6029 N Division St
509-482-4900

Americas Best
9652 N Newport Hwy
509-468-8080

Tacoma
The Optical Shoppe
Inside Fred Meyer
7250 Pacific Ave
253-472-1168

The Optical Shoppe
Inside Fred Meyer
4505 S 19th St E
253-752-4396

Americas Best
1901 S 72nd, STE Ao 17
253-474-4700

Tukwila
Americas Best
17334 Southcenter Pkwy
206-575-4500

Vancouver
Americas Best
9301 NE 5th Ave, STE 106
360-597-0243

Hotel Employees Restaurant Employees Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

February 7, 2012

TO: **All Participants**
Hotel Employees Restaurant Employees Health Trust

This letter describes upcoming changes to your Prescription Plan. Please be sure that you and your family read it carefully. Keep this notice with your benefit booklet for future reference.

Si usted require una copia de esta noticia en Espanol, por favor pongase en contacto con la Oficina de Administracion a 1-800-732-1121, opcion 4.

CHANGE OF PRESCRIPTION DRUG BENEFIT MANAGER – Effective March 1, 2012

In a previous notice, we advised that the Trust has contracted with **informedRx** to manage your prescription drug benefits. This letter serves as an introduction to your new prescription benefit program. By mid-February you will be receiving your **new combination Medical, Dental, Vision, and Prescription Drug Identification (ID) cards.** Along with your new ID cards you will be receiving a welcome kit which will include pertinent prescription benefit information. You will need to present this new ID card at the pharmacy on or after March 1st.

Please note there are no changes to your Medical, Dental, Vision or Prescription benefits. The retail and mail order prescription copayments will remain at $12 for each prescription. Remember, if you purchase a brand-name prescription drug and a generic equivalent is available, you will be responsible for payment of the difference in cost between the two medications, in addition to the copayment.

SPECIAL INSTRUCTIONS FOR WALGREENS PRESCRIPTIONS

If you filled any prescriptions at a Walgreen's retail pharmacy between January 1, 2012 and February 29, 2012 and paid for them in full, you will be eligible for reimbursement, less your applicable co-payment responsibility. Simply contact the Administration Office for a Direct Member Reimbursement form (DMR), attach your prescription and sales receipt, and mail to the Administration Office in the return envelope provided with your claim form.

PLEASE NOTE: Reimbursement for all Walgreen Claims WILL NOT be made until after March 1, 2012.

over

WHAT YOU NEED TO DO WHEN YOU RECEIVE YOUR NEW ID CARDS

- Make sure your name is listed correctly
- Place your new cards into your purse or wallet
- Destroy your old identification cards after February 29, 2012
- Carefully review the packet of materials included with your new ID cards
- Present your new ID card whenever visiting the doctor, hospital or when obtaining a prescription
- **Do not use your new card until March 1, 2012**

WHAT IF I DON'T RECEIVE MY ID CARD OR MY NAME IS MIS-SPELLED?

Please contact the Administration Office to order an ID card or to have your card corrected. You can also call the Administration Office to update your mailing address, verify eligibility and benefits. The phone numbers for assistance are as follows:

- ID card corrections and eligibility verification: 1-800-732-1121, press option 4
- Questions regarding benefits: 1-800-331-6158, press option 0

IMPORTANT NOTE

In order to keep your eligibility records accurate, please keep the **Administration Office** informed of any change in address, dependent status and designated beneficiary. All changes can be submitted to the **Administration Office** by completing a new enrollment form.

Thank you,

Board of Trustees
Hotel Employees Restaurant Employees Health Trust

CJ:lmm opeiu#8
S:\SharedSec\Mailing\Individual\F19\F19-02 – 2012 – New PMB Vendor – informedRx – 03.01

Hotel Employees Restaurant Employees

Hotel Employees Restaurant Employees Trust Funds

2815 SECOND AVENUE • SUITE 300 • P.O. BOX 34203 • SEATTLE, WASHINGTON 98124
TELEPHONE (206) 441-7574 • TOLL-FREE 1-800-732-1121 • FAX (206) 505-WPAS (9727)

Administered by
Welfare & Pension Administration Service, Inc.

December 20, 2011

Important Notice

TO: All Participants
Hotel Employees Restaurant Employees Health Trust

Re: Summary of Material Modification – Important Information Regarding Changes to the Prescription Plan and to the Weekly Disability Benefit

This is a summary of material modifications describing recent benefit changes adopted by the Board of Trustees. Please be sure you and your family read it carefully. Keep this important notice with your June 1, 2004 HERE Health Plan Booklet.

PRESCRIPTION COVERAGE

We are pleased to inform you that effective **March 1, 2012**, your prescription drug benefit program will be administered by InformedRx, replacing the program currently administered by Express Scripts, Inc.

This change is being made to better serve the participants, while maintaining a cost effective program.

You may have heard or received previous communications that beginning January 1, 2012, Walgreens has announced that it will no longer participate in the Express Scripts network. As a result, all Trust Participants will have to pay the full price up front for any prescriptions filled at a Walgreens-owned pharmacy.

During the transition phase to the new program (January and February 2012), you may elect to continue to have your prescriptions processed at Walgreens drug stores. However, you will need to pay the full price of the medication. Under the new program beginning March 1, 2012, these prescriptions can be submitted to InformedRx for reimbursement. You will be reimbursed the amount paid for each eligible prescription, less the applicable $12.00 co-payment.

After March 1, 2012, you may utilize one of 62,000 participating pharmacies in the InformedRx network. This network includes Walgreens, Bartells, Fred Meyer, and Target pharmacies, to name a few. You will receive additional information regarding the new program in the coming weeks.

(over)

WEEKLY DISABILITY BENEFITS

Effective January 1, 2012, the weekly disability benefit will increase from $200 to $220 for participants receiving benefits under eligibility Rule A (Rule A eligibility applies to any participant who works a minimum of 65 or 80 hours per month, depending on the number of hours established under your collective bargaining agreement). For individuals who are receiving weekly disability benefits for a qualifying disability that began prior to December 31, 2011 and that continues on or after January 1, 2012, the 2012 portion of the qualifying disability period will reflect the new benefit.

If you have any questions regarding these changes, please contact the Claims Department at (800) 331-6158, option 0.

Sincerely,

Board of Trustees
Hotel Employees Restaurant Employees Health Trust

GG:lmm opeiu#8
S:\SharedSec\Mailings\F19\F19-02 – Carrier Change – InformedRx – Eff 03.01.2012

Hotel Employees Restaurant Employees

Hotel Employees Restaurant Employees Trust Funds

2815 SECOND AVENUE • SUITE 300 • P.O. BOX 34203 • SEATTLE, WASHINGTON 98124
TELEPHONE (206) 441-7574 • TOLL-FREE 1-800-732-1121 • FAX (206) 505-WPAS (9727)

Administered by
Welfare & Pension Administration Service, Inc.

July 25, 2011

To: All Participants
Hotel Employees Restaurant Employees Health Trust

Re: Summary of Material Modification – Benefit Changes Effective August 1, 2011

This is a summary of material modifications describing recent benefit changes adopted by the Board of Trustees. Please be sure you and your family read it carefully. Keep this important notice with your June 1, 2004 HERE Health Plan Booklet.

This notice contains information on:

- A new Member Assistance Program (MAP)
- The Smoking Cessation Program – Quit For Life®
- Website Information

The Board of Trustees is pleased to announce that effective August 1, 2011 a new Member Assistance Program (MAP) will be available to all eligible participants of the Hotel Employees Restaurant Employees Health Trust. The MAP program is a counseling assessment and referral service through First Choice Health and is offered by the Health Trust to you ***at no cost.***

Enclosed with this notice you will find materials which describe the counseling and Work/Life services available to you the Member, your spouse or domestic partner, and your children up to age 26.

The MAP is available 24-hours per day, 7-days per week. Your privacy is maintained and your contact with MAP is strictly confidential. Contact the MAP toll-free at **(866) 372-7380**.

To learn more about the tools and resources available visit the MAP online at www.FirstChoiceMAP.com and click on the Work/Life Resources button. Enter the username **unite** and the password **here**.

The Board of Trustees would also like to take this opportunity to remind you of a couple of other benefits available to eligible participants of the Health Trust.

Quit For Life® Program
If you or your spouse (or domestic partner) is a tobacco user and you wish to quit, the Quit For Life® Program is available to you at no additional cost (not available to dependent children). The **Quit For Life®** Program is the best method you can use to quit tobacco because it treats

tobacco use as an addiction; not just a bad habit. With personal help from a **Quit Coach®** you will make good decisions about medications, develop new thinking skills and learn how to behave differently in situations where you normally use tobacco.

When you enroll in the program you will receive:

- Unlimited toll-free access to **Quit Coaches®**
- Recommendations on type, dose, and duration of medication if appropriate
- Free nicotine replacement therapy (patch/gum) mailed directly to your home
- Access to Web Coach®, an on-line community where you can get information and support
- Printed Quit Guides to help you stay on track between calls.

For more information about the **Quit For Life®** program or to enroll in the program, call **(800) QUIT-4-LIFE (866-784-8454).**

The HERE Health Trust wants you to be healthy and happy for life. Both the MAP program and the **Quit For Life®** program are useful tools and steps you can take towards good health.

Trust Web-site
The Health Plan has established a web site to provide you with immediate access to your plan information. The site located at **www.heretrust.com** includes the following Trust related material:

- Forms – Claim Forms, Legal Documents, and Notices
- Plan Booklets
- Links to Preferred Provider Organizations, and other useful sites
- Local Unions and International Contact Information

This site will also provide a link to "My Personal Benefit" information, which may be viewed through a secure location requiring the entry of a personal identification number (PIN) and your social security number or 7-digit identification number (as found on your ID card). A PIN will be assigned and mailed to you upon your written request. To request a PIN, please complete a PIN REQUEST FORM which can be printed from the website.

Please note that a PIN will be assigned. For security purposes you *may not* choose your own PIN. "My Personal Benefits" information includes the following data:

- Personal Information – Name, address, gender, birth date, marital status, etc.
- Hours/Contributions – A statement showing recent employers reporting hours and contributions to the Trust on your behalf.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. Should you have any questions, please contact the Administration Office at (206) 441-7574, option 0 or toll free at (800) 732-1121, option 0.

Sincerely,

Board of Trustees
Hotel Employees Restaurant Employees Health Trust

CJ:lmm opeiu#8
SharedSec\Mailings\F19\F19-02 SMM MAP Program – Quit for Life – Website – 20110725

Enclosures

Welcome to HERE
Member Assistance Program (MAP)

First Choice Health™

Healthy Employees. Healthy Companies.™

Our program is confidential and covers employees, spouses, domestic partners, and children up to age 26. HERE provides your MAP services free of charge (no co-pay, deductible or premium).

You can use MAP services to solve a wide range of concerns and problems:

- Marital and family issues
- Depression and anxiety
- Problems with substance abuse
- Problems with gambling
- Balancing work and home
- Personal/family concerns

Your MAP is available 24 hours per day, 7 days per week. Simply call (866) 372-7380 and a Customer Service Representative will assist you. The MAP provides up to 3 face to face visits with a Licensed Behavioral Health Provider who is skilled in assessing your concerns. If preferred you may request an online appointment at www.FirstChoiceMAP.com.

We Invite You To Explore Our Online Tools And Resources

Go to www.FirstChoiceMAP.com and click on the Work/Life Resources button.

username: unite
password: here

You can search a vast electronic library for information, tools and resources: legal forms, financial information, pet care, parenting solutions, health and wellness, family matters, daycare information, eldercare, and much more.

UNITEHERE!

Enhanced Work Life Services

Legal Services: You can talk with an attorney for up to 30 minutes at no charge. Should you decide to retain the attorney, you will receive a 25% discount off the attorney's standard hourly fees (work related issues are not covered).

Financial Services: You may speak with a financial professional by phone for up to 60 minutes at no charge for debt management issues, credit card education/ consultation and budgeting advice (investment advice is not provided).

ID Theft and Fraud Resolution: This benefit can help protect you from theft, fraud, or assist you should you become a victim of a fraud related crime.

Childcare and Eldercare Consultation: You will be connected with a childcare or eldarcare specialist who can assist in arranging care or resources for your child or older parent regardless of their location in the U.S.

Member Assistance Program
One Union Square
600 University Street, Suite 1400
Seattle, WA 98101
(866) 372-7380
Fax: (206) 268-2433
www.FirstChoiceMAP.com

First Choice Health™

Healthy Employees. Healthy Companies.™

Member Assistance Program

Enhanced Services for You and Your Family

24/7
(866) 372-7380
www.FirstChoiceMAP.com

Cut and retain this reference card to access services.

First Choice Health™

Healthy Employees. Healthy Companies.™

www.FirstChoiceMAP.com

Member Assistance Program

We will always exceed your expectations for service. Guaranteed.

All services are confidential and cost free to you and your family.

(866) 372-7380 or TTY (800) 777-4969

Description of MAP Services

First Choice Health Employee Assistance Program (MAP) provides assessment sessions with a licensed mental health professional for a variety of emotional, behavioral, family, relationship, mental health or chemical dependency concerns.

The MAP provides you and your covered family members services that are cost-free, convenient and confidential. MAP coverage includes a spouse or significant other and eligible dependent children.

- Stress & Anxiety
- Depression
- Couples & Relationships
- Parenting & Family Concerns
- Adolescence
- Legal or Financial Consultation
- Alcohol / Drug Problems
- Communication
- Change & Life Transitions
- Impulse Control
- Crisis Management
- Sleep Problems
- Grief & Loss
- Work Conflict
- Gambling Problems
- Child or Eldercare Consultations
- ID Theft Resolution
- Texting / Internet Addictions

- Once you have received your materials, review the resources. Please call if more information is required.
- Your Work Life Expert will follow up, making sure your request has been satisfied.

Please contact the MAP by phone at **(866) 372-7380** with questions or to learn more about the Work Life Resources available to you and your covered family members.

Access your online Work Life Resources at **www.FirstChoiceMAP.com**. Click on the Work Life Resources button and enter your organization's Username and Password. To obtain login information, contact your HR or the MAP at (866) 372-7380.

- Stress & Anxiety
- Depression
- Couples & Relationships
- Parenting & Family Concerns
- Adolescence
- Legal or Financial Consultation
- Alcohol / Drug Problems
- Communication
- Change & Life Transitions
- Impulse Control
- Crisis Management
- Sleep Problems
- Grief & Loss
- Work Conflict
- Gambling Problems
- Child or Eldercare Consultations
- ID Theft Resolution
- Texting / Internet Addictions

Work Life Resources Online or with a Consultant

> Legal Consultation

Through First Choice Health MAP you have access to a free 30-minute legal consultation, face-to-face or by telephone. Typical problems include Family and Domestic Concerns, Motor Vehicle Matters, Civil Issues, Elder Law, Divorce and Parenting, Juvenile Issues and a variety of other concerns. Should you decide to retain the attorney for ongoing services, you will receive a 25% reduction in the attorney's normal hourly fees. Employment-related concerns are not covered.

> Financial Services

First Choice Health MAP provides free financial counselors available for consultation and education. The telephonic consultation includes 30-60 minutes of financial counseling. Topics include: budgeting, estate planning, credit card consolidation, savings and investing, debt management, retirement planning and more.

> Identity Theft Resolution

Many Americans have been victimized by identity theft and consumer fraud. The average consumer spends over 175 hours responding to and resolving instances of identity theft. Our Fraud Resolution Specialists are qualified legal professionals providing step-by-step guidance and consultation about Identity Theft or Fraud.

> Childcare Consultation

This convenient service offers families and parents information whenever a childcare need arises. Qualified childcare professionals help identify resources such as: daycares, summer activities, special needs resources, how to become a parent, school age preparations, and much more.

> Eldercare Services

If you're concerned about an aged or disabled loved one, the MAP can connect you to eldercare experts and resources – regardless of where your family member lives. From understanding Medicare to information about in-home nursing, assisted living and specialty health care providers, this comprehensive service can save you time and increase your peace of mind. The MAP provides this service at no cost to you or your covered family members.

Accessing Your Work Life Resources

As described on the previous pages, consultation is available on a wide range of Work Life issues that can affect you and your family members. You can receive information in the way that best meets your needs: by phone, online access, e-mail, fax or mail.

MAP Work Life Resources are free, confidential and offered by your employer to provide you with assistance in meeting your goals or dealing with life's challenges. Our experts are highly trained and responsive to your specific needs and concerns.

- Contact the MAP by phone or request services through the website at www.FirstChoiceMAP.com.
- You will be connected with a Work Life Expert who will explore your concerns and prepare a customized package of information, resources, provider profiles and educational materials in response to your needs.

> Assessment & Referral

Assessment & Referral means a First Choice Health MAP provider will work with you to determine the nature of your concern and resolve the issue within the available MAP sessions. After your MAP assessment, the provider will make treatment recommendations, if necessary or requested, based on your unique needs.

You can reach the MAP 24 hours per day, 7 days a week. When you call you'll be greeted by a customer service professional ready to respond to your questions, needs and preferences. A mental health counselor is always available to talk with you or your covered family members.

MAP can assist in locating a licensed mental health professional in your area convenient to your home or work.

Our network providers include licensed mental health counselors, psychologists, clinical social workers, marriage & family therapists and chemical dependency professionals.

> Confidential Services

First Choice Health MAP understands the importance of making reliable, confidential services available to employee families. We know that making it possible to consult discreetly with an MAP provider is essential – perhaps the most important role of the Employee Assistance Program. Information about your contact with the MAP is never released without your request and signed consent.

To initiate Assessment & Referral services contact us **at (866) 372-7380** or online at **www.FirstChoiceMAP.com**.

Hotel Employees Restaurant Employees Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

May 6, 2011

To: Active Employees, and Eligible Dependents, Including COBRA Beneficiaries of the Hotel Employees Restaurant Employees Health Trust

Re: Benefit Changes Effective June 1, 2011

This is a summary of material modification describing recent changes adopted by the Board of Trustees.

The Board of Trustees of the Hotel Employees Restaurant Employees Health Trust (Plan) has recently adopted changes to the Plan as required by the Patient Protection and Affordable Care Act (PPACA). These changes apply to all eligible active employees, and their eligible dependents, including COBRA beneficiaries. The following changes become effective June 1, 2011:

Elimination of Pre-existing Conditions Limitation for Participants under Age 19

Effective June 1, 2011, children under age 19 will no longer be subject to the Plan's pre-existing condition limitation. Children under age 19 were previously subject to pre-existing condition limitations, which meant that if a child received treatment for a condition during the three months prior to enrolling in the Plan, eligible claims for that condition would not be payable until the person has been covered by the Fund for three months (measured from the effective date medical coverage began).

Previously, children under age 19 were also subject to a twelve month continuous coverage waiting period to receive transplant benefits. Effective June 1, 2011, this waiting period is removed.

The Plan's pre-existing condition limitations will continue to be effective for members and dependents age 19 and over.

Elimination of Lifetime Benefit Maximums and Implementation of a New Annual Benefit Maximum Effective June 1, 2011

Effective June 1, 2011, the Plan is eliminating the current $1,000,000 medical lifetime benefit maximum. In place of the lifetime maximum, the Plan will be implementing an annual medical benefit maximum of $1,000,000, which will be monitored and applied on a calendar year basis. Individuals whose medical coverage previously ended by reason of reaching the lifetime limit are again eligible to enroll in the Plan. To enroll, the individual must complete an Enrollment Form and return it to the Administration Office with a postmark of no later than June 4, 2011. Coverage will be effective June 1, 2011.

You may obtain an enrollment form in one of the following ways:

- Log on to the Trust website – www.heretrusts.com, click on forms, then medical forms, and select enrollment form
- E-mail request to form@wpas-inc.com. You must include your name, complete address, and 7-digit member identification number (located on the first line of address on the envelope), and include "HERE Health Trust" in the subject line of your e-mail. An enrollment form will be mailed to you the next business day.
- By telephone - call (800) 732-1121, option 4.

The Plan's current $11,000 benefit maximum every 2 calendar years for substance abuse treatment will also be removed effective June 1, 2011. Substance abuse treatment will be subject to the new $1,000,000 annual medical benefit maximum. In addition, the Plan's $250,000 lifetime maximum for Organ Transplants and $25,000 donor expenses per transplant is being removed.

Elimination of Calendar Year Maximums Effective June 1, 2011

Certain calendar year benefit maximums (also monitored and applied on a calendar year basis) are also being removed and are instead subject to the annual $1,000,000 maximum effective June 1, 2011. These benefits are summarized below:

- $2,000 annual maximum on ambulance service
- $30,000 per condition inpatient rehabilitation
- Neurodevelopmental therapy $1,000 per year limit for children under age 6
- Dental accident paid under the medical plan $1,000 per occurrence
- $1,000 hospitalization for dental care
- $1,000 per year outpatient physical therapy
- $2,000 annual maximum on dental benefits, other than orthodontic, for dependent children under the age of 18
- $50 vision exam per calendar year, for dependent children under the age of 18
- $375 per calendar year smoking cessation program provided through Free & Clear

Important Notice Regarding Eligibility Changes

In accordance with the requirements of PPACA, effective June 1, 2011, the Plan will not retroactively cancel coverage except when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of material fact.

It is your responsibility to notify the Administration Office within 30 days if you gain or lose an eligible dependent, such as through marriage or divorce. If you enroll a dependent who does not meet the eligibility requirements of the Plan, or if you fail to notify the Plan of your divorce or other loss of dependent eligibility within 30 days of the event, it is considered intentional misrepresentation of a material fact and the Plan will retroactively terminate coverage for your ineligible dependent. If the Plan pays claims on the ineligible dependent, you may be responsible for claims paid on your ineligible dependent's behalf. Please help us keep your dependent eligibility up-to-date!

Grandfathered Status

This 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.

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 Administration Office at 206-441-7574, or toll free at 800-732-1121. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Sincerely,

Board of Trustees
Hotel Employees Restaurant Employees Health Trust

CJ:lmm opeiu#8
S\SharedSec\Docs\F19-02 – Mailing - PPACA Notice – 20110414

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.

Hotel Employees Restaurant Employees Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124

Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

Date: September 30, 2010

To: All Plan Participants
Hotel Employees Restaurant Employees Health Trust

Re: Dependent Coverage Extension to Age 26

In accordance with the Patient Protection and Affordable Care Act (PPACA) as amended, effective January 1, 2011, the Hotel Employees Restaurant Employees Health Trust (HERE) will provide dependent coverage to children of participants up to age 26.

The Department of Labor (DOL) and Department of Health and Human Services (HHS) jointly issued interim final rules to implement the dependent coverage extension to age 26. The interim final rules specify that an adult child can qualify for this coverage even if he or she is no longer living with a parent, is not a dependent on a parent's tax return, or is no longer a student. Both married and unmarried adult children can qualify for the dependent coverage extension, although that coverage does not extend to an adult child's spouse or children.

These recently issued regulations extending dependent coverage to age 26 also provide the possibility of coverage for a child whose coverage ended, a child who was denied coverage or a child who was not eligible for coverage.

The HERE Health Trust is conducting a special enrollment in which plan participants will have the opportunity to enroll or re-enroll their children. The special enrollment period starts on October 1, 2010 and will continue through November 30, 2010. Coverage will be effective **January 1, 2011.**

If you have a child who qualifies, and you wish to enroll them in the plan, you must complete an enrollment form and return it to the Administration Office. You may obtain an enrollment form by doing one of the following:

1. Download and print an enrollment form at the Trust's website **www.heretrust.com –** click on "Forms", then click "Medical Forms", and then select "Enrollment/Beneficiary Form".
2. Send an e-mail to the Administration Office – address your e-mail to **form@wpas-inc.com**. You must include your name, complete address, and 7-digit member identification number (located on the first line of address on the envelope or on your ID card). An enrollment form will be mailed to you the next business day.
3. To request a form by phone call (800) 732-1121, option 4.

Please note the Administration Office will require documentation such as a birth certificate, legal guardianship order, and marriage certificate if the adult child is married.

Please keep a copy of this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions.

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding this Plan change, please contact the Plan Administration Office at (800)732-1121, option 4.

In accordance with ERISA reporting requirements this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.

CJ:lmm opeiu#8
S:\SharedSec\Docs\BenefitChanges\Health&Welfare\F19-02 PPACA Age 26 Notice

Hotel Employees Restaurant Employees Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

May 2009

TO: All Participants
Hotel Employees Restaurant Employees Health Trust

RE: Summary of Material Modification – Benefit Changes Effective June 1, 2009

This is a summary of material modifications describing recent benefit changes adopted by the Board of Trustees. Please be sure you and your family read it carefully. Keep this important notice with your June 1, 2004 HERE Health Plan Booklet.

This notice is to inform you of important changes to your health plan benefits that will go into effect June 1, 2009. Included are the following benefit updates to your June 1, 2004 Health Plan Booklet:

- New Domestic Partnership benefits
- New Tobacco Cessation Program
- New language to cover contraceptive devices
- New organ transplant benefit lifetime maximum

Please read these sections carefully and keep this letter with your Health Plan Booklet and other important Trust documents so you can refer to them when necessary.

Domestic Partnership Benefits
Eligible dependents have now been expanded to include domestic partners. You and your domestic partner must meet criteria in order to be eligible for benefits. The criteria include:

- Each individual is 18 years of age or older;
- Share a close personal relationship and are each other's sole domestic partners;
- Not legally married to anyone;
- Not related by blood closer than would bar marriage;
- Currently share the same regular and permanent residence;
- Jointly share financial responsibility for "basic living expenses" including the cost of food, shelter, and other costs such as medical expenses; and
- Have registered as a Domestic Partner in Washington or Oregon, and qualify for coverage in those states, based on applicable eligibility criteria.

If you meet all of the eligibility requirements, your domestic partner (and any eligible dependent children of a domestic partner) will be insured under the Plan the same as any other dependent enrolled under this Plan. Please refer to the June 2004 Health Plan Booklet for the definition of an Eligible Dependent.

How to Enroll - If you are interested in enrolling and determining if you qualify for this coverage, you must complete a Declaration of Domestic Partnership form. To obtain this form, please contact the Administration Office at (800)732-1121, option 4.

Tobacco Cessation
A new program available to eligible members and their spouse or domestic partner (dependent children are not covered) for tobacco cessation, has been added to your current Health Plan. To participate, you need to contact the sponsor organization, Free & Clear®, and enroll in their Quit for Life™ program. The program provides personalized telephone counseling, educational materials, online interactive tools, and free nicotine replacement products (such as nicotine patches and gum). **For information on the program or to register, call 1-866-Quit-4-Life (866-784-8454).**

The new tobacco cessation program being sponsored by Free & Clear replaces the current benefit as stated on page 30 of your June 2004 Health Plan Booklet. Required prescription medications for smoking cessation are paid under the drug plan. If you started the existing smoking cessation program prior to June 1, 2009 you will be allowed to complete that program.

Contraceptive Devices
The "Sterilization Procedures" benefit currently outlined on page 30 in your Health Plan Booklet will be replaced with "Family Planning" and will read to include these voluntary procedures that are covered for eligible members and their spouse (dependent children are not covered):

- Cervical cap/ring
- Diaphragm
- IUD insertion (and medically necessary removal of)
- Norplant
- Tubal ligation (not reversal)
- Vasectomy (not reversal)

Over-the-counter products are not covered. Oral contraceptives are covered under the prescription drug benefit and are limited to coverage for eligible members and their spouse or domestic partner (dependent children are not covered).

The Limitations and Exclusions section on page 36 of your Health Plan Booklet will now read as: **Family planning or contraceptive devices except as specifically provided.**

Organ Transplant Benefit Lifetime Maximum
The Trustees have approved an increase to the organ transplant lifetime maximum benefit from $200,000 to $250,000 effective for services incurred on or after June 1, 2009.

If you have any questions regarding these new benefit changes, please contact the Administration Office at 1-800-331-6158.

Trust Administration Office
Hotel Employees Restaurant Employees Health Trust

Hotel Employees Restaurant Employees Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

January 2009

TO: **All Participants**
Hotel Employees Restaurant Employees Health Trust

FROM: **Trust Administration Office**

RE: **Summary of Material Modification Model Newborns' Act Disclosure**

This is a Summary of Material Modification describing recent benefit changes adopted by the Board of Trustees. Please be sure that you and your family read this notice carefully. It should be kept with your benefit booklet or insurance records for future reference.

Model Newborn's Act Disclosure

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

Board of Trustees,
Hotel Employees Restaurant Employees Health Trust

Hotel Employees Restaurant Employees Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

November 11, 2008

TO: All Participants
Hotel Employees Restaurant Employees Health Trust

RE: Summary of Material Modification – Benefit Changes Effective January 1, 2009

This is a Summary of Material Modification describing recent benefit changes adopted by the Board of Trustees. Please be sure that you and your family read this notice carefully. It should be kept with your benefit booklet or insurance records for future reference.

The Board of Trustees is pleased to announce that effective January 1, 2009 the eye examination benefit will increase from $35 to $50 per eligible person per exam. Eye exams are limited to one per eligible person per year.

In addition to the increased benefit, the Board of Trustees has expanded the National Vision Plan provider listing to include America's Best vision providers. An updated provider listing is enclosed in this packet.

For a complete description of vision benefits and limitations and exclusions, please refer to your Summary Plan Description booklet dated June 2004.

Board of Trustees,
Hotel Employees Restaurant Employees Health Trust

AMERICA'S BEST CONTACTS & EYEGLASSES

STORE	ADDRESS	CITY	ST	ZIP	PHONE	ENTITY
5254	6375 Ulali Drive	Keizer	OR	97303	(503) 428-5096	AmericasBest
5251	9710 Se Washington St Ste D	Portland	OR	97216	(503) 257-7770	AmericasBest
5252	9225 Sw Hall Blvd	Tigard	OR	97223	(503) 598-8884	AmericasBest
5377	1810 S. 320th St., Suite A	Federal Way	WA	98003	(253) 237-5031	AmericasBest
5376	1350 Galaxy Drive, Suite D	Lacey	WA	98516	(360) 918-0449	AmericasBest
5371	3333 184th St Sw	Lynnwood	WA	98037	(425) 744-1177	AmericasBest
5401	9652 N Newport Hwy	Spokane	WA	99218	(509) 468-8080	AmericasBest
5373	1901 S 72nd St Ste Ao	Tacoma	WA	98408	(253) 474-4700	AmericasBest
5372	17334 Southcenter Pkwy	Tukwila	WA	98188	(206) 575-4500	AmericasBest

The Optical Shoppe℠

STORE	ADDRESS	CITY	ST	ZIP	PHONE	ENTITY
7609	11425 Sw Beaverton Hwy	Beaverton	OR	97005	(503) 643-5590	Fred Meyer
7626	325 5th St	Brookings	OR	97415	(541) 469-5556	Fred Meyer
7657	23105 Sw Tualatin Valley Hwy	Hillsboro	OR	97123	(503) 356-5501	Fred Meyer
7625	2655 Shasta Way Ste 3	Klamath Falls	OR	97603	(541) 882-7082	Fred Meyer
7614	2424 Crater Lake Hwy	Medford	OR	97504	(541) 779-0362	Fred Meyer
7630	150 Ne 20th St	Newport	OR	97365	(541) 265-4201	Fred Meyer
7611	1839 Molalla Ave	Oregon City	OR	97045	(503) 656-2453	Fred Meyer
7615	1111 Ne 102nd Ave	Portland	OR	97220	(503) 255-7782	Fred Meyer
7627	2500 Main Ave N	Tillamook	OR	97141	(503) 815-3855	Fred Meyer
7612	19200 Sw Martinazzi Ave	Tualatin	OR	97062	(503) 692-5040	Fred Meyer
7616	1451 Highway 101 Alt	Warrenton	OR	97146	(503) 861-9829	Fred Meyer
7650	801 Auburn Way N	Auburn	WA	98002	(253) 735-4732	Fred Meyer
7640	2041 148th Ave Ne	Bellevue	WA	98007	(425) 644-4226	Fred Meyer
7636	20901 Sr-410	Bonney Lake	WA	98391	(253) 863-9798	Fred Meyer
7647	16735 Se 272nd St Ste C	Covington	WA	98042	(253) 639-4077	Fred Meyer
7649	8530 Evergreen Way	Everett	WA	98208	(425) 353-2750	Fred Meyer
7658	2811 W 10th Ave Ste C	Kennewick	WA	99336	(509) 734-2511	Fred Meyer
7652	700 Sleater Kinney Rd Se	Lacey	WA	98503	(360) 491-8440	Fred Meyer
7639	4615 196th St Sw Ste 170	Lynnwood	WA	98036	(425) 778-2611	Fred Meyer
7646	9925 State Ave	Marysville	WA	98270	(360) 653-3498	Fred Meyer
7631	18805 State Route 2 Ste A	Monroe	WA	98272	(360) 805-9323	Fred Meyer
7638	1100 N Meridian	Puyallup	WA	98371	(253) 848-9600	Fred Meyer
7632	365 Renton Center Way Sw	Renton	WA	98055	(425) 255-4630	Fred Meyer
7648	17801 108th Ave Se	Renton	WA	98055	(425) 271-9211	Fred Meyer
7654	915 Nw 45th St Ste B	Seattle	WA	98107	(206) 789-8694	Fred Meyer
7633	7250 Pacific Ave	Tacoma	WA	98408	(253) 472-1168	Fred Meyer
7634	4505 S 19th St Ste 3	Tacoma	WA	98405	(253) 752-4396	Fred Meyer

Hotel Employees Restaurant Employees Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

October 27, 2008

TO: All Participants
Hotel Employees Restaurant Employees Health Trust

RE: Benefit Updates

This is a summary of material modifications describing recent benefit changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully. Keep this important notice with your June 1, 2004 HERE Health Trust Plan book.

Enclosed are the following benefit updates to your June 1, 2004 Health Trust Plan book:

- A new section on Transplant Benefits, which replaces the section on pages 33-34
- The new Subrogation Policy, which replaces the section on page 60, "Trustees' Right to Subrogation"

Weekly Disability Benefits for Active Employees:

The Board of Trustees is pleased to announce that effective June 1, 2007 the weekly disability benefit was increased from $110 per week to $200 per week. This increase applies only to participants who are eligible under Rule A. The Rule B benefit will remain at the current $90 per week. (See page 19 of the 2004 Health Plan booklet.)

If you have any questions concerning the above information, please feel free to contact the Administration Office at (800) 331-6158, Option 0.

Board of Trustees
Hotel Employees Restaurant Employees Health Trust

CJ:mc opeiu#8
S:\SHARED SEC\Docs\F19\F19BenefitUpdates.doc/

Enclosures

Note: This replaces the Transplant Benefit section on pages 33-34 of the June 1, 2004 HERE Health Trust Plan Book

Transplant Benefit

Important: Neither you nor your dependent are eligible to receive any benefits related to a transplant until the first day of the thirteenth month of continuous coverage under this Plan, whether or not the condition is preexisting or an emergency. See *Medical Benefits – Waiting Periods – Transplant Waiting Period*, at page 23.

The benefits of this Plan will be provided for **medically necessary** services or supplies related to all approved transplants to a combined lifetime maximum of $200,000 as follows, as determined by the UR Coordinator:

Benefits: A transplant recipient who is covered under this Plan will be eligible for the following transplants, subject to the limits described in this Benefit:

- Heart
- Heart/lung (combined)
- Kidney
- Kidney/pancreas (combined)
- Islet cell
- Lungs – single/bilateral/lobar
- Liver
- Small bowel
- Small bowel/liver/Multivisceral
- Cornea
- Bone marrow (including self-donated and unrelated donors) or other forms of stem cell rescue (but only covered for certain conditions – see the Limitations and Exclusions discussion in this Transplant Benefit section, below).

Benefits for all transplants must be authorized by the UR Coordinator in writing, in advance. Approval will be based upon the Member's medical condition, the qualifications of the providers, appropriate medical indications for the transplant, and appropriate, proven medical procedures for the type of condition. All transplants must be performed in a facility approved by the UR Coordinator. If a transplant is not successful, only one retransplant will be covered, subject to the $200,000 lifetime maximum benefit.

Out-of-Network Area: Benefits will be provided outside the service area at 80% of the **allowed amount** under the Out-of-Network benefits of this Plan. You must follow all requirements of this benefit including, but not limited to, obtaining pre-approval from the UR Coordinator and using a facility approved by the UR Coordinator.

Donor Organ Procurement Benefits: Donor organ procurement costs will be covered to a maximum of $25,000 per transplant if the recipient is covered for the transplant under this Plan. Donor organ procurement benefits will be charged against the recipient's $200,000 lifetime maximum benefit.

Travel Expenses: Travel and lodging expenses for you and your family will be covered when you are required by your **physician** to travel 30 miles or more outside the service area for **medically necessary** services related to an approved transplant. Benefits will be paid at 90% to a maximum of $2,500 per transplant episode requiring travel and must be approved in advance by the **Trust Administration Office** and is subject to the $200,000 lifetime maximum benefit.

Limitations and Exclusions: No benefits will be provided for the following:

- Nonhuman, artificial or mechanical transplants.
- When the recipient is not covered under this Plan.
- Experimental investigational services or supplies.
- Donor organ procurement costs incurred outside the United States unless approved by the UR Coordinator.

- Stem cell rescue, bone marrow transplants and chemotherapy associated with stem cell rescue or bone marrow transplants, except as specified below:
  - With regard to autologous (self-donor) stem cell rescue, autologous (self-donor) bone marrow transplants and chemotherapy associated with autologous stem cell rescue or autologous bone marrow transplants, coverage is available for treatment of only the following malignancies/conditions:
    - Non-Hodgkins lymphoma
    - Hodgkins Lymphoma
    - Neuroblastoma
    - Acute lymphocytic or non-lymphocytic leukemias
    - Germ cell tumor
    - Metastatic breast cancer on an Approved Clinical Trial
    - Multiple myeloma on an Approved Clinical Trial
    - Chronic myelogenuous leukemia
    - Ewing's sarcoma
    - Wilms Tumor

    Those malignancies/conditions not listed but that are not considered experimental and investigational and/or are commonly accepted in the medical community may also be covered. Each case must be individually reviewed and approved by either First Choice Health at (800) 231-6935 or Providence Preferred at (800) 638-0449.
  - With regard to allogeneic (related or unrelated) stem cell rescue, allogeneic bone marrow transplants and chemotherapy associated with allogeneic stem cell rescue or allogeneic bone marrow transplants, coverage is available for treatment of only the following malignancies/conditions:
    - Acute lymphocytic or non-lymphocytic leukemias
    - Chronic myelogenous leukemia
    - Aplastic anemia
    - Hodgkins lymphoma
    - Non-Hodgkins lymphoma
    - Severe combined immunodeficiency (not AIDS)
    - Wiskott-Aldrich syndrome
    - Sickle cell anemia
    - Kostmann's Syndrome
    - Leukocyte adhesion deficiencies
    - Infantile malignant osteopetrosis
    - Neuroblastoma
    - Homozygous beta-thalassemia
    - Myelodysplastic syndromes
    - Mocupolysaccaridoses
    - Mucolipidoses
    - Multiple myeloma on an Approved Clinical Trial
    - Ewing's Sarcoma
    - X-linked proliferative syndrome
    - Megakaryocytic thrombocytopenia

    Those malignancies/conditions not listed but that are not considered experimental and investigational and/or are commonly accepted in the medical community may also be covered. Each case must be individually reviewed and approved by either First Choice Health at (800) 231-6935 or Providence Preferred at (800) 638-0449.
- Donor organ procurement costs, when donor organ procurement benefits are available through other group coverage, including an employer-sponsored group health plan (whether insured or self-insured).
- When government funding of any kind is available.
- Lodging, food, or transportation costs, unless otherwise specified under this Plan.
- All services and expenses not approved by the UR Coordinator. Any services or supplies relating to the transplant if furnished before the recipient has met the 12-month transplant waiting period. (See *Medical Benefits – Waiting Periods – Transplant Waiting Period*, at page 23.)

"Approved Clinical Trial" means each of the following criteria has been met. These criteria for an Approved Clinical Trial apply to Multiple Myeloma and Metastatic breast cancer, specifically autologous or allogeneic stem cell rescue for Multiple Myeloma and autologous stem cell rescue for Metastatic breast cancer.

- The trial has been approved by the National Institutes of Health, NIH), the Food and Drug Administration, or the Department of Veterans Affairs, and
- The trial protocol has been reviewed and approved by an Institutional Review Board (IRB) qualified under federal law, and
- The facility and personnel providing the treatment or utilizing the supplies are capable of doing so by virtue of their experience or training, and
- The trial is not a Phase I trial.

Note: This replaces the Trustees' Right to Subrogation section on page 60 of the June 1, 2004 HERE Health Trust Plan Book

Subrogation of Claims Against Other Parties for Claims Paid Under the Plan

The Fund reserves the right to recover claim payments made under any of its Plans on behalf of an employee or dependent where the claim results from or is related to an injury or illness that is the responsibility of a third party. You are obligated to reimburse the Fund in full for any claims paid relating to such injury or illness. If you recover any amount from a third party and fail to repay the Fund for the claims it has paid, the Plan will deduct the amount paid from any of your future benefit claims as a set off. What is a third party and when are they for responsible for your injuries or illness? Here are some examples:

- If you are in an auto accident and the other driver is at fault, the third party is the other driver and his/her insurance company.
- If you are in an auto accident and the other driver is uninsured, your auto insurance policy's "uninsured motorist's" provision is a third party for this purpose.
- If you are injured in an auto accident and covered under a "no fault" provision of your own insurance policy, your policy is the third party.
- If you are injured on the job, your employer's workers compensation policy is the third party.
- If you fall in a store because there was a spill near a shelf that no one bothered to clean up, the store is the third party.

The plan will pay claims for expenses incurred because of an illness or injury for which a third party is (or may be) responsible as long as you and/or your dependents sign a loan agreement with the fund. You should know that by submitting the claim for payment by the plan you (and a covered dependent if he or she suffers the illness or injury) are deemed under the plan to have agreed to each of the following conditions:

- You and/or your dependents must contact the Fund office immediately after you and/or your dependents have suffered an illness or injury and request a copy of the HERE Health and Welfare Trust Fund Loan Agreement. By signing the Loan Agreement, you and/or your dependents and your legal counsel recognize that the Fund has no obligation to pay any benefits and that any benefits paid shall be considered a loan that you must reimburse to the Fund from any recovery received related to the illness or injury. ***The Fund reserves the right to refuse to pay claims for expenses incurred because of an illness or injury for which a third party is (or may be) responsible unless you and/or your dependent and your legal counsel sign the Loan Agreement.***
- If you or your dependents sue or recover compensation, reimbursement, damages or any other payment of any kind from the third party for the illness or injury, the Fund has a lien (a "security interest") on any amount(s) you or your dependents receive or may become entitled to receive from the third party (or the third party's insurance company) up to the amount of Plan benefits paid because of the illness or injury. You must advise the third party that this is a condition of the Plan.
- You or your dependents will furnish the Fund with a copy of any complaint you or your dependents file to recover damages from a third party within no more than two days of the date of the filing.

- If you or your dependents receive payment(s) of any kind from the third party (or from the third party's insurance company), you and/or your dependents will promptly reimburse the Fund for any claims paid because of the illness or injury. If you or your dependents sue or recover payment of any kind from a third party for an illness or injury (whether or not these payments are characterized in any way as compensation for your injuries or for health care claims), the Fund shall have the right of first reimbursement out of the amount recovered. The Fund explicitly rejects the "Make Whole Doctrine": This right of first reimbursement shall apply even if the amount you or your dependents receive from the third party is less than your actual loss resulting from the illness or injury.
- The Fund explicitly rejects the "Common Fund Doctrine" with respect to attorney's fees and other costs of litigation and assumes no responsibility for payment of any kind from a third party – including legal costs and attorney's fees. Expenses related to any recovery from a third party shall not reduce the amount due the Fund.
- If you or your dependents do not sue the third party for the illness or injury, the Fund reserves the right to sue the third party for the amount of Plan benefits paid on your or your dependents' behalf, and for the Fund's attorney's fees.
- You and your dependents will help the Fund recover the Plan benefits from the third party by taking every reasonable step necessary to secure payment from the third party and/or assisting the Fund to recover payment from the third party, including expressly agreeing that the Fund may join your lawsuit as a party and/or intervener.
- You and your dependents will sign any and all papers that will help the Fund recover Plan benefits from the third party.
- You and your dependents will tell the Fund immediately when you receive payment from a third party in connection with the illness or injury by calling the HSBA phone number listed on page 92 of this Summary Plan Description.
- If you or your dependents have uninsured motorist or under-insured motorist coverage under an automobile liability insurance policy that applies to an illness or injury cause or contributed to by a third party, the conditions described above also apply to your rights under that insurance policy.

If you or your dependents fail or refuse to assist the Fund in recovering damages from a third party, the Fund may:

Offset what is paid on your, and/or your dependents', future claims against the claims paid for which the Fund should have been reimbursed because of the illness or injury caused by the third party until the Fund is completely reimbursed for the cost of these claims, including but not limited to costs incurred in collection, including:

- File a lawsuit against you or your dependents to fully recover the amount the Fund should have been reimbursed; and/or
- Take any other action deemed appropriate by the Board of Trustees.

If you or your dependents do not receive payment from a third party to reimburse you for an illness or injury caused by the third party, you do not have to reimburse the Fund for any benefits properly paid to you or your dependents. If you do receive payment from the third party, you do not have to pay the Fund more than the amount the third party paid to you or your dependents.

If you have questions about how to comply with these third party liability rules, contact the Trust Fund Office.

Hotel Employees Restaurant Employees Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

TO: **All Participants of the Hotel Employees Restaurant Employees Health Trust**

FROM: **The Board of Trustees**

RE: **Dental Plan Changes Effective January 1, 2008**

This is a Summary of Material Modification describing a recent benefit change adopted by the Board of Trustees. Please be sure that you and your family read this notice carefully. It should be kept with your benefit booklet or insurance records for future reference.

This is to inform you of important changes to your Dental Plan benefits that go into effect January 1, 2008.

The following materials are enclosed:

- New Language for Dental Implant Benefits
- New Schedule of Benefits for Pacific Dental Alliance Providers
- New Pacific Dental Alliance Provider Listing
- New Schedule of Benefits for Non-Pacific Dental Alliance Providers

Please read these documents carefully and keep them with your Plan Booklet, and other important Trust documents so you can refer to them when necessary.

If you have any questions regarding these changes, please contact the Administration Office at 1-800-331-6158.

Trust Administration Office
Hotel Employees Restaurant Employees Health Trust

GG:mc opeiu#8
S:\SHARED SEC\Docs\F19\F19-02 Dental Benefit Ltr.doc

Enclosures

HOTEL EMPLOYEES RESTAURANT EMPLOYEES HEALTH TRUST

Dental Benefit Update

The following provisions will be included under the Dental Plan effective January 1, 2008:

- **Implants**

Surgical placement or removal of implants or attachments to implants is covered up to the allowance of a crown. Replacement of implants and superstructures is covered only after 5 years have elapsed from any prior provision of the implant. These benefits are subject to the calendar year maximum provided by the plan.

GG:mc opeiu#8
S:\SHARED SEC\Docs\F19\F19-02DentUpdateJan08.doc

HOTEL EMPLOYEES RESTAURANT EMPLOYEES HEALTH TRUST

SCHEDULE OF DENTAL BENEFITS EFFECTIVE JANUARY 1, 2008

FOR PACIFIC DENTAL ALLIANCE PROVIDERS

Procedure Code	Description	Benefit Allowance Current	Benefit Allowance Revised Effective 1/1/08
Diagnostic			
150	Comprehensive Oral Evaluation	$31	$35
210	Xray - Complete Series	$68	$75
230	Intraoral Periapical Each Add.	$3	$5
Preventive			
1110	Prophylaxis - Adult	$70	$90
Restorative			
2391	Resin - One Surface, Posterior	$89	$100
2392	Resin - Two Surface, Posterior	$119	$140
2393	Resin - Three Surface, Posterior	$150	$180
2394	Resin - Four Surface, Posterior	$134	$220
Endodontics			
3310	Root Canal Therapy - Anterior	$300	$450
3320	Root Canal Therapy - Bicuspid	$400	$550
3330	Root Canal Therapy - Molar	$500	$650
Periodontics			
4341	Periodontal Scaling and Root Planning	$94	$125
4910	Periodontal Maintenance	$73	$125
Prosthodontics			
5110	Complete Dentures - Maxillary	$600	$750
5120	Complete Dentures - Mandibular	$600	$750
Oral Surgery			
7140	Extraction - Erupted Tooth or Root	$70	$100
7210	Surgical Extraction - Erupted	$150	$200

- OVER -

The dental offices listed below will accept the HERE Trust Dental Plan as payment-in-full.

This means HERE members and their families who are covered by the Trust Dental Plan will pay nothing for dental care provided within the limits of the dental plan.*

Washington State Locations

(Offices of Pacific Dental Alliance)

Bellevue/Factoria
(425) 401-5000
Affordable Dental Care
12826 SE 40th Lane
Ste 201

Bellingham
(360) 734-3011
Lee Family Dental
3800 Byron Ave.
Ste 122

Bremerton
(360) 792-0300
Avenue Dental Care
2741 Wheaton Way
Ste B

Burien
(206) 988-0500
Affordable Dental Care
15726 1st Ave. S.

Edmonds
(425) 778-6333
Avenue Dental Care
23805 Highway 99
Ste 100

Everett
(425) 438-8584
Avenue Dental Care
8625 Evergreen Way
Ste 212

Federal Way
(253) 946-3895
Sterling Dental Care
30620 Pacific Hwy S.
Ste 111

Kennewick
(509) 735-9999
Avenue Dental Care
7521 W. Deschutes Ave.

Kent/Covington
(253) 630-3500
Affordable Dental Care
16720 SE 271st St.
Ste 211

Mt. Vernon
(360) 424-7921
Patel Dental Care
120 S. 15th St.
Ste A

Olympia/Tumwater
(360) 943-5420
Affordable Dental Care
6015 Capitol Blvd. SW

Puyallup
(253) 435-5656
Avenue Dental Care
10317 122nd St. E.
Ste D

Spokane (North)
(509) 467-8000
Avenue Dental Care
755 E. Holland Ave.

Spokane Valley
(509) 926-1500
Avenue Dental Care
12122 E. Cataldo Ave.

Tacoma
(253) 471-2655
Affordable Dental Care
4704 S. Oakes St.
Ste 103

Dentists: Steven Paige, Aditi Agarwal, Kenza Houki, Choong Lee, Bob Virk, Evy Kollia, Danlu Lee, Wendy Yeung, Katherine Kim, Rattan Bains, Naguib Youssef, Andrea Doan, Michael Nguyen, Navdeep Virk, Trent Webb, Angelina Fu, Gabor Klade, Spencer Cammack, Joe Lee, Varun Sharma, Jasjot Mann, Rezene Laurel, Michael Kim, Shioon Kim, Raman Patel.

Oregon State Locations

(Offices of Access Dental)

Gresham
(503) 465-0005
Avenue Dental Care
1388 E. Powell Blvd.
Drs.: Bob Virk and Brian Waldau

Clackamas
(503) 786-3000
Avenue Dental Care
10001 SE Sunnyside Rd., Suite 250
Drs.: Bob Virk and Benjamin Beard

- This offer applies to members covered by the HERE Trust Dental Plan. This offer is valid through January 2010. Implants, implant crowns, crowns with gold, all porcelain crowns, porcelain onlays/inlays, and specialty services performed in or out of these offices are not included.

- OVER -

HOTEL EMPLOYEES RESTAURANT EMPLOYEES HEALTH TRUST
SCHEDULE OF DENTAL BENEFITS EFFECTIVE JANUARY 1, 2008 FOR NON PACIFIC DENTAL ALLIANCE PROVIDERS

Procedure Code	Description	Benefit Allowance Current	Benefit Allowance Revised Effective 1/1/08
Diagnostic			
120	Periodic Oral Examination	$19	$21
130	Emergency Oral Examination	$25	$20
140	Limited Oral Evaluation	$25	$21
150	Comprehensive Oral Evaluation	$23	$31
210	Xray - Complete Series	$48	$68
220	Intraoral Periapical First Film	$7	$10
230	Intraoral Periapical Each Add.	$4	$3
240	Intraoral Occlusal Film	$22	$15
274	Bitewings Four Films	$19	$26
330	Panoramic Film	$46	$50
460	Pulp Vitality Tests	$16	$25
Preventive			
1110	Prophylaxis - Adult	$34	$70
1120	Dental Prophylaxis - Children	$34	$42
1203	Fluoride (Excluding Prophy) - Children	$16	$15
1204	Fluoride (Excluding Prophy) - Adult	$16	$15
1351	Sealant per Tooth	$0	$25
1510	Space Maintainer Fixed Unilated	$113	$125
1515	Space Maintainer Fixed Bilateral	$170	$150
Restorative			
2140	Amalgam One Surface	$32	$60
2150	Amalgam Two Surface	$49	$75
2160	Amalgam Three Surface	$67	$99
2161	Amalgam Four/More Surface	$85	$120
2330	Comp Resin One Surface Anterior	$45	$83
2331	Comp Resin Two Surface Anterior	$69	$94
2332	Comp Resin Three Surface Anterior	$102	$150
2335	Comp Resin Four/More Surface Anterior	$134	$165
2391	Resin - One Surface, Posterior	$48	$89
2392	Resin - Two Surface, Posterior	$74	$119
2393	Resin - Three Surface, Posterior	$110	$150
2394	Resin - Four Surface, Posterior	$134	$180
2750	Crown Porcelain with High Noble	$365	$575
2751	Crown Porcelain with Predomina	$365	$400
2752	Crown Porcelain with Noble Metal	$365	$520
2790	Crown Full Cast High Noble Metal	$322	$609
2920	Recement Crown	$27	$40
2931	Prefab Stainless Steel Crown	$87	$150
2950	Crown Buildup	$84	$126
2951	Pin Retention per Tooth Addition	$21	$25
2952	Cast Post/Core in Addition to	$123	$300
2954	Prefab Post/Core in Add to Crown	$108	$150
Endodontics			
3110	Pulp Cap Direct (Excl Final Resin)	$22	$25
3220	Therapeutic Pulpotomy Excluded	$50	$75
3310	Root Canal Therapy - Anterior	$235	$300
3320	Root Canal Therapy - Bicuspid	$316	$400
3330	Root Canal Therapy - Molar	$391	$500
3340	Four/More Canals Excluding	$0	$750
3346	Anterior Retreatment of Root Canal	$316	$500

- OVER -

SCHEDULE OF DENTAL BENEFITS EFFECTIVE JANUARY 1, 2008 FOR NON PACIFIC DENTAL ALLIANCE PROVIDERS

Procedure Code	Description	Benefit Allowance Current	Benefit Allowance Revised Effective 1/1/08
Endodontics (cont.)			
3347	Bicuspid Retreatment of Root Canal	$468	$600
3348	Molar Retreatment of Root Canal	$563	$700
Periodontics			
4210	Gingivectomy Gingivoplasty 4	$155	$275
4220	Gingival Curettage Per Quadrant	$55	$125
4249	Crown Lengthening Hard Tissue	$155	$500
4260	Osseous Surg-Inc Flap Entry	$348	$900
4263	Bone Replacement Graft	$179	$350
4271	Free Soft Tissue Graft	$181	$600
4321	Provisional Splinting Extracor	$139	$300
4341	Periodontal Scaling and Root Planning	$82	$94
4910	Periodontal Maintenance	$60	$73
Prosthodontics			
5110	Complete Dentures - Maxillary	$542	$600
5120	Complete Dentures - Mandibular	$542	$600
5130	Immediate Upper Denture	$542	$850
5140	Immediate Lower Denture	$542	$850
5211	Upper Partial Acrylic Base	$278	$750
5213	U Partial Cast Metal Frame	$581	$650
5214	L Partial Predom Base Cast Bas	$581	$650
5510	Repair Broken Complete Denture	$47	$300
5520	Replace Missing/Broken Tooth	$38	$125
5610	Repair Resin Denture Base	$47	$125
5620	Repair Cast Framework	$62	$75
5630	Repair or Replace Broken Clas	$55	$75
5640	Replace Broken Teeth Per Tooth	$38	$75
5650	Add Tooth to Existing Partial	$62	$125
5740	Reline Upper Partial Denture	$139	$250
5750	Reline Upper Complete Denture	$155	$150
5751	Reline Lower Complete Denture	$155	$150
5760	Reline Lower Partial Denture	$155	$150
5761	Reline Lower Partial Denture	$155	$150
5810	Interim Complete Denture (Upper)	$193	$350
5820	Interim Partial Stayplate Dent	$193	$350
5821	Interim Partial Stayplate Lower	$193	$350
5850	Tissue Conditioning Maxillary	$62	$60
Other			
6241	Pontic Porcelain with Predominant	$297	$400
6751	Crown Porcelain with Predomina	$379	$400
6930	Recement Bridge	$49	$80
Oral Surgery			
7111	Simple Extraction First Tooth	$42	$75
7140	Extraction - Erupted Tooth or Root	$42	$70
7210	Surgical Extraction - Erupted	$68	$150
7220	Removal of Impacted Tooth So	$98	$147
7230	Removal of Impacted Tooth Pa	$135	$147
7240	Removal of Impacted Tooth Co	$179	$210
7250	Surgical Removal of Residual	$78	$150
7310	Alveoloplasty in Conjunct W/E	$98	$200
7510	Surg Incision & Drain of Abcess	$41	$125

Hotel Employees Restaurant Employees Trust Funds

2815 2nd Avenue, Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

January 12, 2007

TO: ALL ELIGIBLE PLAN PARTICIPANTS
HOTEL EMPLOYEES RESTAURANT EMPLOYEES HEALTH TRUST

This letter describes upcoming changes to your prescription plan. Please be sure that you and your family read it carefully. Keep this notice with your benefit booklet or insurance records.

CHANGE OF PRESCRIPTION DRUG BENEFIT MANAGER – Effective February 1, 2007

The Board of Trustees is pleased to announce that it has been successful in contracting with Express Scripts Inc. to manage your prescription drug benefits. This letter serves as an introduction to your new prescription benefit program. By the end of January you will be receiving your new combination Medical, Dental, Vision, and Prescription Drug Identification (ID) cards along with additional information explaining the new program.

In an effort to further protect your personal information, the new ID cards will list a unique 7-digit identification number, rather than listing the last 4 digits of your social security number.

Please note there are no changes to your Medical, Dental, Vision or Prescription benefits. The retail and mail order prescription copayments will remain at $12 for each prescription. Remember, if you purchase a brand-name prescription drug and a generic equivalent is available, you will be responsible for payment of the difference in cost between the two medications in addition to the copayment.

The Trust was unable to obtain prescription refill records from the previous mail order vendor. If you currently have mail order prescriptions with refills through NMHCRx, those prescriptions will not be transferred to Express Scripts. To continue the convenience of mail order prescriptions follow these steps:

1. Ask your doctor to write a new prescription for up to a 90-day supply of your medication, plus refills for up to one year, if appropriate.
2. Complete and sign a New Patient Home Delivery Form (this form will come with your new ID cards), do not mail before January 18, 2007.
3. Mail your new prescription, copayment and completed form to the address indicated on the Home Delivery Form
4. Your doctor can fax your prescription directly to Express Scripts at 800.396.2171.

WHAT YOU NEED TO DO WHEN YOU RECEIVE YOUR NEW ID CARDS

- Make sure your name is listed correctly
- Place your new cards into your purse or wallet
- Destroy your old identification cards after January 31, 2007
- Carefully review the packet of materials included with your new ID cards
- Present your new ID card whenever visiting the doctor, hospital or when obtaining a prescription
- Do Not Use your new card until February 1, 2007

WHAT IF I DON'T RECEIVE MY ID CARD OR MY NAME IS MIS-SPELLED?

Please contact the Administration Office to order an ID card or to have your card corrected. You can also call the Administration Office to verify eligibility and benefits. The phone numbers for assistance are as follows:

ID card corrections and eligibility verification:	800.732.1121, press option 4
Questions regarding benefits:	800.331.6158, press option 0

Board of Trustees
Hotel Employees Restaurant Employees Health Trust

CJ:mc opeiu#8/ S:\SHARED SEC\Docs\F19\ESIannouncementltrDrft#1-20070108.doc

12 de enero de 2007

A: TODOS LOS PARTICIPANTES DEL PLAN QUE REÚNEN LOS REQUISITOS
EMPLEADOS DEL HOTEL, EMPLEADOS DEL RESTAURANTE, CONSORCIO DE ALUD

Esta carta describe los próximos cambios a su plan de farmacia. Por favor, asegúrese de leerla atentamente junto a su familia. Guarde este aviso con su folleto de beneficios o documentos del seguro.

CAMBIO DEL ADMINISTRADOR DE BENEFICIOS DE MEDICAMENTOS DE VENTA CON RECETA - En vigor el 1ro de febrero de 2007

La Junta Directiva se complace en anunciar que ha firmado con éxito un contrato con Express Scripts Inc. para administrar sus beneficios de medicamentos de venta con receta. Esta carta sirve de introducción para su nuevo programa de beneficios de medicamentos con receta. A finales de enero usted recibirá sus nuevas tarjetas de identificación (ID) que combinan los seguros médico, dental, oftalmológico y de medicamentos con receta, junto con información adicional que explica el nuevo programa.

En un esfuerzo para proteger aún más su información personal, las nuevas tarjetas de identificación contendrán un número de identificación único de 7 dígitos, en lugar de los 4 últimos dígitos de su número de seguro social.

Por favor, tenga en cuenta que sus beneficios médicos, dentales, oftalmológicos o de medicamentos con receta no han cambiado. Los copagos de los medicamentos con receta que se venden al público y los pedidos por correo siguen siendo de $12 por receta médica. Recuerde, si usted compra un medicamento con receta de marca registrada y un equivalente genérico está disponible, usted será responsable de pagar la diferencia de precio entre los dos medicamentos, además del copago.

El Consorcio no pudo obtener del proveedor anterior los registros correspondientes a la reposición por correo de las recetas. Si usted tiene en este momento recetas para pedir por correo y que se surten de nuevo por medio de NMHCRx, esas recetas no se transferirán a Express Scripts. Para seguir teniendo la oportunidad de ordenar sus recetas por correo, siga los pasos a continuación:

1. Pídale a su doctor que escriba una nueva receta por una cantidad de medicamento que dure hasta 90 días, con posibilidad de volverla a surtir durante un año, si corresponde.
2. Complete y firme un Formulario de Entrega a Domicilio para Pacientes Nuevos (recibirá este formulario con sus nuevas tarjetas de identificación); no lo envíe por correo antes del 18 de enero de 2007.
3. Envíe por correo su nueva receta, copago y formulario completo a la dirección indicada en el Formulario de Entrega a Domicilio
4. Su doctor puede enviar la receta directamente por fax a Express Scripts al 800.396.2171.

QUÉ NECESITA HACER CUANDO RECIBA SUS NUEVAS TARJETAS DE IDENTIFICACIÓN

- Asegúrese de que su nombre esté correcto
- Guarde las nuevas tarjetas en su bolso o billetera
- Destruya las tarjetas de identificación antiguas después del 31 de enero de 2007
- Revise con cuidado el paquete de materiales que se incluye con sus nuevas tarjetas de identificación
- Presente su nueva tarjeta de identificación cada vez que visite al doctor, vaya al hospital o necesite una nueva receta
- No utilice su nueva tarjeta antes del 1ro de febrero de 2007

¿QUÉ PASA SI NO RECIBO MI TARJETA DE IDENTIFICACIÓN O SI MI NOMBRE ESTÁ MAL ESCRITO?

Por favor, póngase en contacto con la oficina administrativa para solicitar una tarjeta de identificación o para que le corrijan la suya. También puede llamar a la oficina administrativa para verificar su elegibilidad y beneficios. Los números de teléfono para obtener ayuda son los siguientes:

Correcciones a la tarjeta de identificación y verificación de la elegibilidad:	800.732.1121, presione la opción 4
Preguntas con respecto a los beneficios:	800.331.6158, presione la opción 0

Junta Directiva
Empleados del hotel, Empleados del restaurante, Consorcio de Salud

HOTEL EMPLOYEES RESTAURANT EMPLOYEES HEALTH TRUST

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Pursuant to regulations issued by the federal government, the Trust is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes protected health information as defined in the Privacy Rules of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). As required by law, the Trust has established a policy to guard against unnecessary disclosure of your health information. This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights in regard to such information.

PROTECTED HEALTH INFORMATION

Protected health information generally means information that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (3) identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

USE AND DISCLOSURE OF HEALTH INFORMATION

Your health information may be used and disclosed without an authorization for the purposes listed below. The health information used or disclosed will be limited to the "minimum necessary," as defined under the Privacy Rules.

To Make or Obtain Payment. The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Trust may use your health information to pay claims, or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits.

To Facilitate Treatment. The Trust may disclose information to facilitate treatment which involves the provision, coordination or management of health care or related services. For example, the Plan may disclose the name of your treating physician to another treating physician for the purpose of obtaining x-rays.

To Conduct Health Care Operations. The Trust may use or disclose health information for its own operations to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's participants. Health care operations include such activities as: contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management, medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, including cost management and planning related

analyses and formulary development, and accreditation, certification, licensing or credentialing activities).

In Connection With Judicial and Administrative Proceedings. If required or permitted by law, the Trust may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. The Trust will make reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

When Legally Required For Law Enforcement Purposes. The Trust will disclose your health information when it is required to do so by any federal, state or local law. Additionally, as permitted or required by law, the Trust may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Trust has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Conduct Health Oversight Activities. The Trust may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In the Event of a Serious Threat to Health or Safety. The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, federal regulations require the Trust to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

To Your Personal Representative. The Trust may disclose your health information to an individual who is considered to be your personal representative under applicable law.

To Individuals Involved in Your Care or Payment for Your Care. The Trust may disclose your health information to immediate family members, or to other individuals who are directly involved in your care or payment for your care.

To Business Associates. The Trust may disclose your health information to its Business Associates, which are entities or individuals not employed by the Trust, but which perform functions for the Trust involving protected health information, such as claims processing, utilization review, or legal, consulting, accounting or administrative services. The Trust's Business Associates are required to safeguard the confidentiality of your health information.

For Workers' Compensation. The Trust may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

For Disclosure to the Plan Trustees. The Trust may disclose your health information to the Board of Trustees (which is the plan sponsor) and to necessary advisors for plan administration functions, such as those listed in this summary, or to handle claim appeals, solicit bids for services, or modify, amend or terminate the plan. The Trust may also disclose information to the Trustees regarding whether you are participating or enrolled in the plan.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Trust will not disclose your health information other than with your written authorization. Authorization forms are available from the Privacy Contact Person, listed below. If you have authorized the Trust to use or disclose your health information, you may revoke that authorization in writing at any time. The revocation should be in writing, include a copy of or reference your authorization and be sent to the Privacy Contact Person, listed below.

Special rules apply to disclosure of psychotherapy notes. Your written authorization will generally be required before the Plan will use or disclose psychotherapy notes. Psychotherapy notes are separately filed notes about your observations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed to defend against litigation filed by you.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Trust maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in the payment of your care. However, the Trust is not required to agree to your request. If you wish to request restrictions, please make the request in writing to the Trust's Privacy Contact Person listed below.

Right to Confidential Communications. You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Trust's Privacy Contact Person, listed below. The Trust will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceedings. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person, listed below. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person, listed below. The Trust may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting be amended is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

If the Trust denies a request for amendment, you may write a statement of disagreement. The Trust may write a rebuttal statement and provide you with a copy. If you write a statement of disagreement, then your request for amendment, your statement of disagreement, and the Trust's rebuttal will be included with any future release of the disputed health information.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Contact Person listed below. The request should specify the time period for which you are requesting the information, but may not start earlier than **April 14, 2003** when the Privacy Rules became effective. Accounting requests may not be made for periods of time going back more than six (6) years. An accounting will not include disclosure made to carry out treatment, payment, and health care operations; disclosures that were made to you; disclosures that were incident to a use or disclosure that is otherwise permitted by the Privacy Rules; disclosures made pursuant to an authorization; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person, listed below. You will also be able to obtain a copy of the current version of the Trust's Notice at its web site, www.wpas-inc.com.

Privacy Contact Person. To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Trust has also designated a Privacy Official, listed below.

Privacy Contact Person
Claims Manager
Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124
Phone No: 206-441-7574
Toll Free: 800-331-6158
Fax No: 206-441-9110

Privacy Official
Gilbert Lynn
Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124
Phone No: 206-441-7574
Toll Free: 800-331-6158
Fax No: 206-441-9110

DUTIES OF THE TRUST

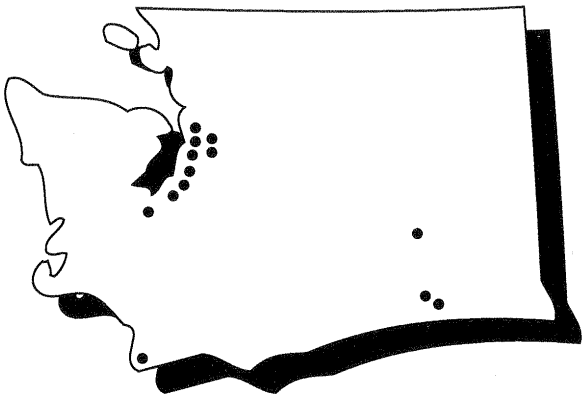
The Trust is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Contact Person identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.

EFFECTIVE DATE

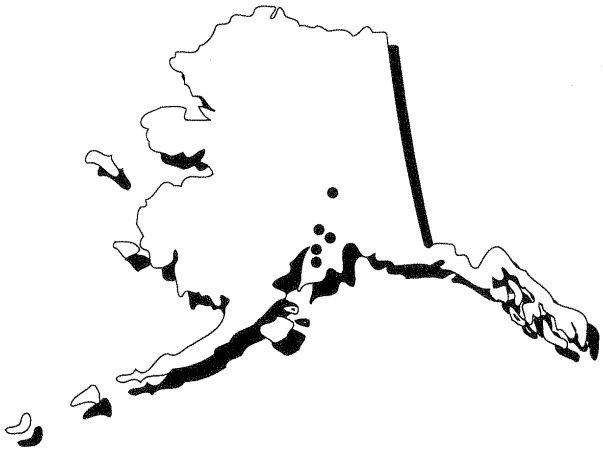
This Notice is effective **April 14, 2003**.

HERE HEALTH TRUST VISION BENEFIT LOCATIONS

WASHINGTON



ALASKA



Auburn
The Optical Shoppe
Inside Fred Meyer
801 Auburn Way N
253-735-4732

Bellevue
The Optical Shoppe
Inside Fred Meyer
2041 148th NE
425-644-4226

Bonney Lake
The Optical Shoppe
Inside Fred Meyer
20901 Hwy. 410
253-863-9798

Covington
The Optical Shoppe
Inside Fred Meyer
16735 SE 272nd St.
253-639-4077

Everett
The Optical Shoppe
Inside Fred Meyer
8530 Evergreen Way
425-353-2750

Kennewick
The Optical Shoppe
Inside Fred Meyer
2811 W. 10th Avenue
509-734-2511

Kent
The Optical Shoppe
Inside Fred Meyer
25250 Pacific Hwy. S
253-839-1773

Lacey
The Optical Shoppe
Inside Fred Meyer
700 Sleater-Kiney Rd.
360-491-8440

Lynnwood
The Optical Shoppe
Inside Fred Meyer
4615 196th St. SW
425-778-2611

Marysville
The Optical Shoppe
Inside Fred Meyer
9925 State Ave.
360-653-3498

Monroe
The Optical Shoppe
Inside Fred Meyer
18805 State Rt. #2
360-805-9323

Puyallup
The Optical Shoppe
Inside Fred Meyer
1100 N. Meridian St.
253-848-9600

Renton
The Optical Shoppe
Inside Fred Meyer
365 Renton Center Way SW
425-255-4630

The Optical Shoppe
Inside Fred Meyer
17801 108th Ave. SE
425-271-9211

Richland
The Optical Shoppe
Inside Fred Meyer
101 Wellsian Way
509-943-6270

Seattle
The Optical Shoppe
Inside Fred Meyer
18325 Aurora Ave. N
206-542-3464

The Optical Shoppe
Inside Fred Meyer
100 NW 85th St.
206-782-0129

The Optical Shoppe
Inside Fred Meyer
915 NW 45th Street
206-789-8694

Tocoma
The Optical Shoppe
Inside Fred Meyer
7250 Pacific Ave.
253-472-1168

The Optical Shoppe
Inside Fred Meyer
4505 S 19th St. E.
253-752-4396

Vancouver
The Optical Shoppe
Inside Fred Meyer
11325 SE Mill Plain Blvd.
360-256-8129

Anchorage
The Optical Shoppe
Inside Fred Meyer
1000 E Northern Lights Blvd.
907-279-8651

The Optical Shoppe
Inside Fred Meyer
7701 DeBarr Rd.
907-333-6960

The Optical Shoppe
Inside Fred Meyer
2300 Abbott Road
907-336-2140

Eagle River
The Optical Shoppe
Inside Fred Meyer
13401 Old Glenn Hwy.
907-622-0835

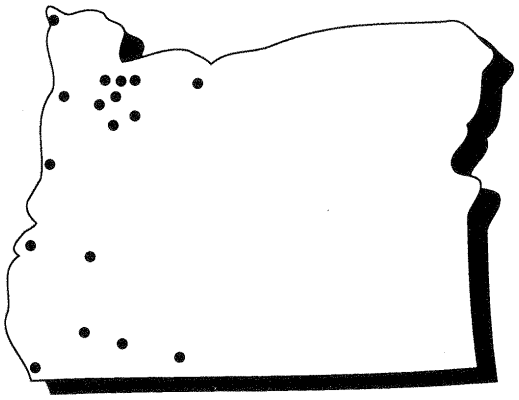
Fairbanks
The Optical Shoppe
Inside Fred Meyer
3755 Airport Way
907-474-4900

Soldotna
The Optical Shoppe
Inside Fred Meyer
43843 Sterling Hwy.
907-260-3316

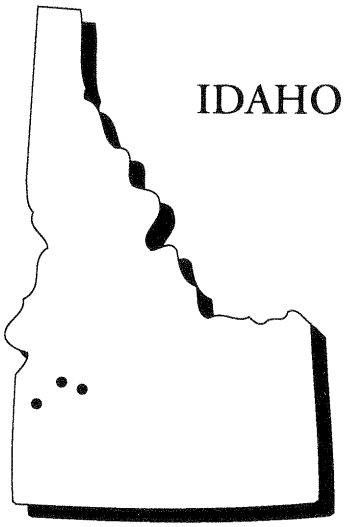
Wasilla
The Optical Shoppe
Inside Fred Meyer
1501C E. Parks Hwy.
907-357-1455

HERE HEALTH TRUST VISION BENEFIT LOCATIONS

OREGON



IDAHO



Beaverton
The Optical Shoppe
Inside Fred Meyer
11425 SW Beaverton Hwy.
503-643-5590

The Optical Shoppe
Inside Fred Meyer
15995 SW Walker Rd.
503-690-0793

Brookings
The Optical Shoppe
Inside Fred Meyer
325 Fifth St.
541-469-5556

Canby
The Optical Shoppe
Inside Fred Meyer
1401 SE 1st Avenue
503-263-4583

Clackamas
The Optical Shoppe
Inside Fred Meyer
16301 SE 82nd Dr.
503-657-9504

Coos Bay
The Optical Shoppe
Inside Fred Meyer
1020 S First Ave.
541-267-7877

Cornelius
The Optical Shoppe
Inside Fred Meyer
2200 Baseline St.
503-359-0336

Grants Pass
The Optical Shoppe
Inside Fred Meyer
1101 Grants Pass Pkwy.
541-474-5841

Gresham
The Optical Shoppe
Inside Fred Meyer
2497 SE Burnside Rd.
503-661-8796

Hillsboro
The Optical Shoppe
Inside Fred Meyer
22075 NW Imbrie Dr.
503-681-9550

The Optical Shoppe
Inside Fred Meyer
23105 SW Tualatin Valley Hwy.
503-356-5501

Klamath Falls
The Optical Shoppe
Inside Fred Meyer
2655 Shasta Way
541-882-7082

Medford
The Optical Shoppe
Inside Fred Meyer
2424 Crater Lake Hwy.
541-779-0362

Newport
The Optical Shoppe
Inside Fred Meyer
150 NE 20th St.
541-265-4201

Oregon City
The Optical Shoppe
Inside Fred Meyer
1839 Molalla Ave.
503-656-2453

Portland
The Optical Shoppe
Inside Fred Meyer
1111 NE 102nd Ave.
503-255-7782

The Optical Shoppe
Inside Fred Meyer
14700 SE Division
503-761-1975

The Optical Shoppe
Inside Fred Meyer
8955 SE 82nd Ave.
503-788-1383

Portland (con't)
The Optical Shoppe
Inside Fred Meyer
3030 NE Weidler
503-284-1077

Roseburg
The Optical Shoppe
Inside Fred Meyer
929 NW Garden Valley Rd.
541-672-7566

The Dalles
The Optical Shoppe
Inside Fred Meyer
1215 W Sixth St.
541-296-6139

Tillamook
The Optical Shoppe
Inside Fred Meyer
2500 N Main St.
503-815-3855

Tualatin
The Optical Shoppe
Inside Fred Meyer
19200 SW Martinazzi
503-692-5040

Warrenton
The Optical Shoppe
Inside Fred Meyer
1451 Hwy. 101
503-861-9829

Boise
The Optical Shoppe
Inside Fred Meyer
10751 W Overland Rd.
208-327-9809

Garden City
The Optical Shoppe
Inside Fred Meyer
5425 Chinden Blvd.
208-322-1457

Nampa
The Optical Shoppe
Inside Fred Meyer
60 Second St. S
208-465-5861

NMHCRx

PARTICIPATING CHAIN PHARMACIES IN OREGON AND WASHINGTON

Albertson's Pharmacy

Bartell Drugs

Bi-Mart Pharmacy

Costco Pharmacy

Drug Emporium

Fred Meyer Pharmacy

Haggen Pharmacy

Hi School Pharmacy

K-Mart Pharmacy

Long's Drug

Medicine Shoppe

QFC Pharmacy

Rite Aid Pharmacy

Safeway Pharmacy

Shopko Pharmacy

Target Pharmacy

Tidyman's Pharmacy

Wal Mart Pharmacy

Walgreen's Pharmacy

**NOTE: For a more complete list of participating pharmacies, contact NMHCRx @ 1-800-880-1188*

Pacific Dental Alliance

Affiliated Provider List*

Bremerton (360) 792-0300	Avenue Dental Care 2741 Wheaton Way, Suite B Bremerton, WA 98310
Everett (425) 438-8584	Affordable Dental Care 8625 Evergreen Way, Suite 212 Everett, WA 98208
Factoria/Bellevue (425) 401-5000	Affordable Dental Care 12826 SE 40th Lane, Suite 201 Bellevue, WA 98006
Federal Way (253) 946-3895	Evergreen Dental Care 30620 Pacific Hwy. S., Suite 111 Federal Way, WA 98003
Mount Vernon (360) 848-7473	Evergreen Dental Care 2105 Continental Place Mount Vernon, WA 98273
Olympia (360) 943-5420	Affordable Dental Care 2600 Martin Way, Suite A Olympia, WA 98506
Puyallup (253) 435-5656	Affordable Dental Care 11707 101st Avenue E Puyallup, WA 98373
Tacoma (253) 471-2655	Affordable Dental Care 4704 South Oakes St., Suite 103 Tacoma, WA 98409
Spokane (509) 926-1500	Avenue Dental Care 12122 E Cataldo Ave. Spokane, WA 99206

G:\user\shareoss\forms-originals\052202\cj

INTRODUCTION

To Eligible Employees:

We are pleased to present you with this new and up-to-date Plan Booklet of the amended and restated Hotel Employees Restaurant Employees Health Trust Plan, effective June 1, 2004 The Plan provides Weekly Disability, Medical, Vision, Hearing Aid Device, Dental, Life Insurance and Accidental Death and Dismemberment Benefits.

We encourage you to read this Plan Booklet carefully so that you are aware of all your health and welfare benefits under the Plan.

If you have any questions, please contact the **Trust Administration Office** for assistance.

Sincerely,

Board of Trustees
Hotel Employees Restaurant Employee Health Trust

Employer Trustees	**Union Trustees**
Michael Bashaw, Chairman	Richard F. Sawyer, Secretary
Jill Ridlehoover	Erik VanRossum
Lee Kaufman	Jeff Richardson
Howard Cohen	Elizabeth Freeman
John Taffin	Omar Perestrejo
Brad Hutton	Enrique Fernandez

IMPORTANT!

The Board of Trustees has the full and exclusive authority, in its discretion, to interpret and apply the Plan (except with respect to Life Insurance Benefits and Accidental Death and Disability Benefits, which are provided by LifeWise Assurance Company), including its rules for eligibility. See *General Plan Provisions — Plan Interpretation; Board's Discretionary Authority* below at page 63.

Only the Board of Trustees is authorized to interpret the Plan. No employer or local union, no representative of any employer or local union, and no individual Trustee is authorized to interpret the Plan - nor can any such person act as an agent of the Board of Trustees to guarantee benefit payments.

No agreement between an employer and a union may change, override or otherwise affect the Plan in any way.

The Hotel Employees Restaurant Employees Health Trust provides benefits to the extent money is available to pay for the benefits. The Plan is not guaranteed to continue indefinitely. The Board of Trustees may make amendments to the Plan, including amendments that affect the eligibility rules and the amount and nature of benefits. Amendments may be made on a prospective or retroactive basis. The Board of Trustees also has the authority to terminate the Plan at any time.

Refer your questions concerning the Plan to the **Trust Administration Office**. Telephone contact with the **Trust Administration Office** does not guarantee eligibility for benefits under the Plan or eligibility for benefit payments. Eligibility for benefits under the Plan and eligibility for benefit payments are determined only when a claim is submitted to the Trust.

In order to keep your eligibility records accurate, please keep the **Trust Administration Office** informed of any change in address, dependent status and designated beneficiary. All changes can be submitted to the **Trust Administration Office** by completing a new enrollment form.

Table of Contents

Summary of Benefits

The following is the only summary of benefits provided by the **Hotel Employees Restaurant Health Trust Plan**. You or your dependents may receive benefits only if you are eligible for benefits under the Plan.

Weekly Disability Benefits for Employees Only

Eligibility Rule A	$110 each week
Eligibility Rule B	$ 90 each week

Benefits Begin:

• due to accident	1st day
• due to illness or pregnancy and you are hospitalized	1st day
• due to illness or pregnancy and you are not hospitalized	5th day

Maximum Benefit Payment Period: 16 weeks

Medical Benefits

After you have satisfied your co pay and any deductible requirements, benefits will be provided at the payment levels specified below or in the Benefits section of this Plan Booklet. Additional benefits may in some cases be available and will be described in the Benefits section of this Plan Booklet.

Benefits Within the PPO Network Service Area (Washington and Oregon)

<table>
<tr><th>BENEFITS</th><th></th></tr>
<tr><td></td><td>
<u>PPO IN-NETWORK BENEFITS (Washington and Oregon)</u> <u>OUT-OF- NETWORK BENEFITS outside (Washington and Oregon)</u>
You must preauthorize all inpatient hospital admissions (except maternity admissions) and outpatient surgery except for surgery that is done in a physician's office. Failure to do so will result in a $250 benefit reduction (not to exceed $500) for all related expenses incurred in excess of the deductible for each surgery or hospitalization that is not preauthorized.

Emergency hospital admissions or emergency surgeries must be authorized within 48 hours of the time you are admitted to the hospital or the surgery is performed.

To be eligible for this level of benefits, you must use a Preferred Provider. You pay a copay at the time you receive most outpatient services and a percentage of eligible expenses.

The Out-of-Network Benefits offers you the freedom to choose from any non-Preferred Providers. You pay a copay at the time you receive most outpatient services and a percentage of eligible expenses. In addition, the yearly deductible will be applied to eligible expenses and will be your responsibility to pay.
</td></tr>
</table>

BENEFITS		
Lifetime Maximum	$1,000,000	
Annual Deductible	None	$500 per person; $1,500 per family
Percentage Payable	90%	60%
Out-of-Pocket Maximum	$5,000 per person; $15,000 per family per calendar year (copayments are not included)	$10,000 per person; $30,000 per family per calendar year (copayments and deductibles are not included)
COVERED SERVICES		
Preventive Care	90% after $20 copay on Doctor exam fee (no copay on lab or x-ray services)	No coverage except for 60% for mammograms (no copay) Subject to the deductible
Office and Outpatient Professional Visit	90% after $20 copay	60% after $20 copay and deductible
Diagnostic X ray/Lab Services	90%	60% after deductible
Inpatient Hospital & Skilled Nursing Facility (SNF)	90% SNF limited to 90 days each calendar year	60% after deductible SNF limited to 90 days each calendar year
Outpatient Hospital	90% after $20 copay (except no copay on surgery, radiation or chemotherapy)	60% after $20 copay (except no copay on surgery, radiation or chemotherapy) and deductible
Emergency Room	90% after $75 per visit (waived if admitted)	60% after $75 copay per visit (waived if admitted) and deductible
Ambulance	80% after deductible to $2,000 maximum payable each calendar year	
Chemical Dependency	90% to $11,000 each 2 calendar years Professional visit subject to $20 copay	60% after deductible to $11,000 each 2 calendar years Professional visit subject to $20 copay
Home Health Care	90% for 130 visits each calendar year ($20 copay applies to each visit)	60% after $20 copay per visit and deductible for 130 visits each calendar year

BENEFITS		
Hospice Care	90% with 6 months lifetime maximum Professional visits subject to $20 copay	60% after deductible with 6 months lifetime maximum Professional visits are subject to deductible and the $20 copay
Maternity	90% after copay	60% after copay and deductible
Mental Disorders		
Inpatient	90% to 12 days per calendar year	60% after deductible to 6 days per calendar year
Outpatient	90% after $20 copay per visit to a maximum of 15 visits per calendar year	60% after $20 copay per visit and deductible to a maximum of 12 visits per calendar year
Neurodevelopmental Therapy		
Inpatient	90%	60% after deductible
Outpatient	90% after $20 copay per visit to $1,000 combined maximum each calendar year	60% after $20 copay per visit and deductible to $1,000 combined maximum for all services each calendar year
Podiatric Service	90% after $20 copay	60% after $20 copay and deductible
Prescription Drugs	$12 copay at Participating Pharmacies, $12 copay through mail order generic drugs required, or pay difference Participating Pharmacies – 34 day supply Mail Order – 90 day supply	
Rehabilitative Care Inpatient	90% to $30,000 each condition	60% after deductible to $30,000 each condition
Outpatient	90% after $20 copay per visit to $1,000 each calendar year	60% after $20 copay per visit and deductible to maximum of $1,000 each calendar year

BENEFITS		
Smoking Cessation Programs	80% to $500 lifetime subject to $20 copay for professional visits and deductible	
TMJ		
Inpatient	90%	60%, after deductible
Outpatient	90% after $20 copay $1,000 maximum each calendar year; $5,000 lifetime combined maximum	60% after $20 copay and deductible $1,000 each calendar year; $5,000 lifetime combined maximum
Organ Transplants	90% to a lifetime maximum of $200,000 (pre authorization required)	90% after deductible to a lifetime maximum of $200,000 (pre authorization required)
Hearing Aid Device Benefit	Benefits for examination, device, and related covered services are paid at 100% to a maximum of $1,000 once in any three consecutive years. Benefits are subject to $20 copay Deductible does not apply	

Benefits Outside the PPO Network Service Area (Washington and Oregon)

If you receive care outside the PPO Network Service Area, benefits will be paid at 80% (deductible applies) of the out-of-network **allowed amount** for covered services. If you live inside the PPO Network Service Area and are admitted to a hospital on an emergency basis while traveling outside the PPO Network Service Area, you will receive the In-Network inpatient benefit payment percentage on covered charges, provided you follow the preauthorization guidelines outlined on page 23.

Vision Benefits

Paid according to the schedule beginning on page 37.

Hearing Aid Device Benefits

The Plan will provide benefits at 100% for both members and dependents to a maximum of $1,000 on covered services once in any three consecutive calendar years subject to benefit limitations beginning on page 39.

Dental Benefits

Paid according to the schedule beginning on page 40.

Life Insurance Benefits

Employee	$7,500
Spouse	$3,000
Dependent Child	$2,000

Accidental Death & Dismemberment Benefits

Principal Sum

Employee	$7,500

Contact Information

For Information Regarding	Contact
Eligibility for Benefits or Life/AD&D	**Trust Administration Office** WPAS, Inc. (206) 441-7574 (800) 331-6158 Fax: (206) 441-9110
Website	www.WPAS-inc.com
Claims: Medical, Dental, Vision, Time Loss	**Trust Administration Office** WPAS, Inc. (206) 441-7574 (800) 331-6158 Fax: (206)441-9110
Website	www.WPAS-inc.com
Prescription Drugs	NMHCRx
Retail and Mail Order	Customer Service (800) 880-1188
Website	www.nmhcrx.com
Hospital Utilization Review (for hospital or surgical pre-authorization)	**Local 8 members (Washington)** UR Coordinator First Choice
Inside Washington	(206) 292-8255 (800) 231-6935
Outside Washington	(800) 345-5767
Website	www.fchn.com
	Local 9 members (Oregon) UR Coordinator Providence Preferred (503) 574-6400 (800) 638-0449
Website	www.providence.org/oregon/providers
Vision	National Vision, Inc. (888) 822-6901
Website	www.nationalvision.com

Plan Document and Summary Plan Description

This Plan Booklet constitutes the Plan's summary plan description within the meaning of ERISA section 102. This Plan Booklet, together with the insurance contract(s) with LifeWise Assurance Company for Life Insurance and Accidental Death and Dismemberment Benefits, constitutes the Plan's plan document within the meaning of ERISA section 402.

Eligibility and Enrollment

You and your dependents may become eligible for benefits under the **Hotel Employees Restaurant Employees Health Trust** Plan if you satisfy one of the two following conditions:

1) you work as an employee in a collective bargaining unit for which the employer has entered into a collective bargaining agreement; or

2) you are not an employee in such a collective bargaining unit, but you work as an employee for an employer in employment covered by a special agreement.

If you do not satisfy either of these two conditions, you and your dependents cannot become eligible for benefits under the Plan.

If you satisfy condition (1), you can become eligible for benefits under Eligibility Rule A or Eligibility Rule B, described below, depending on the number of hours you work per month. Contact the **Trust Administration Office** to determine the Eligibility Rule under which you may earn eligibility.

If you satisfy condition (2), you can become eligible for benefits under Eligibility Rule A only in accordance with the terms of the special agreement.

Eligibility for Benefits for Employees Who Work Required Hours under Eligibility Rule A

Eligibility Rule A Required Hours

Your eligibility for benefits is based upon the number of hours you work under a collective bargaining agreement or special agreement.

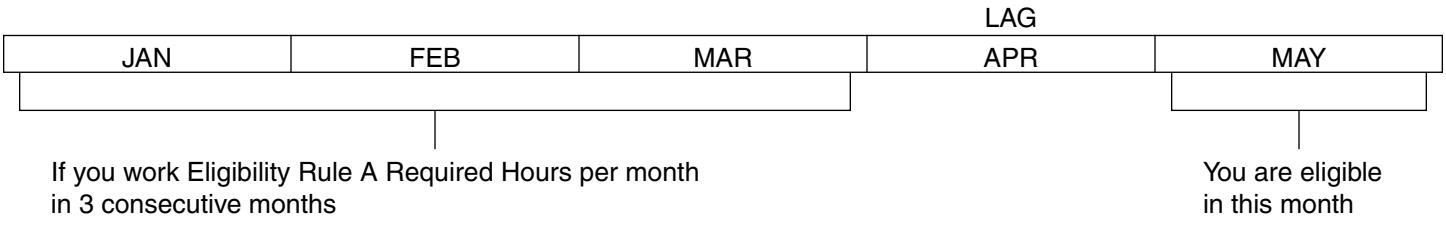
You are eligible for benefits under Eligibility Rule A if you work a minimum of 65 or 80 hours per month depending upon the actual number of hours established by your employer and your union in the collective bargaining agreement (or established in a special agreement).

Initial Employee Eligibility / Date Coverage Begins

You will be eligible for benefits on the first day of the second calendar month following three consecutive months during which you have worked Eligibility Rule A Required Hours in each month and your employer has paid all required employer contributions on your behalf. In addition, you may have to satisfy a probationary period established by the collective bargaining agreement or special agreement.

Example:

Your first day of employment is January 1. If you work Eligibility A Required Hours per month during the months of January, February, and March, and your employer makes the required contribution, you will be eligible for benefits May 1.



This lag month is necessary for the processing of reported hours by the **Trust Administration Office**.

Generally, you are not required to make any application for eligibility for benefits.

Benefits for which You are Eligible

When you are eligible under Eligibility Rule A, you are eligible for all the Benefits of the Plan: Weekly Disability, Medical, Vision, Dental, Hearing Aid, Life Insurance and Accidental Death and Disability Benefits. There is an exception when you fail to elect to make required employee contributions, as described below.

Some Employees Must Make Employee Contributions for Full Benefits

Your collective bargaining agreement may require you to elect to make employee contributions through payroll deduction to be eligible for all Benefits under Eligibility Rule A. Your employer will notify you of any employee contribution election requirement.

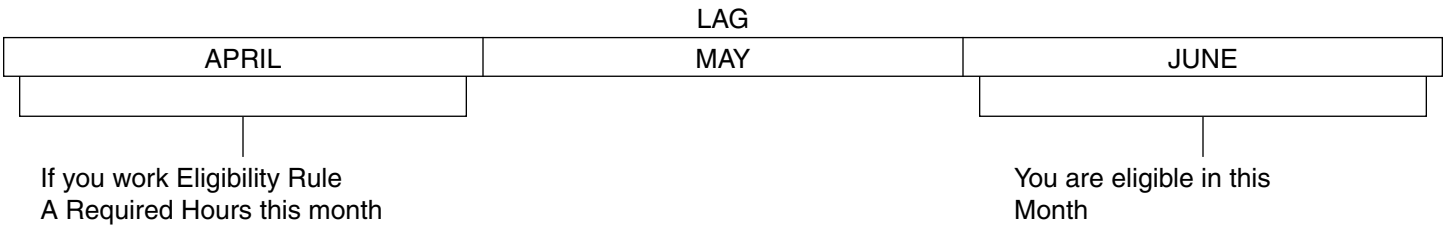
If you are required to elect to make an employee contribution, but you don't make that election, you and your dependents will be eligible only for Vision and Life Insurance Benefits. You and your dependents will not be eligible for Medical, Dental and Hearing Aid Benefits. You will not be able to elect to make employee contributions until a special enrollment period (see *Special Enrollment Period (to Elect to Make Employee Contributions)* below) or the next open enrollment period.

Continuing Coverage

Once you've met the initial Eligibility Rule A requirements, you continue to be eligible for benefits under Eligibility Rule A in the second month following any month in which you work Eligibility Rule A Required Hours each month and for which your employer has paid all required employer contributions (and remitted all required employee contributions).

Example:

You have met the initial eligibility requirements described above. You continue to work the Eligibility A Required Hours in April and your employer makes the required contributions, you will be eligible for benefits in June.



Reinstatement of Eligibility

If your eligibility ends because you work less than Eligibility Rule A Required Hours in a month, you may reinstate your eligibility on the first day of the 2nd month (lag) following the month in which you work Eligibility Rule A Required Hours and your employer has paid all required employer contributions for you; however, if you are not eligible for more than 6 consecutive months, you must reestablish your initial eligibility as described above.

Example:

You have met the initial Eligibility Rule A requirements and are eligible for benefits. In April you work less than the Eligibility Rule A Required Hours. In May you work Eligibility Rule A Required Hours, and your employer makes the required contributions based on your hours in May. Because you did not work sufficient hours in April, your eligibility for benefits under Eligibility Rule A ends at the end of May. Because you worked sufficient hours in May and your employer made the appropriate contributions, your eligibility for benefits under Eligibility Rule A is reinstated effective for July.

Example

Assume the facts in the Example above, except that you work less than Eligibility Rule A Hours from April through October, a period of 7 months. Your eligibility for benefits under Eligibility Rule A ends at the end of May. Because you worked less than Eligibility Rule A Hours for 7 months, you can become eligible under Eligibility Rule A only if you reestablish your initial eligibility as described above.

If your eligibility ends because of insufficient employer contributions have been received on your behalf, your eligibility can be reinstated only if your employer pays all required employer contributions for you.

Example

You have met the initial Eligibility Rule A requirements and continue to work Eligibility Rule A Required Hours. Your employer fails to make sufficient contributions on your behalf based on your hours in May, June, July and August. Your eligibility for benefits ends on the last day of June.

In September your employer makes sufficient contributions on your behalf for your May and June hours, but not for your July or August hours. Your eligibility for benefits is reinstated for July and August. But your eligibility ends at end of August, because the employer has made no contributions for your July hours.

See *Continuation of Coverage When Employer Fails to Make Required Contributions* at page 19.

When Your Eligibility Ends

- If you work less than Eligibility Rule A Required Hours in any month, but you work at least Eligibility Rule B Required Hours, your eligibility under Eligibility Rule A ends on the last day of the month following the month you fail to work the required hours. Your eligibility will continue under Eligibility Rule B. See *Benefits for Employees Who Work Required Hours under Eligibility Rule B*, below.
- If you work less than Eligibility Rule B Required Hours, your eligibility under Eligibility Rule A ends on the last day of the month following the month you fail to work the required hours, and you do not become eligible under Eligibility Rule B.

If your eligibility under Eligibility Rule A ends due to your termination of employment or a reduction in hours of work, you will also be eligible to elect to continue coverage for certain Benefits under Eligibility Rule A under COBRA. See *Continuation of Benefits under COBRA* below at page 12.

Eligibility for Your Dependents

Under Eligibility Rule A, your dependents can be eligible for Medical, Dental, Vision, Hearing Aid, and Life Insurance Benefits. However, if you are required to elect to make employee contributions, but don't make those contributions, your dependents will be eligible only for Vision and Life Insurance Benefits.

Your eligible dependents are:

- Your legal spouse.
- For the Medical, Vision, Hearing, Dental and Life Insurance Benefits coverage, your unmarried children who are under age 19 and chiefly dependent on you, your spouse or non- covered legal parent for support, provided they are:
  - your natural children, adopted children or child legally placed for adoption including a child for whom you have assumed a total or partial legal obligation for support in anticipation of adoption, or
  - your stepchildren if they live with you in your home in a regular parent-child relationship; or
  - your legally designated minor ward.

Your parents and/or grandchildren are not eligible dependents.

If you are covered as an employee, you cannot be covered as a dependent child.

Dependents who are in full-time military service are not eligible dependents.

When Dependent Coverage Begins

For eligible dependents, coverage begins when your coverage begins under Eligibility Rule A. Coverage for your eligible dependents continues as long as your coverage continues under Eligibility Rule A

If you are covered under Eligibility Rule A and you acquire a dependent either through adoption, placement for adoption, birth of a child, or marriage, coverage begins retroactive to the date of birth of a newborn child, the date of placement of an adoptive child, the date of assumption of total or partial legal obligation for support of a child in anticipation of adoption, or in the case of marriage, the date of marriage.

If your group's contract does not require a rate payment for the natural newborn or adoptive child, you do not have to complete an application for the child. However, for both newborns and adopted children, the Trust Administration Office should receive applications within 31 days to prevent delays in claims processing.

If you are not covered under Eligibility Rule A because you have not elected to make employee contributions, you and certain dependents may be able to become covered under Eligibility Rule A. See *Eligibility and Enrollment — Special Enrollment Period (When Employee Contributions are Required)* at page 6 below.

For dependent Life Insurance Benefits (payable to you), your unmarried children (as described and limited under *Eligibility for Your Dependents* immediately above) are covered from 14 days following birth, through the day before their 19th birthday.

Qualified Medical Child Support Order

If you are eligible for coverage under Eligibility Rule A, but your child is not eligible for dependent coverage, your child will be eligible for coverage for Medical, Dental, Vision and Hearing Aid Benefits under Eligibility Rule A if he or she is an alternate recipient under a qualified medical child support order (QMCSO), to the extent required under the QMCSO and consistent with ERISA.

Provide a copy of a medical child support order issued by a court to the **Trust Administration Office**.

The Trustees have adopted procedures for determining whether a medical child support order (whether issued by a court or child support enforcement agency) is a QMCSO. You or your dependent can obtain, without charge, a copy of the Plan's QMCSO procedures from the **Trust Administration Office**.

Eligibility for Benefits for Employees Who Work Required Hours under Eligibility Rule B

Eligibility Rule B Required Hours

Your eligibility for benefits is based upon the number of hours you work per month under a collective bargaining agreement. Eligibility under Eligibility Rule B is authorized by the Trust for individuals who work a minimum number of hours per month (but not less than 30 hours per month) established by your employer and your union in the collective bargaining agreement. **Please note that not all collective bargaining agreements provide for eligibility under Eligibility Rule B.**

Contact the **Trust Administration Office** to determine the Trust rule under which you may earn eligibility.

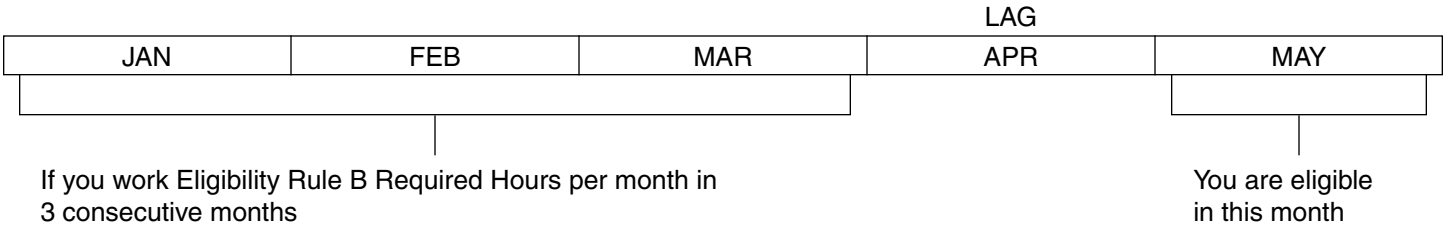
If you work Eligibility Rule B Required Hours in a month, you may establish and maintain eligibility for yourself only under the following guidelines. **Under Eligibility Rule B you are not eligible for Vision Benefits, Hearing Benefits or Dental Benefits and your dependents are not eligible for any Benefits under the Plan.**

Initial Employee Eligibility/Date Coverage Begins

You will be eligible for benefits on the first day of the second calendar month following three consecutive months during which you have worked Eligibility Rule B Required Hours in each month and your employer (see page 6) has paid all required employer contributions on your behalf.

Example:

Your first day of employment is January 1. If you work Eligibility B Required Hours per month during the months of January, February and March, and your employer makes the required contribution, you will be eligible for benefits May 1.



This lag month is necessary for the processing of reported hours by the Trust Administration Office.

Some Employees Must Make Employees Contributions for Full Benefits

To be eligible for all Benefits under Eligibility Rule B, you may be required to elect to make employee contributions through payroll deduction, as outlined in your collective bargaining agreement. Your employer will notify you of any employee contribution election requirement.

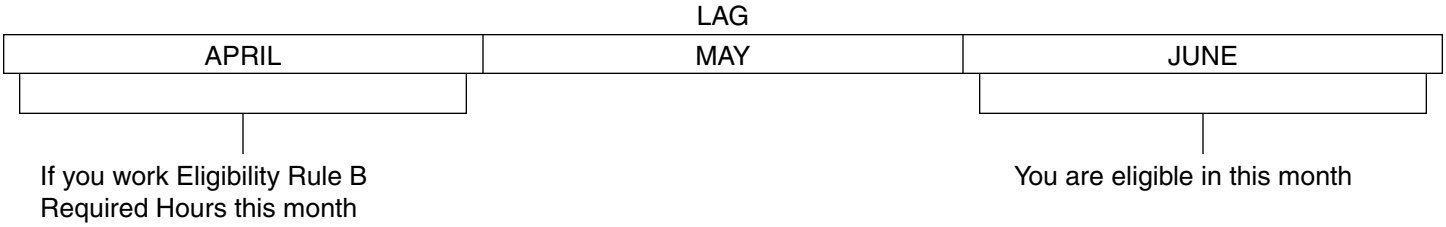
If you are required to elect to make an employee contribution, but you don't make that election, you will be eligible only for Vision and Life Insurance benefits. You will not be to elect to make employee contributions until a special enrollment period (see *Special Enrollment Period (to Elect to Make Employee Contributions)*, below) or the next open enrollment period.

Continuing Coverage

Once you've met the initial Eligibility Rule B requirements, you continue to be eligible under Eligibility Rule B in the second month following any month in which you work Eligibility Rule B Required Hours each month and for which your employer has paid all required employer contributions (and remitted all required employee contributions).

Example:

You have met the initial eligibility requirements described above. You continue to work the Eligibility B Required Hours in April and your employer makes the required' contributions, you will be eligible for benefits in June.



When Your Eligibility Ends

If you work less than Eligibility Rule B Required Hours in any month, your eligibility ends on the last day of the month following the month you fail to work the required hours.

Reinstatement of Eligibility

If your eligibility ends because you work less than Eligibility Rule B Required Hours in a month or insufficient employer contributions have been received on your behalf; you may reinstate your eligibility 'on the first day of the 2nd month (lag) following the month in which you work Eligibility Rule B Required Hours and your employer has paid all required employer contributions for you; however, if you are not eligible for more than 6 consecutive months, you must reestablish your initial eligibility as described above.

Note: When you work Eligibility Rule A Required Hours in some months and at least Eligibility Rule B Required Hours in other months, you should check with the **Trust Administration Office** to determine which months your dependents are eligible for coverage.

Special Enrollment Period (When Employee Contributions are Required)

This Special Enrollment Period section applies only if:

- you were required to elect to make employee contributions;
- your failed to elect to make employee contributions; and
- you experience involuntary loss of other coverage, become married or a child is born to you, you adopt a child or a child is placed for adoption with you.

If the conditions described below are satisfied, you may be able to elect to make employee contributions and to become eligible for Eligibility Rule A or Eligibility Rule B benefits.

Involuntary Loss of Other Coverage

This Involuntary Loss of Other Coverage provision describes how you may elect to make employee contributions when you, your spouse or your child loses coverage under another health care program. "Health care program" means an employer sponsored group health plan or health insurance coverage (for example, a policy of individual health insurance).

You may elect to pay employee contributions if you satisfy all the following conditions:

- you, your spouse, or your child (as the case may be) was covered under a health care program at the time coverage under this Plan was previously offered;
- coverage under the other health care program for you, your spouse or your eligible child terminated as a result of:
  - loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or a change in the number of hours of employment);
  - termination of employer contributions toward such coverage; or
  - you, your spouse or your eligible child was covered under COBRA at the time coverage under this Plan was previously offered and COBRA coverage has been exhausted;
- you are eligible under either Eligibility Rule A or Eligibility Rule B;
- you complete and file with the **Trust Administration Office** a Payroll Deduction Authorization within 30 days after coverage under the other health program ended;
- you provide evidence of the other coverage and the loss of the other coverage; and
- you pay employee contributions for the 3 (three) consecutive months that end immediately before the month in which the **Trust Administration Office** receives your Payroll Deduction Authorization.

After you satisfy the above conditions, you become eligible for Eligibility Rule A or Eligibility Rule B benefits for the month that begins after the **Trust Administration Office** receives your Payroll Deduction Authorization. Thereafter you continue to be eligible for benefits under Eligibility Rule A or Eligibility Rule B as described under *Continuing Coverage* on pages 6 and 9.

For purposes of this *Involuntary Loss of Coverage* provision, "COBRA coverage has been exhausted" when an individual's COBRA coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases:

- due to the failure of the employer or other responsible entity to remit premiums on a timely basis; or
- when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA coverage available to the individual.

Marriage

You may elect to pay employee contributions if you satisfy all the following conditions:

- you marry;
- you are eligible under either Eligibility Rule A or Eligibility Rule B;
- you complete and file with the **Trust Administration Office** a Payroll Deduction Authorization within 30 days after the date of marriage; and
- you pay employee contributions for the 3 (three) consecutive months that end immediately before the month in which the **Trust Administration Office** receives your Payroll Deduction Authorization.

After you satisfy the above conditions, you become eligible for Eligibility Rule A or Eligibility Rule B benefits on the first of the month that begins after the **Trust Administration Office** receives your Payroll Deduction Authorization. Thereafter you continue to be eligible for benefits under Eligibility Rule A or Eligibility Rule B as described under *Continuing Coverage* on pages 6 and 9.

Birth of Your Child, Adoption of Your Child or Placement of a Child for Adoption with You

You may elect to pay employee contributions if you satisfy all the following conditions:

- a child is born to you, you adopt a child or a child is placed with you for adoption;
- you are eligible under either Eligibility Rule A or Eligibility Rule B;
- you complete and file with the **Trust Administration Office** a Payroll Deduction Authorization within 30 days after the date of birth, adoption or placement for adoption; and
- you pay employee contributions for the 3 (three) consecutive months that end one before the month in which the **Trust Administration Office** receives your Payroll Deduction Authorization.

After you satisfy the above conditions, you become eligible for Eligibility Rule A or Eligibility Rule B benefits as of the date of birth, adoption or placement for adoption and for the remainder of the month. Thereafter you continue to be eligible for benefits under Eligibility Rule A or Eligibility Rule B as described under *Continuing Coverage* on pages 6 and 9.

When Coverage Ends

Your coverage under the Plan will end on the earliest of the following dates:

- The last day of the month in which your eligibility ends.
- When the Plan is discontinued.
- The last day of the month, following the month in which your employer is no longer required by a collective bargaining agreement to contribute to this Trust.
- If the Trust does not receive all required employer contributions on your behalf for any month, the last day of the following month. However, your coverage will continue for up to two months without employer contribution if:
  - ➢ you have met initial eligibility requirements;
  - ➢ you work for more than one employer for Eligibility Rule A Required Hours each month for coverage under Eligibility Rule A or Eligibility Rule B Required Hours each month for coverage under Eligibility Rule B;
  - ➢ the only reason employer contributions are not received is that no employer is required under its collective bargaining agreement to make an employer contribution on your behalf: and
  - ➢ you notify the **Trust Administration Office**.

Your dependent's coverage under the Plan will end on the earliest of the following dates:

- The last day of the month in which your eligibility ends.
- The last day of the month following the month in which you work less than Eligibility Rule A Required Hours.
- The last day of the month in which the dependent no longer meets the definition of an eligible dependent.
- When the Plan is discontinued.

Continuation of Benefits for Certain Children with Physical or Mental Handicap

Benefits under Eligibility Rule A continue for unmarried children who depend chiefly on you for support and are incapable of earning a living due to mental or physical handicap, as long as the incapacity began before age 19 and the child was eligible and covered under the Plan the day before his or her 19th birthday. Coverage continues throughout the incapacity of your eligibility continues. This coverage is not automatic; you must submit proof to the **Trust Administration Office** within 31 days after the child reaches the limiting age.

Limited Extended Medical or Dental Benefits When Coverage Ends

If Medical Benefits end while either you or your dependents are totally disabled, Medical Benefits will be paid for any accidental injury or illness of the individual causing the continuous total disability. Benefit payments for current expenses directly related to the disabling condition only will continue for up to 12 months. Extended Medical Benefits will stop immediately when the individual becomes covered under any group plan with similar benefits or under Medicare or regains eligibility under this Plan.

"Total disability" means

- solely because of nonoccupational illness or injury, you or your dependent is prevented from engaging in any occupation for which you, he or she is reasonably qualified by education, training, or experience, and are performing no work for compensation; or

- if your dependent was not previously employed, then, solely because of nonoccupational illness or injury, your dependent is prevented from engaging in most of the normal activities of a person of like age and sex in good health.

Note: The extended Medical Benefit does not provide coverage for any charges except those directly related to the disabling condition.

If Dental Benefits end for you or your dependents for any reason, charges for prosthetic devices (including bridges and crowns) are covered if they were ordered while the individual was covered, then installed or delivered within 30 days after coverage ends.

Continuation of Benefits under COBRA

Federal law (known as "COBRA") in certain instances permits you and/or your eligible dependents to continue Medical, Dental, Vision and Hearing Aid Benefits coverage by self-payments when coverage under those Benefits otherwise would end. COBRA continuation coverage does not apply to other Benefits, such as Weekly Disability Benefits, Life Insurance Benefits or Accidental Death & Dismemberment Benefits.

Following is a description of COBRA continuation coverage, when it may become available to you and your dependents, and what you and they need to do to protect the right to receive it. COBRA continuation coverage is available to you and your eligible dependents only when you or they are entitled to elect to continue coverage under COBRA and only for up to the maximum coverage periods required by COBRA. As is the case with regular coverage under the Plan, eligibility for benefits and benefit payments under COBRA continuation coverage are determined only when a claim is properly submitted to the **Trust Administration Office**.

Benefits that are paid under COBRA continuation coverage during any period when COBRA does not require coverage are treated as benefit over payments, even if the self-payment for the period has been made.

Events That Can Trigger the Right to Elect COBRA continuation Coverage

The continuation period begins with the first month after the last month of regular coverage.

You may elect COBRA continuation coverage only if you will lose coverage under the Plan because either one of the following triggering events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason .

Your spouse may elect COBRA continuation coverage only if he or she will lose coverage under Eligibility Rule A because any of the following events happens:

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason
4. You become divorced from your spouse.

   Note: If the triggering event is divorce, you or your spouse must provide notice to the **Trust Administration Office** within a notice period, as described below.

Your dependent child may elect COBRA continuation coverage only if he or she will lose coverage under Eligibility Rule A because any of the following events happens:

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason;
4. You become divorced from your spouse; or
5. Your child no longer meets the definition of an eligible dependent under the plan.

   Note: If the triggering event is divorce or your child no longer being eligible as a dependent, you or the child must provide notice to the **Trust Administration Office** within a notice period, as described below.

"Qualified Beneficiary" and "Qualifying Event"

When you, your spouse or your dependent child will lose coverage due to one of the triggering events described above, you, he or she is considered a "qualified beneficiary." A qualified beneficiary's loss of coverage due to one of the triggering events described above is a "qualifying event."

Child Covered by Qualified Medical Child Support Order

If your child is covered under the Plan pursuant to a qualified medical child support order received by the **Trust Administration Office** while you are covered under Eligibility Rule A, he or she has the same rights your eligible

dependent child has to elect COBRA continuation coverage. See *Eligibility and Enrollment — Benefits for Employees Who Work Required Hours under Eligibility Rule A — Eligibility for Your Dependents*.

Notice of Qualifying Event to the Trust Administration Office

The Trust offers a qualified beneficiary the opportunity to elect COBRA continuation coverage only after the **Trust Administration Office** has been properly notified that a qualifying event has happened.

Notice from the Employer

When the qualifying event is a loss of coverage because of:

- the end of your employment or reduction of your hours of employment, or
- your death,

your employer must notify the **Trust Administration Office** of that qualifying event by the 10th day of the month following the month in which the termination, reduction in hours or death occurs

Notice from You or Your Dependent — Important!

When the qualifying event is a loss of coverage because of:

- your divorce from your spouse, or
- your child's losing eligibility for coverage as a dependent child,

you, your spouse, or dependent child, must notify the **Trust Administration Office** within 60 days after that triggering event occurs (for example, the date a divorce decree is entered or the date a dependent child attains age 19).

You may notify the **Trust Administration Office** by telephone or by written notice that you fax, mail or personally deliver to the **Trust Administration Office**. See *How to Provide Notice to the **Trust Administration Office***, below.

The notice must contain the following:

- the name of the Plan ("Hotel Employees Restaurant Employees Health Trust Plan")
- your name (the name of the covered employee)
- the name(s) of the qualified beneficiary(ies)
- the triggering event (divorce or child's loss of dependent status); and
- the date on which the triggering event occurred.

If you fax, mail or deliver a notice, you may, but are not required to, use the *Notice of COBRA Qualifying Event (Divorce or Child's Ceasing to be a Dependent)* form at the end of this booklet.

If the notice:

- is not telephoned or faxed, mailed or delivered in writing to the **Trust Administration Office**,
- is not post-marked or received by the **Trust Administration Office** within the 60-day period, or
- does not contain the required content described above,

then the right to elect COBRA continuation coverage is lost; the Trust will not offer the qualified beneficiary the opportunity to elect COBRA continuation coverage and coverage for the qualified beneficiary will end with end of regular Plan coverage.

Trust Administration Office's Election Notice to Qualified Beneficiary(ies)

After the **Trust Administration Office** receives the appropriate qualifying event notice (see above), the **Trust Administration Office** will notify each qualified beneficiary of his or her right to elect COBRA continuation coverage. The election notice will include information regarding rights and obligations under COBRA continuation coverage, including cost for the coverage, payment procedures and plan requirements, and an election form.

If you receive election information at your address, but your spouse or other eligible dependent does not live with you at the address, you must notify the **Trust Administration Office** immediately of the names of the dependents and their current addresses.

Electing COBRA continuation Coverage

COBRA continuation coverage is not automatic. You (or your eligible dependent) must elect COBRA continuation coverage.

How to Elect; Election Deadline

You or your eligible dependent must elect COBRA continuation coverage on the election form included with the **Trust Administration Office**' election notice.

To elect COBRA continuation coverage, the completed election form must be mailed (post-marked) or personally delivered to the **Trust Administration Office** within 60 days after the date the **Trust Administration Office** sent the election notice, or, if later within 60 days after regular Plan coverage ended. See *How to Provide Notice to **Trust Administration Office***, below.

If the election form is not mailed to (postmarked) or received by the **Trust Administration Office** within the 60-day election period, the right to elect COBRA continuation coverage is lost and no COBRA continuation coverage will be provided.

If a qualified beneficiary rejects COBRA continuation coverage, he or she may change the rejection and elect COBRA continuation coverage until the end of the 60-day election period.

Who May Elect

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. This means, for example, that even if you don't want COBRA continuation coverage, your spouse or dependent child has an independent right to elect it.

You or your spouse may elect COBRA continuation coverage for all qualifying family members. You or your spouse may elect COBRA continuation coverage only for your dependent children.

You, your spouse and dependent children may elect COBRA continuation coverage even if covered under another employer-sponsored group health plan or entitled to Medicare.

You, your spouse, and other eligible dependents should read the information the **Trust Administration Office** sends concerning COBRA continuation coverage election rights.

Consequences of Electing or not Electing COBRA continuation Coverage

In considering whether to elect COBRA continuation coverage, a qualified beneficiary should take into account that a failure to elect and continue COBRA continuation coverage will affect his or her future rights under Federal law.

- First, the qualified beneficiary can lose the right to avoid having pre-existing condition exclusions applied to him or her by other group health plans. If the qualified beneficiary has more than a 63-day gap between the last day of coverage under this Plan and the first day of coverage under another plan, the other plan may be able to exclude coverage for his or her preexisting conditions. However, electing and continuing COBRA continuation coverage under this Plan may help the qualified beneficiary to avoid having such a gap.
- Second, the qualified beneficiary will lose a guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if he or she does not elect and continue COBRA continuation coverage for the maximum period of coverage.

A qualified beneficiary also should take into account that he or she has special enrollment rights under Federal law. A qualified beneficiary has the right to request special enrollment in another group health plan for which he or she is otherwise eligible (such as a plan sponsored by the employer of the qualified beneficiary's spouse) within 30 days after his or her regular coverage ends under this Plan because of a qualifying event. If the qualified beneficiary elects and continues COBRA continuation coverage under this Plan for the maximum coverage period available, he or she will also have the same special enrollment right at the end of the maximum COBRA continuation coverage period.

What is COBRA Continuation Coverage?

COBRA continuation coverage provides the same Medical, Dental, Vision and Hearing Aid Benefits coverage that the Trust gives to other covered employees or their dependents under the Plan who are not receiving COBRA continuation coverage. You cannot continue Weekly Disability, Life Insurance or Accidental Death and Disability Benefits Under COBRA. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other covered employees or dependents covered under the Plan, including the right to add coverage for eligible dependents under Eligibility Rule A during a special enrollment period (due to the loss of other health program coverage or marriage, birth, adoption or placement for adoption) or to add or drop coverage for dependents under Eligibility Rule A during open enrollment.

If Medical, Dental, Vision and Hearing Aid Benefits for active employees or their dependents is modified, COBRA continuation coverage is modified in the same manner.

If you or your dependents lose coverage under Eligibility Rule A, COBRA continuation coverage is Medical, Dental, Vision and Hearing Benefits or Medical only benefits. If you lose coverage under Eligibility Rule B, COBRA continuation coverage is only Medical Benefits.

COBRA continuation Coverage as a Qualified Beneficiary for Newborn Child or Child Placed For Adoption

Your newborn child or child placed with you for adoption can be a qualified beneficiary, having the rights of a qualified beneficiary, if all the following requirements are satisfied:

- You are (1) a former employee and covered under COBRA continuation coverage under Eligibility Rule A, or (2) a current employee and covered under Eligibility Rule A, and your former spouse is covered on the COBRA continuation option under Eligibility Rule A.
- The child is born to you or placed for adoption with you during the period of your (or, in the case of your divorce, your former spouse's) COBRA continuation coverage under Eligibility Rule A.
- The child is enrolled in the Plan during the period of COBRA continuation coverage.

As a qualified beneficiary, your child has rights that a qualified beneficiary's newly enrolled dependent (say, a qualified beneficiary's new spouse) would not have.

Example.

Assume you lose coverage under Eligibility Rule A (because your employment ended or your work hours were reduced). You elect COBRA continuation coverage. Shortly after COBRA continuation coverage begins, you marry. During the 13th month of your COBRA continuation coverage you and your spouse have a newborn child. You die during the 17th month of your COBRA continuation coverage. Coverage for your spouse terminates at the end of the month in which you die. Your spouse timely notifies the **Trust Administration Office** of this second qualifying event. Coverage for your child — but not for your spouse — is extended for up to an additional 18 months beyond the first 18 months of your COBRA continuation coverage period.

How Long COBRA continuation Coverage Lasts

For each qualified beneficiary who properly elects COBRA continuation coverage within the 60-day election period and for whom the **Trust Administration Office** has received a timely First Payment of the COBRA continuation coverage premium, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage under the Plan. COBRA continuation coverage period begins with the first month after the last month of regular coverage.

When the qualifying event is:

- your death;
- your divorce; or
- your child losing eligibility as a dependent,

COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage lasts for up to 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended.

- 11-month extension for disability of qualified beneficiary. COBRA continuation coverage is extended for up to an additional 11 months, for a total maximum of up to 29 months, if all the following conditions are satisfied:
  - you, your spouse or dependent child is a qualified beneficiary and is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of COBRA continuation coverage.
  - you or other qualified beneficiary notify the **Trust Administration Office** within 60 days after the date of the SSA's determination and before the end of the 18-month period of COBRA continuation coverage; and
  - the notice satisfies the requirements below.

  You may notify the **Trust Administration Office** by telephone or by written notice that you fax, mail or personally deliver to the **Trust Administration Office.** See *How to Provide Notice to Trust Administration Office*, at page 18.

  The notice must contain the following

  - the name of the Plan ("Hotel Employees Restaurant Employees Health Trust Plan");
  - your name (the name of the covered employee);
  - the name of the disabled qualified beneficiary;
  - and the date on which the qualified beneficiary was determined to be disabled.

  The notice must include a copy of the Social Security Administration's determination. If you provide notice by telephone, you must provide a copy of the determination to the **Trust Administration Office**.

  If you fax, mail or deliver a notice, you may, but are not required to, use the *Notice of COBRA Second Qualifying Event — Disability Determination — Cessation of Disabled Status* form at the end of this booklet.

If the notice:

- is not telephoned or faxed, mailed or delivered in person to the **Trust Administration Office**,
- is not post-marked or received by the **Trust Administration Office** within the 60-day period and before the end of the 18-month period,
- does not contain the required content described above, or
- does not include the Social Security Administration's disability determination,

then the right to an extension of COBRA continuation coverage beyond the 18-month period is lost.

- Second qualifying event extension of 18-month period of continuation coverage. If any of the following events happens during the 18-month period while your spouse or dependent child is receiving COBRA continuation coverage,
  - you die,
  - you divorce, or
  - your child loses eligibility under the Plan as dependent,

  the spouse (only in the case of death or divorce) and dependent child can get up to an additional 18 months of COBRA continuation coverage, for a total maximum of 36 months.

  This extension is available only if you or your spouse or dependent child, notify the **Trust Administration Office** of the event in a timely fashion.

  You may notify the **Trust Administration Office** by telephone or by written notice that you fax, mail or personally deliver to the Trust Administration within 60 days of the date of the event. See *How to Provide Notice to Trust Administration Office* at page 69.

  The notice must state the name of the Plan ("Hotel Employees Restaurant Employees Health Trust Plan"), your name (the name of the covered employee), the name of the disabled qualified beneficiary; the event (death, divorce or child's loss of status); the date the event happened (for example, date child attained age 19).

  If you fax, mail or deliver a notice, you may, but are not required to, use the *Notice of COBRA Second Qualifying Event — Disability Determination — Cessation of Disabled Status* form at the end of this booklet.

  If the notice:

  - is not telephoned or faxed, mailed or delivered in person to the **Trust Administration Office**,
  - is not post-marked or received by the **Trust Administration Office** within the 60-day period, or
  - does not contain the required content described above,

  then COBRA continuation coverage will not be extended beyond the 18-month period.

- Extension for spouse or child dependent due to your earlier entitlement to Medicare. If you become entitled to Medicare benefits during the 18-month period that ends the date of your triggering event (end of your employment or reduction of hours), then the COBRA continuation coverage period for your spouse and dependent child is extended beyond the 18-month period. Their COBRA continuation coverage period ends 36 months after the date you became entitled to Medicare benefits.

Family and Medical Leave Act

If you take leave under the Family and Medical Leave Act of 1993, special rules apply to the continuation of your Medical, Dental, Vision and Hearing Benefits. See *Eligibility and Enrollment — Family and Medical Leave Act,* at page 5.

Early Termination of COBRA continuation Coverage

COBRA continuation coverage ends automatically (even before the maximum COBRA continuation period expires) when:

- Required COBRA continuations are not paid when due. (COBRA continuation coverage ends on the last day of the month for which the full self-payment was received.)
- A qualified beneficiary becomes covered under another group health plan (as employee or dependent) - unless the other plan limits or excludes coverage for preexisting condition. (Coverage ends for that qualified beneficiary.) If, however, the other plan has such a limitation or exclusion, COBRA continuation coverage ends when the other plan's limitation or exclusion expires, or, if earlier, when the COBRA continuation coverage period expires.
- The qualified beneficiary becomes entitled to Medicare. (Coverage ends for that qualified beneficiary.)
- The Trust no longer provides Medical, Dental, Vision and Hearing Benefits.

- The employer that contributed to the Plan on behalf of the employee whose coverage (or whose eligible dependent's coverage) ended ceases to have an obligation to make employer contributions to the Trust because either (a) the Local Union has been decertified as the representative of the bargaining unit or (b) the Local Union has disclaimed representation of the bargaining unit.
- If the COBRA continuation coverage is extended the continuation period from up to 18 months to up to 29 months (due to Social Security disability), but it is finally determined that the individual is not disabled for Social Security purposes. (COBRA continuation coverage ends on the last day of the first month that begins more than 30 days after the final determination.) You or the qualified beneficiary must notify the **Trust Administration Office** in writing at its address of the Social Security Administration's determination within 30 days after the determination. See Addresses for Mailing or Delivering Notices to **Trust Administration Office**," below, at page 51.

COBRA continuation coverage also terminates for any reason that would terminate coverage of a covered employee or dependent who is not receiving continuation coverage (such as fraud).

Payment for COBRA continuation Coverage

First Payment

COBRA continuation coverage becomes effective only after (1) COBRA continuation coverage is properly elected within the 60-day election period and (2) first payment for COBRA continuation coverage is paid within 45 days after the election is made. If the first payment is not made in the 45-day period, COBRA continuation coverage never becomes effective. No benefits are paid for any period of COBRA continuation coverage for which the self-payment has not been received.

The first payment must cover the cost of COBRA continuation coverage from the time regular coverage under the Plan would have otherwise terminated through the last month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the **Trust Administration Office** to confirm the correct amount of your first payment.

Monthly Payments

After the first payment is made, payments are due the first of the month for that month's COBRA continuation coverage. If you make the monthly payment on or before the first of the month, your COBRA continuation coverage will continue for that month without any break.

Grace periods for Monthly Payments

Although monthly payments are due first of the month, there is a 30-day grace period to make the monthly payment. If payment is not made by the first of the month, COBRA continuation coverage is suspended for nonpayment. If a monthly payment is made after first of the month but during the 30-day grace period, COBRA continuation coverage is suspended as of the due date and then retroactively reinstated (going back to the due date) after the periodic payment is made. This means that any claim for benefits expenses incurred on or after the first of the month while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you or your dependent fails to make a monthly payment before the end of the 30-day grace period for that payment, COBRA continuation coverage automatically ends as of the last day of the month for which timely payment was made.

How to Make Payments

The **Trust Administration Office** will provide you a coupon booklet to help keep track of the monthly COBRA premium payments.

Mail your payments, together with the coupon for the month, to the **Trust Administration Office** at:

Hotel Employees Restaurant Employees Health Trust
P.O. Box 34085
Seattle, WA 98124

Note: this is special post office box for COBRA payments. Do not use any other post office box of the **Trust Administration Office**.

A check that is returned because there are insufficient funds (sometimes called an "NSF check") is <u>not</u> payment.

You or your dependent also may make your payment by check or in cash at the **Trust Administration Office**, at its address under *How to Provide Notice to **Trust Administration Office***, below.

For more information about the COBRA continuation coverage and the current self-payment rates, contact the **Trust Administration Office**.

How to Provide Notice to Trust Administration Office

To mail a notice to the **Trust Administration Office**, address the envelope to:

Hotel Employees Restaurant Employees Health Trust
P.O. Box 34203
Seattle, WA 98124

Note: do not use this mailing address to mail COBRA premium payments. See ***How to Make Payments*****, immediately above.**

To personally deliver a notice to the **Trust Administration Office**, bring it to:

Hotel Employees Restaurant Employees Health Trust
2815 Second Avenue, Suite 300
Seattle, Washington 98121

To fax a notice to the **Trust Administration Office**, send it to (206) 441-9110.

To provide a notice by telephone, call: (206) 441-7574 or (800) 732-1121, option 4.

You should also keep a copy, for your records, of any notices you or your eligible dependents mail or deliver to the **Trust Administration Office**.

If You Have Questions

If you or your dependents have questions about your COBRA continuation coverage, you or they should contact the **Trust Administration Office**. See *How to Provide Notice to* ***Trust Administration Office*** above.

You also may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) for more information about your rights under ERISA, including COBRA continuation coverage under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa.**

Keep the Trust Administration Office Informed of Address Changes

In order to protect your and your family's rights to elect COBRA continuation coverage, you should keep the **Trust Administration Office** informed of any changes in the addresses of family members. It is your responsibility to keep up-to-date your (and your dependents') addresses on file with the **Trust Administration Office**.

Continuation of Benefits under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you would lose coverage for Medical, Dental, Vision or Hearing Aid Benefits because you are absent from your employment to perform service in the uniformed services of the United States, you may elect to continue coverage for yourself and your dependents for up to a maximum of 18 months from the date that service begins.

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

If your absence is due to a uniformed services leave of 30 days or less, coverage for you and your eligible dependents continues on the same terms and conditions as before your absence. This means that if the employer contributes 100% of the required contribution for coverage, it must continue to make that contribution. If you are required to pay a portion of the contribution, the employer must contribute its share and you must pay your share.

If your absence is due to a uniformed services leave of 31 days or more, you may elect to continue coverage by self-payment. The self-payment premium amount is established by the Trust. The premium is payable in monthly installments.

No Benefits are available under the Plan for your conditions that are incurred or aggravated during your performance of duties in the uniformed services.

Continuation coverage ends on the earlier of:

- the last day of the 18-month period that begins when your uniformed services leave begins; or
- the day after you fail to return to covered employment within the time allowed by USERRA.

Reinstatement of Eligibility following Uniformed Service Leave. If you were eligible for coverage under the Plan when your uniformed services leave began and upon completion of service you notify your employer of your intent to return to employment as specified in USERRA, your eligibility will continue as it was the day before the your uniformed services

leave began.

Continuation of Benefits under the Family and Medical Leave Act

If you take leave under the Family and Medical Leave Act of 1993 (the "FMLA") when you are covered under the Plan, your employer must continue your Medical, Dental, Vision and Hearing Aid Benefits during the leave on the same terms and conditions as before the leave. This means that if the employer contributes 100% of the required contribution for coverage, it must continue to make that contribution. If you are required to pay a portion of the contribution, the employer must contribute its share and you must pay your share. Your employer is required to denote that it is paying for coverage during a period of FMLA leave on its contribution remittance report to the Trust.

This continuation of coverage under FMLA ends on the last day of the month in which:

- you return to work;
- you would have been laid off and your employment relationship terminated had you not been on FMLA leave;
- coverage under the Plan would otherwise end (i.e., Plan maximum has been paid);
- the month following the month no contributions have been received by your employer; or
- your FMLA leave ends.

FMLA leave ends when the period of FMLA leave expires, or, if earlier, when you notify your employer that you will not return to work.

If you fail to return to work after your FMLA leave ends, you may become eligible to COBRA continuation coverage for up to 18 months (subject to certain extensions), starting the first day of the month that begins after FMLA leave ends.

Your employer determines whether your leave of absence is FMLA. If requested, you must submit proof to the **Trust Administration Office** that your leave is leave under the FMLA.

Continuation of Coverage When Employer Fails to Make Required Contributions

If your employer fails to make the required contributions on your behalf, coverage for you and your dependents ends after the second month following the month your employer failed to make contributions.

However, if you have worked the required Eligibility Rule A hours or required Eligibility Rule B hours for a month for which your employer has not made required contributions, you are entitled to elect to continue Medical, Dental, Vision and Hearing Aid Benefits for yourself and your dependents. Generally, the terms and conditions of such continued coverage parallel terms and conditions described above under *Continuation of Benefits under COBRA*, with differences necessary or appropriate to the administration of this type of continuation coverage. (For example, the **Trust Administration Office** needs more time to send notice to you of your right to elect such continuation coverage that would be the case for COBRA continuation coverage.) You must make the appropriate self-payments to the Trust the same as you would make self-payments for continuation coverage under COBRA.

If your employer later makes its required contributions for a month for which you have made a self-payment, the Trust will refund the self-payment to you.

This continuation of coverage is not required by the COBRA law and is not subject to the COBRA law.

Weekly Disability Benefits for Active Employees

Weekly benefits are payable if you are totally disabled as the result of a non occupational injury or illness (including a pregnancy-related condition).

Your Weekly Disability Benefit

Eligibility Rule A	$110 per week
Eligibility Rule B	$90 per week

The disability must begin while you're covered under the Plan. You are considered totally disabled if you cannot work full time at your regular occupation because of your disability.

- Your benefits begin according to this schedule
- If you're unable to work because of a non-occupational accident, benefits begin the first day you are out.
- If you're unable to work because of a non-occupational illness or a pregnancy-related condition and you are hospitalized, benefits begin the first day you are hospitalized.

- If you're unable to work because of a non-occupational illness or a pregnancy-related condition and you are not hospital confined, benefits begin the fifth day you are out.

Benefit Payment Period

To receive benefits, you must be seen and treated by a physician regularly. Your coverage will continue for up to 16 weeks as long as you're certified by a physician as unable to work at your regular occupation because of the disability.

Reinstatement of Benefits

Your benefits will be reinstated after your disability ends if you return to active work for a continuous period of two weeks, provided you work at least 30 hours during that period. You then will be eligible for a new period of benefits, for the same disability, according to the schedule.

If you return to active work for a least one full day after a disability, then experience a second disability due to entirely different cause, you will be eligible for .a new period of benefits for the second disability.

Exclusions

Plan benefits are not payable for a disability for which you're entitled to benefits from workers compensation or a similar law. Weekly Disability Benefits are for active employees only and is not available to dependents.

Taxation of Benefits

Weekly disability benefits are subject to Federal income taxes and Social Security (FICA) taxes. The liability for FICA taxes is divided equally between employee and employer. The plan is required by federal law to withhold and deposit the employee's share of the FICA tax.

How to File a Claim for Benefits

Obtain a time loss form from the **Trust Administration Office** or your Local Union Office.

Complete the employee's portion of the form completely and sign it.

The physician who is treating you for the disabling condition must complete the doctor portion of the form.

Your employer must complete the employer portion of the form.

Return the form to the **Trust Administration Office** for processing.

H.E.R.E. Trust
P.O. Box 34355
Seattle, WA 98124-1355
(206) 441-7574
(800) 331-6158

Weekly Disability Benefits are paid by the **Trust Administration Office** once a week to you.

Total disability or totally disabled, as it applies to this benefit only, means you are prevented from performing any and every duty pertaining to your occupation. House confinement during your disability is not required. However, no benefits will be paid for any period of disability during which you are not under the care of and certified as totally disabled by a legally qualified physician.

Deadline for Filing Claims

All claims must be submitted within 15 months of date of disability. However, if your coverage terminates, all claims must be submitted within 6 months of the date of termination. Claims not submitted within this time limit will not be paid.

Medical Benefits

Inpatient Hospital, Surgical Authorization and Medical Review

Anytime your doctor recommends admission to the **hospital** or a surgery that will be performed in a setting other than the doctor's office, you or your doctor must contact the Plan's Utilization Review (UR) Coordinator at First Choice or Providence Preferred to request a preauthorization. For all **hospital** admissions (excluding maternity and medical emergencies), you must obtain preauthorization prior to admission. Emergency **hospital** admissions or emergency surgeries must be authorized by the UR Coordinator at First Choice or Providence Preferred within 48 hours of the time

you are admitted to the **hospital** or the surgery is performed, or as soon as reasonably possible. **Failure to preauthorize the hospital admission or surgery or authorize the emergency admission or surgery will result in a $250 benefit reduction on all related services (but not to exceed $500 of the expense incurred in excess of the deductible) for each surgery or hospitalization that is not pre-authorized.**

The preauthorization by the UR Coordinator is performed by trained medical personnel and is intended to improve the quality of the medical care you receive while controlling the costs to you and the Plan. The UR Coordinator may be contacted at the following telephone numbers:

Members under Local 8	First Choice Health Network, Inc. (206) 292-8255 Seattle (800) 231-6935 Inside Washington (800) 345-5767 Outside Washington
Members under Local 9	Providence Preferred 503-574-6400 (800) 638-0449

The UR Coordinator will need the following information:

(1) The name of the patient.

(2) The name of the **hospital**, admitting **physician** or surgeon, and telephone number.

(3) The expected date of admission or surgery.

The UR Coordinator, together with your **physician**, will then:

(1) Review the reason for admission or surgery and the procedure to be performed;

(2) Discuss any appropriate optional treatment setting;

(3) Determine the number of days needed for any **hospital** admission.

During any **hospital** stay, the UR Coordinator is in contact with the **hospital** and **physician** to assure that the prescribed care is being administered and that the patient is released from any **hospital** stay when hospitalization is no longer needed.

Since most health care plans already include these requirements, your doctor will be able to assist you in seeking the pre-authorization for any admission or surgery. However, it is your responsibility to assure that the appropriate pre-authorization is obtained.

In-Network (Preferred) Provider

Your Plan includes a **Preferred provider** Network. A **Preferred provider** (PPO) is a provider located in Washington and Oregon, who, at the time services are rendered, has a **Preferred provider** agreement in effect with First Choice Health Network, Inc. (FCHN) or Providence Preferred. **Preferred provider** agreements specify that when the provider furnishes care to a covered participant, the provider agrees to accept the **allowed amount** as payment in full; you are only responsible for deductibles, co-payments, **out-of-pocket** amounts, amounts in excess of the stated benefits maximums and charges for non-covered services and supplies. Your Plan is designed to provide a higher level of benefits and lower **out-of-pocket** costs whenever you use a PPO In-Network **Preferred provider**. Should you decide not to use a PPO In-Network **Preferred provider**, you may use any covered licensed provider; however, your **out-of-pocket** costs will be higher as detailed in this Plan Booklet. Since the contracting status of a provider is subject to change at any time, it is important to confirm the status of a provider before services are rendered. For information regarding PPO In-Network **Preferred provider**s, you may access the First Choice Provider Network online at www.fchn.com or at (206) 292-8255 or (800) 231-6935 inside Washington or (800) 345-5767 for outside Washington. For Providence Preferred call (503) 574-6400 or (800) 638-0449 or online at www.providence.org/healthplans.

Emergency Care

If you have a **medical emergency**, go to the nearest appropriate facility. In an emergency, treatment by a provider that is not a PPO In-Network provider will be recognized for 24 hours, or as long as it reasonably takes to come under the care of a PPO In-Network provider. If you are admitted to a **hospital** outside the service area, you must call the UR Coordinator within 24 hours to continue to receive the highest level of benefits. Benefits will be provided at the level specified in the Summary of Benefits for PPO In- Network benefits.

Care Outside the PPO Network Area

Outside the PPO Network area, benefits will be provided for care received from an out-of-area network provider (see *Medical Benefits — Definition of Terms*) based on the **allowed amount** at the level specified in the Summary of Benefits.

If you live inside the Network area and are admitted to a **hospital** while traveling outside the service, area, you must contact your **Preferred provider** Network within 24 hours (or the next business day) to receive In-Network benefits.

Remember to present your identification card when you seek medical care or receive treatment at a doctor's office or at a **hospital**. If your care is received within the Network area, choosing an In-Network provider can decrease your **out-of-pocket** expenses. By using your identification card, participating providers can submit your claims for you.

See the Claim Filing Information section for information on submitting claims.

Medical Plan Copays and Deductible

This section includes information on how your Plan covers the services and supplies listed in the following Benefits section. Each of the key factors in this section (**copays**, deductible, **out-of-pocket**) affects how your claim will be paid.

Copays

Each covered person will be required to pay the dollar amounts specified below or as specified in the Benefits section starting on page 24.

- $20 **copay** for each **outpatient** professional service (except lab and x-ray services and routine vision exams) performed in the office, home, **hospital outpatient** department, or other facility. **Copays** apply to all **outpatient** professional services as noted in the Benefits section.
- $75 **copay** for each visit to a **hospital** emergency room for illness, injury, or surgery (waived if directly admitted to the **hospital** as an **inpatient**).

Copays cannot be used to satisfy your annual deductible and will not accumulate toward your **out-of-pocket** limits.

The Calendar Year Deductible

The deductible is the cost of covered medical expenses you incur for out-of-Network covered medical services and are responsible to pay before your benefits are available. No deductible is required for In-Network covered charges incurred for covered medical services.

The Out-of-Network deductible amount under this Plan is $500 per person, per calendar year.

The **allowed amount** for Out-of-Network services can be applied to your deductible; however, any **copays** required by your Plan will not apply to your deductible.

Family Deductible: If three or more covered family members incur eligible deductible expenses totaling three person deductible amounts in a calendar year, no further deductible will be required from any family member during that calendar year.

Deductible Carry-Over: Covered medical expenses 'incurred during the last three months of a calendar year and applied to the deductible, may also be applied to the next year's deductible.

Family Accident Deductible: If two or more covered family members are injured in the same accident, they need to satisfy only one deductible for any benefits provided in that and the next calendar year as a result of the accident.

If Hospitalization Continues From One Calendar Year Into the Next: A second deductible will not be required for any treatment prior to your discharge from the **hospital**. Additional **out-of-pocket** also will not be required for any treatment prior to your discharge from the **hospital** if you have met the appropriate **out-of-pocket** limit for the calendar year in which the hospitalization began.

How to Submit Proof of Your Deductible: As you incur deductible medical expenses, your provider should bill the **Trust Administration Office** direct. If direct billing is not possible, submit your claim as specified in the Claim Filing Information section of this Plan Booklet as you incur expenses.

Cost Containment Provisions

Your Plan includes a health management program designed to encourage you to be aware of-and involved in-decisions about the most appropriate level of medical care.

Please read the following sections on second surgical opinions and preadmission approval carefully. It is important that you follow these procedures in order to get full use of your benefit coverage. Otherwise, your benefits could be significantly reduced. Remember, too, that benefits for these procedures are subject to waiting periods, any calendar year deductible, and all other provisions of this Plan, as described in this Plan Booklet.

Voluntary Second Surgical Opinion

If you choose to have a voluntary second surgical opinion before having surgery, the **physician**'s services and any related x-ray and laboratory services for the second opinion will be provided in full, not subject to the deductible or **copay** provisions of this Plan.

A third opinion will also be covered in the same manner as the second surgical opinion (provided in full, not subject to the deductible or copay provisions) if the first two opinions do not agree, but no additional opinions will be covered. Once you receive the second opinion, even if the **physician**s do not agree, the decision to have the surgery will rest with you.

If you have any questions on the voluntary second surgical opinion process, you may call the **Trust Administration Office**.

Pre-Authorization for Hospital Admission or Surgery

Prior to an **inpatient** admission, follow the steps of the pre-authorization process on page 20. The authorization will be valid for six months, but a new authorization should be obtained for each admission or readmission. If pre-authorization is not obtained, the **Trust Administration Office** will determine whether **inpatient** care was **medically necessary** when the claim is submitted.

It is not necessary to request pre-authorization for maternity admissions.

If the UR Coordinator determines that an **inpatient** level of care is not **medically necessary**, benefits for the facility care, including any related **physician**'s services, will be provided at 50% of the allowed amount or the amount that would have been paid had the services been received in an appropriate alternative setting, whichever is greater.

If you have any questions on the pre-authorization process, you may call the **Trust Administration Office**.

Maximum Benefits

The benefits of this Plan are limited to a $1,000,000 lifetime maximum per covered person. This maximum applies to all combined benefits provided under this Plan. In addition, on January 1 of each calendar year the amount charged against your lifetime maximum will be reduced by the lesser of $20,000 or the amount of benefits paid for charges incurred during the prior calendar year.

Waiting Periods

Transplant Waiting Periods

You will not be eligible for any benefits related to a transplant, including autologous bone marrow transplants, stem cell rescue and associated chemotherapy, until the first day of the thirteenth month of continuous coverage under this Plan, whether or not the condition is preexisting or an emergency. Benefits related to a transplant which was performed prior to your effective date of coverage under this Plan will be subject to the preexisting condition waiting period described below.

Waiting Periods for Preexisting Conditions:

No benefits are provided to you (or your dependent) for a pre-existing condition during the pre-existing condition waiting period. This rule does not apply to:

- pregnancy;
- a newborn child who is covered under this Plan or other creditable coverage within 31 days of birth; or
- a child who is adopted by you or placed for adoption with you before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan or other creditable coverage. Exceptions. If a child is covered by the Plan before the date of the adoption or placement for adoption, no benefits are provided for a pre-existing condition during the pre-existing condition waiting period that occurs before that date. If a newborn or adopted child or child placed for adoption first became covered under other creditable coverage before becoming covered by this Plan, and there has been a significant break in coverage, then no benefits are provided for a pre-existing condition during the pre-existing condition waiting period.

Definitions. For purposes of this ***Waiting Period for Pre-existing Conditions***:

- "Pre-existing condition" means any condition (physical or mental), regardless of the cause, for which medical advice, diagnosis, care, or treatment was recommended or received within the lookback period. Genetic information is not a "condition" when there is no diagnosis of the condition related to such information.
- "Treatment" includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines.
- "Pre-existing condition waiting period" means the exclusion period, reduced by the period of creditable coverage that occurs before the enrollment date (but not by creditable coverage that occurs before a significant break in coverage).
- "Creditable coverage" means coverage under any of the following types of health care coverage: employer-sponsored group health plan coverage (including coverage under insured and self-insured plans and under COBRA); health insurance coverage, including individual health insurance coverage; Part A or B of Medicare; Medicaid (other than the program for distribution of pediatric vaccines); medical and dental care for members and certain former members of

the U.S. armed forces and other uniformed services and their dependents; Medical care program of the Indian Health Service or of a tribal organization; State health benefits risk pool; Federal Employee Health Benefits Program; any plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage to individuals who are enrolled in the Plan; or Peace Corps plan.

"Creditable coverage" doesn't include coverage consisting solely of: coverage only for accident (including accidental death and dismemberment); disability income insurance; liability insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance (for example, mortgage insurance); coverage for on-site medical clinics; limited scope dental, limited scope vision benefits or long-term care benefits that are provided under a separate policy, certificate or contract of insurance or are not integral to a plan; coverage only for a specified disease or illness; hospital indemnity or other fixed-dollar indemnity insurance, if offered independently or as non-coordinated coverage; Medicare supplemental health insurance; coverage supplemental to medical and dental care coverage for members and certain former members of the U.S. armed forces and other uniformed services and their dependents; and coverage supplemental to similar supplemental coverage provided to coverage under a group health plan.

You may request a "Certificate of Creditable Coverage" from your prior group health plan to document such creditable coverage. If you need assistance in obtaining such a certificate from a prior group health plan, the **Trust Administration Office** will assist you.

- "Enrollment date" and exclusion period are defined as follows:

If	the enrollment date is	the exclusion period begins on the enrollment date and ends after
you and your dependents become eligible for benefits when you first work sufficient Eligibility Rule A Required Hours or Eligibility Rule B Required Hours	the first day of the 3 consecutive-month period during which you have worked Eligibility Rule A Required Hours or Eligibility Rule B Required Hours	7 (seven) full consecutive calendar months
a new spouse or child becomes covered when you are eligible for benefits under Eligibility Rule A or B	the first day of coverage	3 (three) full consecutive calendar months
you are required to make employee contributions, and you or your dependent later enroll during an open enrollment or special enrollment (see *Special Enrollment Period (When Employee Contributions are Required)* at page 10)	the first day of coverage	

- "Lookback period" means the 3 consecutive-month period that ends on the enrollment date.

"Significant break in coverage" means a period of 63 consecutive days during all of which you (or your dependent) was not covered under creditable coverage. Neither a waiting period (within the meaning of ERISA § 704(b)(4)) nor an affiliation period (within the meaning of ERISA § 701(g)(2)) is taken into account in determining a significant break in coverage.

You or your dependent will not be eligible for Medical Benefits for preexisting conditions until you, he or she has been covered under the Plan for three consecutive months. This three-month period is reduced by one day for each day of creditable coverage.

Benefits

All benefits are provided only as specified under this Plan.

All covered benefits are subject to the limitations, exclusions, and provisions of this Plan.

Preventive Care

The following services will be provided:

- Routine well baby care from birth.
- Routine pediatric, routine gynecological and adult physical examinations.
- Pediatric and adult immunizations.
- Office calls and related laboratory and x-ray services for cancer screening. (Mammography services are covered under the regular benefits of the Plan.)

Preventive care benefits are not available for services by Out-of-Network providers except for mammography which is covered under the regular benefits of the Plan. **Copays** apply to all services except x-ray and laboratory.

Professional Services

The services of a covered provider who is not a facility that provides **inpatient** services, will be provided for diagnosis and treatment of injury and illness, including x-ray, laboratory, surgery, second opinions for surgery and injectable drugs for covered conditions in the office, home, **hospital** or **skilled nursing facility**. The services of a **physician**, a **physician**'s assistant, or an advanced registered **nurse** practitioner specializing in women's health and midwifery will be provided to a female for covered women's health care services. Covered women's health care services include gynecological care and general examinations as medically appropriate and medically appropriate follow-up visits.

Hospital Services and Supplies

The **inpatient** and **outpatient** services of a covered **hospital** will be provided for injury and illness (including services of staff providers billed by the **hospital**). Room and board will be limited to the **hospital**'s average semiprivate room rate. You will be responsible to pay the $75 emergency room **copay** each time you go to the **hospital** emergency room. All other services of the **hospital outpatient** department, except **outpatient** surgery, radiation and chemotherapy, are subject to the $20 **outpatient** professional **copay**.

Acupuncture

The professional benefits of this Plan will be provided to a 12-visit limit per year for acupuncture services when performed by a covered provider, except that acupuncture for chemical dependency treatment will be provided separately under the chemical dependency treatment benefit. See *Medical Benefits — Special Conditions — Chemical Dependency Treatment* at page 32.

Ambulance Services

The services of an approved ground ambulance company will be provided to a maximum of $2,000 per calendar year if other transportation would endanger your health and the purpose of the transportation is not for personal or convenience reasons. Benefits for licensed air ambulance service will be provided to the nearest **hospital** equipped to render the necessary treatment, based upon review and approval by the **Trust Administration Office** and subject to the limitation listed in the Summary of Benefits.

Ambulatory Surgical Center

The services and supplies of a licensed, Medicare approved ambulatory surgical center will be covered for treatment of injury or illness.

Diabetes Care Training

The **outpatient** benefits of this Plan will be provided for services by a covered provider for diabetic self-management training and education, including nutritional therapy, if recommended by a **physician** with expertise in diabetes.

Growth Hormone

Services and supplies will be provided for growth hormone when performed and billed by a covered infusion therapy provider for growth hormone deficiency in children, Turner's syndrome, growth failure in children secondary to chronic renal insufficiency prior to renal transplant, or for the promotion of wound healing in patients with severe, acute burns. Growth hormone treatment of these listed conditions is covered when authorized by the **Trust Administration Office** in advance. Benefits for growth hormones are provided to a maximum of $25,000 per calendar year. No other benefits for growth hormone will be provided under this Plan.

Home Health

Eligibility: The services of an approved home health agency will be covered for **medically necessary** treatment of an illness or injury, subject to the conditions and limitations specified below.

All of the following must be satisfied to be covered under this benefit:

- You must be homebound, which means that leaving the home could be harmful, involves a considerable and taxing effort, and you are unable to use transportation without the assistance of another.
- Your condition must be serious enough to require confinement in a **hospital** or **skilled nursing facility** in the absence of home health services.

Covered Services: Benefits are limited to the following services and must be provided by employees of and billed by the home health agency:

- Nursing services.
- Physical, occupational, speech and respiratory therapy services.
- Medical social services.
- Home health aide services. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records, and personal care or household service that are needed to achieve the medically desired results.
- Medical supplies dispensed by the home heath agency that would have been provided on an **inpatient** basis
- Nutritional guidance.
- Nutritional supplements such as diet substitutes administered intravenously or by enteral feeding.

Note: For professional services or home medical equipment, see *Medical Benefits — Benefits — Professional Services* at page 25 and *— Home Medical Equipment* at page 26.

Limitations and Exclusions: Home health benefits are limited to a maximum of 130 visits per calendar year.

If the benefit is exhausted, you may apply to the **Trust Administration Office** for an extension of benefits. Limited extensions may be granted by the **Trust Administration Office** if it determines that the treatment is **medically necessary**.

Any expenses for home care which qualify both under this benefit and under any other benefit of this Plan may be covered only under the benefit the **Trust Administration Office** determines to be the most appropriate.

No benefits will be provided for the following:

- Services normally provided under a hospice program.
- Services to individuals other than the patient (for example, services to family members of the patient).
- Services of volunteers, household members, family or friends.
- Food, clothing, housing or transportation. (See Medical Benefits — Benefits — Description of Benefits — Ambulance Services at page 25.)
- Supportive environmental or convenience items, such as but not limited to ramps, handrails or air conditioners.
- Homemaker or housekeeping services, except as specifically provided above under the home health aide benefit of this *Home Health Benefit*.
- Financial or legal counseling services.
- Custodial or maintenance care.
- Hourly care services.
- Services or supplies not specifically set forth as a covered benefit, or limited or excluded under the regular *Limitations and Exclusions* of this Plan at page 33.

Home Medical Equipment

Home medical equipment rented or purchased (if approved by the **Trust Administration Office**) from an approved home medical equipment company will be provided for therapeutic use. If home medical equipment is rented, the benefit is limited to the amount of the purchase price. Such equipment includes crutches, wheelchair, kidney dialysis equipment, standard **hospital** beds, equipment for the administration of oxygen, and **medically necessary** diabetic equipment such as blood glucose monitors, insulin infusion devices and insulin pumps. To be covered, equipment must meet the criteria described in this paragraph. Equipment ordered before your effective date of coverage will not be provided. Equipment ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be provided. Repair or replacement of home medical equipment due to normal use or growth of a child will be provided. “Home medical equipment” means the equipment can withstand repeated use; its only function is for treatment of the medical condition, or it contributes to the improvement of function related to the condition and is generally not useful in the absence of the condition; usable only by the patient, not primarily for the comfort or hygiene of the patient, not for exercise and it is

appropriate for home use. Equipment whose primary purpose is preventing illness or injury, items primarily designed to assist a person caring for the patient, and items generally useful in the absence of the condition will not be covered. No benefits will be provided for items such as, but not limited to, air conditioners, humidifiers, over-the-counter arch supports, corrective shoes, heating pads, enuresis (bed wetting) training equipment, hearing aids, exercise equipment, weights, whirlpool baths, keyboard communication devices, adjustable beds, orthopedic chairs or personal hygiene items. The fact that an item may serve a useful medical purpose will not ensure that benefits will be provided. The **Trust Administration Office** may elect to provide benefits for a less costly alternative item.

Home Phototherapy

Services and supplies furnished by a licensed home phototherapy provider will be provided for newborn hyperbilirubinemia (newborn jaundice) subject to PPO In-Network and Out-Of-Network benefits. Co-pay and deductible apply.

Hospice Benefit

Eligibility: If you or one of your dependents is terminally ill, the services of a licensed hospice will be covered for palliative care (medical relief of pain and other symptoms) for the terminally ill patient, subject to the conditions and limitations specified below.

Covered Outpatient Services: Benefits are limited to the following services and must be provided by employees of and billed by the hospice:

- Nursing services.
- Physical, speech, occupational, and respiratory therapy services.
- Medical social services.
- Home health aide services. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, competing appropriate records, and personal care or household services that are needed to achieve the medically desired results.
- Medical supplies dispensed by the hospice that would have been provided on an **inpatient** basis.
- Nutritional guidance.
- Nutritional supplements such as diet substitutes administered intravenously or by enteral feeding, subject to the infusion therapy benefit limit of this Plan.
- Respite care for a minimum of four or more hours per day (continuous care of the patient to provide temporary relief to family members or friends from the duties of caring for the patient).

Note: For professional services or home medical equipment, see *Medical Benefits — Benefits — Description of Benefits — Professional Services and — Home Medical Equipment*.

Covered Inpatient Services: When you are confined as an **inpatient** in a licensed hospice that is not a **hospital** or **skilled nursing facility**, the same benefits that are available in your home will be available to you as an **inpatient**. In addition, a semiprivate room benefit will be provided. The services must be provided by employees of and billed by the hospice. This **inpatient** hospice benefit will be limited to 14 days during the six-month benefit period. For services in a **hospital** or **skilled nursing facility**, see the **hospital** and **skilled nursing facility** benefits of this Plan.

Limitations and Exclusions: Hospice benefits are limited to a maximum of six months. In addition, hospice benefits will have the following limits:

- Visits of four or more hours in which skilled care is required by a registered **nurse**, licensed practical **nurse** or home health aide, will be limited to a combined total of 120 hours.
- Respite care of four or more hours per day in which no skilled care is required will be limited to a combined total of 120 hours per three-month period.
- Any expenses for hospice care that qualify both under this benefit and under any other benefit of this Plan will be covered only under the benefit the **Trust Administration Office** determines to be the most appropriate.

If the benefit is exhausted, you may apply to the **Trust Administration Office** for an extension of benefits. Limited extensions may be granted if the **Trust Administration Office** determines that the treatment is **medically necessary**.

No benefits will be provided for the following:

- Services for spiritual or bereavement counseling.
- Services to other family members
- Services of volunteers, household members, family or friends.

- Food, clothing, housing or transportation. (See the ambulance benefit of this Plan.)
- Supportive environmental or convenience items, such as but not limited to ramps, handrails, or air conditioners.
- Homemaker or housekeeping services, except as specifically provided under the home health aide benefit.
- Financial or legal counseling services.
- Custodial or maintenance care, except that benefits will be provided for palliative care to a terminally ill patient, subject to the limits stated.
- Services or supplies not specifically set forth as a covered benefit, or limited or excluded under the regular limitations and exclusions of this Plan.

Hospitalization for Dental Services

Services and supplies for hospitalization will be provided for dental services (including anesthesia), if hospitalization is **medically necessary** to safeguard your health as documented by your **physician**. Benefits will be provided to $1,000 per calendar year and will cover the services of a covered **physician**, a covered ambulatory surgical center, and the **inpatient** and **outpatient** services of a covered **hospital**. Benefits are not available for the charges of a **dentist**; hospitalization for myofascial pain syndrome and any related appliances; or hospitalization for malocclusions or other abnormalities of the jaw, as specifically provided in the TMJ benefit description on page 30.

Infusion Therapy

Service and supplies will be provided for infusion therapy when performed and billed by a licensed infusion therapy provider. Drugs and supplies used in conjunction with infusion therapy will be provided only under this infusion therapy benefit. This benefit is subject to PPO In Network and Out-Of-Network provisions. Deductible and Co-pay apply.

Preadmission Testing For Surgery

The services of a **physician** and **hospital** will be provided for **outpatient** preadmission testing for surgery at the **hospital** where you will be confined, it you are admitted within 48 hours after testing begins.

Prostheses

Benefits will be provided for purchase of a prosthesis for functional reasons when replacing a missing body part, when obtained from a licensed prosthetic provider. No benefits are provided for cosmetic prostheses except for necessary external and internal breast prostheses following a mastectomy. An item ordered before your effective date of coverage will not be provided. An item ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be provided. Repair or replacement of an item due to normal use or growth of a child will be provided. The **Trust Administration Office** may elect to provide benefits for a less costly alternative item. For other special equipment, see the *Special Equipment and Supplies* benefit below.

Skilled Nursing Facility

The **inpatient** services and supplies of a licensed nursing facility will be provided for illness, accidental injury, or physical disability, limited to 90 days per calendar year. Room and board is limited to the facility's average semiprivate room rate. Your **physician** must submit for approval by the **Trust Administration Office** and periodically provide a written treatment plan specifically describing the services to be provided. No **custodial care** is provided.

Special Equipment and Supplies

The following will be paid at 80% of the allowed amount: braces, splints, casts; colostomy bags and related supplies; catheters; surgical appliances; syringes and needles for allergy injections; and dressings **medically necessary** for wounds, cancer, burns or ulcers. Formulas for the treatment of phenylketonuria will be covered. Items ordered before your effective date of coverage will not be provided. Repair or replacement of items due to normal use or growth of a child will be provided.

Mammography

The x-ray benefits of this Plan will be provided for screening or diagnostic mammography services, if recommended by a **physician**, **physician**'s assistant or advanced registered **nurse** practitioner.

Neurodevelopmental Therapy

The benefits described below will be provided for **medically necessary** neurodevelopmental therapy treatment to restore and improve function for children age six and under. In addition, this benefit includes maintenance services where significant deterioration of the patient's condition would result without the service. Benefits will be provided as follows:

- The service of a licensed provider for physical, speech and occupational therapy will be provided in the office, home or **hospital outpatient** department.

- Regular **inpatient hospital** and **skilled nursing facility** benefits will be provided for an **inpatient** neurodevelopmental therapy admission when care cannot safely be provided on an **outpatient** basis. **Hospital** services must be provided in a **hospital** approved by the **Trust Administration Office** for rehabilitative care.
- Your **physician** must submit for advance approval by the **Trust Administration Office** and must periodically submit a written 'treatment plan specifically describing the neurodevelopmental therapy services to be provided.
- Benefits will be limited to $1,000 per calendar year for all neurodevelopmental therapy services combined. The services of a licensed massage therapist will be provided for physical therapy only upon referral by the patient's **physician**. **Copays** apply to **outpatient** treatment. You will not be eligible for both the Rehabilitative Services benefit and this benefit for the same condition. (This benefit is not subject to any **out-of-pocket** provision.)
- No benefits will be provided for **custodial care**; maintenance (except as specified above), nonmedical self-help, recreational, educational or vocational therapy; mental disorder care; chemical dependency rehabilitative treatment; gym or swim therapy.

Newborn Infants

When you (if you are female) are eligible for benefits under Eligibility Rule A or Eligibility Rule B or your wife (if you are male) is eligible for benefits under Eligibility Rule A, the professional and **hospital** benefits of the Plan will be provided for routine care of your newborn child while hospitalized for the first 72 hours following birth, not subject to the application requirements if any, for newborns described under *Benefits for Employees Who Work Required Hours under Eligibility Rule A — Newborn and Adopted Children* at page 7.

Prenatal Testing

Benefits will be provided for prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy, when **medically necessary** in procedures during pregnancy. in accordance with Washington State Board of Health standards.

Rehabilitative Services

The benefits described below will be provided for rehabilitative care when **medically necessary** to restore and improve function previously normal but lost due to illness or injury, including function lost as a result of congenital anomalies. Benefits will be provided as follows:

Regular **inpatient hospital** and **skilled nursing facility** benefits will be provided for an **inpatient** rehabilitative admission for physical, speech and occupational therapy, to a maximum of $30,000 per condition. You must be continuously covered under this Plan from the onset of the condition. Covered Services must be provided in a licensed Medicare approved facility for rehabilitative services. Treatment must occur within three calendar years from the date of your first **hospital** or **skilled nursing facility** rehabilitative care admission while covered under this Plan.

Physical, occupational or speech therapy in the office, home or **hospital outpatient** department will be paid to $1,000 per calendar year. Services must be provided by a licensed provider for physical, occupational and speech therapy only. The initial claim must be submitted with the **physician**'s prescription for the rehabilitative services. **Copays** apply to **outpatient** treatment. (This benefit is not subject to any **out-of-pocket** provision.)

If you had an **inpatient** rehabilitative admission for the condition and did not exhaust your $30,000 **inpatient** benefit, you may apply to the **Trust Administration Office** for additional **outpatient** benefits beyond the $1,000 limit. Limited extensions may be granted up to the balance of the unused **inpatient** benefit if the **Trust Administration Office** determines the services to be **medically necessary**.

No benefits will be provided for **custodial care**; maintenance, nonmedical self-help, recreational, educational or vocational therapy; mental disorder care; learning disabilities or developmental delay; chemical dependency rehabilitative treatment; gym or swim therapy.

Repair of Teeth

The services of a licensed **dentist** (D.M.D. or D.D.S.), or a licensed denturist will be provided for repair or accidental injury (trauma) to natural teeth that are whole and functionally sound or have been restored to a sound functional capacity. Benefits will be provided for the treatment of the injury for a period of 12 consecutive months from the date of the injury at 80% of the allowed amount to a maximum of $1,000 per occurrence. Treatment must begin within 30 days of the injury. You or your dependent will be responsible to pay any additional charges not paid by the Plan. This benefit is secondary to any dental plan you may have. This benefit will not be provided for injury caused by biting or chewing or for dental implants. No other charges of a **dentist** or denturist are covered under this Plan, except when specifically provided otherwise. (This benefit is not subject to any **out-of-pocket** provision)

Smoking Cessation

The services of a licensed **physician** or licensed **psychologist**, or licensed smoking cessation provider, will be provided for a smoking cessation program to a lifetime maximum of $500. To receive benefits for smoking cessation, you must complete the full course of treatment. No benefits will be provided for **inpatient** services; vitamins, minerals and other supplements; acupuncture; over-the-counter drugs or prescription drugs prescribed by your covered provider to ease nicotine withdrawal, however, drugs prescribed to ease nicotine withdrawal are covered under the prescription drug benefit of this Plan (see *Medical Benefits — Benefits — Prescription Drugs* below); books or tapes; or hypnotherapy unless performed by a licensed provider. No other benefits for smoking cessation will be provided under this Plan. (This benefit is not subject to any **out-of-pocket** provision).

Sterilization Procedures

Benefits will be provided for sterilization procedures, subject to the waiting periods described in the Limitations section, if any. Reversals of these procedures will not be covered.

Temporomandibular Joint Disorders (TMJ)

Benefits will be provided for medical services furnished by a licensed **physician** or **hospital**, or a licensed physical therapist, for treatment of temporomandibular joint disorders. The TMJ disorder must have one or more of the following characteristics: pain; in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint or an abnormal range of motion or limitation of motion of the temporomandibular joint.

Benefits will be limited to a maximum of $1,000 per calendar year, not to exceed a lifetime maximum of $5,000. **Copays** apply to **outpatient** services.

"Medical services" for the purpose of this TMJ benefit mean those services that are:

1) reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and
2) effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and
3) recognized as effective, according to the professional standards of good medical practice; and
4) not investigational or primarily for cosmetic purposes.

All services must be provided or ordered by your **physician** and are subject to the waiting period described in the Limitations section of this Plan Booklet, if any. **Benefits for all surgical services related to TMJ must be authorized by the Trust Administration Office in writing, in advance**. The Plan will waive its pre-authorization requirement for treatment commencing within 48 hours, or as soon as is reasonably possible as determined by the **Trust Administration Office**, after the occurrence of an accidental injury or trauma to the temporomandibular joint. No other benefits for TMJ will be provided by thisPlan.

Spinal Manipulation

Benefits will be provided for 10 spinal adjustments by hand per year when performed by an approved provider. Benefits will be paid at the level specified for PPO In-Network or Out-of-Network in the Summary of Benefits – Medical Benefits.

Prescription Drugs

Prescription Drugs are covered either through the Retail Prescription Program through NMHCRx or the Mail Service Prescription Program through Express Pharmacy Services (EPS).

Retail Prescription Program

The **Retail Prescription Program** is designed for use in purchasing medications that you will be using on a short-term basis and allows you to go to a participating network pharmacy to have prescriptions filled up to a 34-day supply per prescription. To obtain your prescription, you must present your prescription ID card and the **physician**'s prescription to the pharmacist. Through the NMHCRx system, the pharmacist will electronically verify your benefits and eligibility. You do not need to file a claim, all you do is pay the **copay** to the pharmacy. The **copay** you will pay per prescription is:

- $12 for each brand-name prescription drug
- $12 for each generic prescription drug.

If you purchase a brand-name prescription drug and a generic equivalent is available, you will be responsible for payment of the difference in cost between the two medications in addition to the **copay**.

You can call the NMHCRx Customer Service toll –free number at 1-800 880-1188 if you have any questions about your

Retail Prescription Program or their participating pharmacies. In addition, a complete list of the NMHCRx participating pharmacies is available on their web site at www.nmhcrx.com. NMHCRx business hours are 7:00 a.m. to 8:00 p.m. Pacific Standard Time (PST) Monday through Friday; Saturday and Sunday from 7:00 a.m. to 5:00 p.m. (PST) and holiday hours are from 7:00 a.m. to 5:00 p.m. (PST).

Mail Service Prescription Program

The **Mail Service Prescription Program** is designed for use in obtaining maintenance medications for ongoing (long-term) or chronic conditions. When ordering your maintenance medication through the Mail Service Prescription Program, you will get up to a 90-day supply of your maintenance medication for **one (1) copay of $12 for brand-name prescriptions, or one (1) copay of $12 for generic prescriptions.** If you purchase a brand-name prescription and a generic equivalent is available, you will be responsible for payment of the difference in cost between the two medications.

How to use the Mail Service Prescription Program for the first time:

- When your doctor prescribes a maintenance drug, have the prescription written for a 90-day supply as the program can only fill your prescription with the quantity your doctor indicates.
- Obtain an Enrollment/Order Form and Confidential Patient Profile for you and any covered family members. You can obtain this form from Express Pharmacy Services (EPS) or the **Trust Administration Office**.
- Mail the completed form along with the original prescription and **copay** in the pre-addressed, postage-paid envelope that comes with the form.
- Be sure to write the participant's social security number on the back of each prescription

Your drugs will be delivered postage-paid directly to your home. Allow a few extra days the first time you place an order through the Mail Service Prescription Program.

For refills, you simply complete the Prescription Order Form provided with your order and send it back using the postage-paid envelope provided.

You can pay for your prescriptions by check, money order or credit card. Express Pharmacy Services (EPS) Customer Service toll free number is 1-800 222-3383. TDD-Hearing Impaired Customer Service, dial 1-800 238-0756. The web site is www.ehs.com. EPS hours are: 7:00 a. m – 5:00 p.m. EST, Monday-Friday; 7:00 a.m. – 9:00 p.m. EST Saturday.; 8:00 a.m.- 5:30 p.m. EST Sunday.

Covered Prescriptions:

All non-injectable legend drugs, except as excluded, but to include the following:

Anti-psychotic/Anti-anxiety	Antidepressants	Hypnotics/Sedatives (w/limits)	Nutritional Supplements
Migraine Therapies (w/limits)	Insulin & Insulin Syringes	Diabetic Supplies	Folic Acid
Glucometers (1per yr)	Legend drugs w/OTC alternatives	State Controlled Drugs	Prenatal vitamins
Oral Contraceptives	Dental Prescription Drugs	Oral Chemotherapy Agents	Immunosuppressants
Allergic Emergency kits (w/limits)	Acne Products (some limited to age 26)	Oral Anti-fungals (w/limits)	Children's vitamins w/fluoride

**Smoking Cessation covered for a 90-day lifetime therapy only

Exclusions

Misc. Medical Supplies	Alcohol Swabs	Over the Counter Medications (OTC)	Nutritional Supplements
Injectable Vitamins	Injectable/Implantable Contraceptives	Contraceptive Devices	Fertility Drugs
Erectile Dysfunction	Fluorides	Cosmetic Products	Hair Growth
Chemotherapy	Anabolic Steroids	Misc. Needles & Syringes	Specialty Injectables
Weight Loss Drugs	Contraceptive Patches	Immunizations	

Prior Authorizations Required

Prescriptions for the following medications will not be fulfilled without the prior authorization of NMHCRx:

- Wellbutrin 150 mg
- Oral Antifungals
- Medications over $1,000 retail
- Medications over $1,500 mail order

To obtain prior authorization, call NMHCRx at 1-800 880-1188 during its business hours (described above under *Retail Prescription Program* at page 30).

Special Conditions

Maternity Benefits

Medical services including prenatal and postnatal treatment of pregnancy (including false labor), normal or cesarean delivery, complications resulting from pregnancy and voluntary termination of pregnancy shall be treated the same as any other illness or injury and are provided for you or your spouse for services incurred while covered under this Plan. Coverage includes services by a **physician**, **physician**'s assistant, or advanced registered **nurse** practitioner specializing in women's health and midwifery.

Maternity benefits are not subject to the preexisting condition waiting periods described in the Limitations section, if any. Maternity benefits also include coverage for false labor. These maternity benefits are not available for dependent daughters. See the General Information section of this Plan Booklet.

Chemical Dependency

The services and supplies of a licensed **Chemical Dependency Treatment Facility** will be provided for medically necessary **inpatient** and **outpatient** treatment for **Chemical Dependency**, including supportive services. Benefits will be provided to a maximum allowance of $11,000 every two calendar years. Medically necessary detoxification will be covered as a **medical emergency** and expenses incurred will not accrue to the $11,000 two calendar year maximum if the patient is not enrolled in other chemical dependency treatment. Any benefits charged during this or the previous calendar year under this Plan. Acupuncture services related to chemical dependency treatment will be provided under this *Chemical Dependency* benefit and will accrue to the overall chemical dependency benefit maximum. Acupuncture services provided under this chemical dependency benefit do not accrue to the 12 visit limit per year, as specified in the acupuncture benefit.

Prescription drugs related to chemical dependency treatment and prescribed and dispensed through an approved chemical dependency treatment facility will be provided under the benefits of the chemical dependency benefit and will accrue to the overall chemical dependency benefit maximum.

Except in cases of medically necessary detoxification services, the program must submit a pre-notification of treatment at least 10 days before treatment begins, whenever reasonably possible.

When the patient is under court order to undergo a chemical dependency assessment or in other situations pending legal action related to chemical dependency, before any benefits can be considered, the patient must provide at their own expense a chemical dependency treatment plan and an initial chemical dependency assessment performed by a chemical dependency counselor employed by a licensed chemical dependency treatment facility, at least l0 days before treatment begins.

For the purpose of this *Chemical Dependency* benefit, "medically necessary" means indicated in the *Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders, Second Edition*, as published in 1996 by the American Society of Addiction Medicine.

No benefits will be provided for information and referral services, information schools, Alcoholics Anonymous and similar chemical dependency programs, long-term care or **custodial care**, or tobacco cessation programs except as provided in the *Smoking Cessation* benefit at page 30 and emergency service patrol. No other chemical dependency benefits for chemical dependency treatment are provided under this Plan, except as described above for detoxification.

Mental Disorders

	In-Network Benefits	Out-of-Network Benefits
Inpatient care, partial hospitalization and residential treatment	90% to 12 days per calendar year	60% after deductible 6 days per calendar year
Outpatient care, subject to **copay**	90% after $20 **copay** per visit to maximum 15 visits per calendar year	60% after $20 **copay** per visit to maximum 12 visits per calendar year. Deductible applies

Inpatient mental disorder care must be provided by an approved mental health provider, including but not limited to psychiatric **hospital**s and approved community mental health agencies or an approved **hospital** or an approved community mental health agency that has an **inpatient** facility. **Outpatient mental disorder** treatment must be provided by a licensed mental health provider including but not limited to **physician**s, licensed **psychologist**s, registered **nurse**s, MSWs, (Masters Social Work) mental health counselors, marriage and family therapists (however, marriage counseling, and family counseling will not be covered) and licensed community mental health agencies.

If you use the services of any combination of approved providers, the overall benefit maximums are limited to the amounts specified for these benefits. No other benefits for treatment of **mental disorders** will be provided under this Plan. (**Outpatient** benefits are not subject to the **out-of-pocket** maximum.)

Transplant Benefit

> **Important:** Neither you nor your dependent are eligible to receive any benefits related to a transplant until the first day of the thirteenth month of continuous coverage under this Plan, whether or not the condition is preexisting or an emergency. See *Medical Benefits — Waiting Periods — Transplant Waiting Period*, at page 23.

The benefits of this Plan will be provided for **medically necessary** services or supplies related to all approved transplants to a combined lifetime maximum of $200,000 as follows, as determined by the UR Coordinator:

Benefits: A transplant recipient who is covered under this Plan will be eligible for the following transplants, subject to the limits described in this Benefit:

- Heart
- Heart/lung (combined)
- Kidney
- Kidney/pancreas (combined)
- Islet cell
- Lungs – single/bilateral/lobar
- Liver
- Small bowel
- Small bowel/liver/Multivisceral
- Cornea
- Bone marrow (including self-donated and unrelated donors) or other forms of stem cell rescue (but only covered for certain conditions — see the *Limitations and Exclusions* discussion in this *Transplant Benefit* section, below).

Benefits for all transplants must be authorized by the UR Coordinator in writing, in advance. Approval will be based upon the Member's medical condition, the qualifications of the providers, appropriate medical indications for the transplant, and appropriate, proven medical procedures for the type of condition. All transplants must be performed in a facility approved by the UR Coordinator If a transplant is not successful, only one retransplant will be covered, subject to the $200,000 lifetime maximum benefit.

Out-of-Network Area: Benefits will be provided outside the service area at 80% of the **allowed amount** under the Out-of-Network benefits of this Plan. You must follow all requirements of this benefit including, but not limited to, obtaining pre-approval from the UR Coordinator and using a facility approved by the UR Coordinator.

Donor Organ Procurement Benefits: Donor organ procurement costs will be covered to a maximum of $25,000 per transplant if the recipient is covered for the transplant under this Plan. Donor organ procurement benefits will be charged against the recipient's $200,000 lifetime maximum benefit.

Travel Expenses: Travel and lodging expenses for you and your family will be covered when you are required by your **physician** to travel 30 miles or more outside the service area for **medically necessary** services related to an approved transplant. Benefits will be paid at 90% to a maximum of $2,500 per transplant episode requiring travel and must be approved in advance by the **Trust Administration Office** and is subject to the $200,000 lifetime maximum benefit.

Limitations and Exclusions: No benefits will be provided for the following:

- Nonhuman, artificial or mechanical transplants.
- When the recipient is not covered under this Plan.
- Experimental investigational services or supplies.
- Donor organ procurement costs incurred outside the United States unless approved by the UR Coordinator.

- Stem cell rescue, bone marrow transplants and chemotherapy associated with stem cell rescue or bone marrow transplants, except as specified below:
  - With regard to autologous (self-donor) stem cell rescue, autologous (self-donor) bone barrow transplants and chemotherapy associated with autologous stem cell rescue, autologous bone barrow transplants, coverage is available for treatment of only the following malignancies/conditions:
    - Non-Hodgkins lymphoma
    - Hodgkins lymphoma
    - Neuroblastoma
    - Acute lymphocytic or non-lymphocytic leukemias
    - Germ cell tumor
    - Metastatic breast cancer on an Approved Clinical Trial
    - Multiple myeloma on an Approved Clinical Trial
    - Chronic myelogenuous leukemia
    - Ewing's sarcoma
    - Wilms Tumor
  - With regard to allogeneic (related or unrelated) stem cell rescue, allogenic bone marrow transplants and chemotherapy associated with allogeneic stem cell rescue or allogenic bone marrow transplants, coverage is available for treatment of only the following malignancies/conditions:
    - Acute lymphocytic or non-lymphocytic leukemias
    - Chronic myelogenous leukemia
    - Aplastic anemia
    - Hodgkins lymphoma
    - Non-Hodgkins lymphoma
    - Severe combined immunodeficiency (not AIDS)
    - Wiskott-Aldrich syndrome
    - Sickle cell anemia
    - Kostmann's Syndrome
    - Leukocyte adhesion deficiencies
    - Infantile malignant osteopetrosis
    - Neuroblastoma
    - Homozygous beta-thalassemia
    - Myelodysplastic syndromes
    - Mocupolysaccaridoses
    - Mucolipidoses
    - Multiple myeloma on an Approved Clinical Trial
    - Ewing's Sarcoma
    - X-linked proliferative syndrome
    - Megakaryocytic thrombocytopenia
- Donor organ procurement costs, when donor organ procurement benefits are available through other group coverage, including an employer-sponsored group health plan (whether insured or self-insured).
- When government funding of any kind is available.
- Lodging, food, or transportation costs, unless otherwise specified under this Plan.
- All services and expenses not approved by the UR Coordinator. Any services or supplies relating to the transplant if furnished before the recipient has met the 12-mont transplant waiting period. (See *Medical Benefits — Waiting Periods — Transplant Waiting Period*, at page 23.)

"Approved Clinical Trial" means each of the following criteria has been met. These criteria for an Approved Clinical Trial apply to Multiple Myeloma and Metastatic breast cancer, specifically autologous or allogeneic stem cell rescue for Multiple Myeloma and autologous stem cell rescue for Metastatic breast cancer.

- The trial has been approved by the National Institutes of Health (NIH), the Food and Drug Administration, or the Department of Veterans Affairs, and
- The trial protocol has been reviewed and approved by an Institutional Review Board (IRB) qualified under federal law, and
- The facility and personnel providing the treatment or utilizing the supplies are capable of doing so by virtue of their experience or training, and
- The trial is not a Phase I trial.

Limitations and Exclusions

No benefits are provided for the following, unless specifically stated otherwise or unless specifically provided for in this *Medical Benefits* section.

- Services and supplies not **medically necessary** (as defined in *Medical Benefits — Definition of Terms* at page 48) for treatment of an illness or injury, unless otherwise listed as covered.

- Acupuncture, except as specifically provided in the *Acupuncture* in this *Benefits* section and in *Special Conditions — Chemical Dependency* benefits at page 32.
- Ambulance services, except as specified in the *Ambulance Services* benefit at page 25.
- Addiction to or abuse of drugs, alcohol or any other chemical substance whether legal or illegal, except as specifically provided in *Special Conditions — Chemical Dependency* benefit at page 32.
- Any expense or charge for services or supplies which are provided or paid for by the federal government or its agencies; except for:
  - The Veterans Administration, when services are provided or paid for a disability that is not service connected.
  - A military **hospital** or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services.
  - A group health plan established by a government for its own civilian employees and their dependents.
- Charges for services and supplies that are above the **allowed amount** as defined in *Medical Benefits — Definition of Terms* at page 48.
- Charges that in the absence of this Plan the patient would have no obligation to pay.
- Conditions related to military service or declared or undeclared war.
- **Cosmetic surgery** and supplies (including drugs) and the treatment of any direct or indirect complications of such surgery, except:
  - for congenital anomalies; and
  - for reconstructive breast surgery following mastectomies, to the extent required under Federal law as follows:
    - reconstruction of the diseased breast;
    - reconstruction of the nondiseased breast to produce a symmetrical appearance; and
    - prostheses and physical complications of all stages of a mastectomy, including lymphodemas.
- Dental services, except as specified in the Repair of Teeth and Hospitalization for Dental Services Benefits in the "Benefits" section.
- Dyslexia treatment, except as specified in the Neurodevelopmental Therapy Benefit in the "Benefits" section.
- Visual analysis, therapy or training and orthoptics.
- Custodial care.
- Experimental or investigational services or supplies. See *Medical Benefits — Definition of Terms*, below.
- Home Medical Equipment, special equipment or supplies, prostheses, orthopedic or surgical appliances, braces, or foot care appliances (foot orthotics), except as -specifically provided in the *Home Medical Equipment, Prostheses and Orthotics, Special Equipment and Supplies* benefits at pages 28 and 29.
- Hearing aids (unless as specifically provided under the *Hearing Aid Device Benefit*) and cochlear implants.
- Injuries related to professional athletics, including practice.
- An injury or illness to or of you or your dependent that, in the judgment of the Trustees, is or appears to be the responsibility of one or more persons and for which payment is or may be made by a third party (including, but not limited to, automobile, liability, uninsured or underinsured motorist, business or commercial liability, homeowners' liability, and umbrella liability insurance, and medical payment for PIP coverage, regardless who maintains the insurance or coverage). See *General Plan Provisions – Trustees May Advance Medical or Dental Benefits When Injury or Illness may be the Responsibility of a Third Party* at page 59.
- In-vitro fertilization, artificial insemination, embryo transfer, fertility drugs (such as Clomid, Pergonal or Serophene) or any other artificial means of conception.
- Marital and family counseling.
- Neurodevelopmental therapy, except as specifically provided in the *Neurodevelopmental Therapy* benefit at page 28.
- Nursing services, except as specifically provided in the *Professional Services, Home Health and Hospice* benefits at page 25. Private duty nursing or hourly nursing charges are not covered.
- Occupational injury or disease caused by or contributed to or arising out of any employment or occupation for compensation or profit (including any arising out of self-employment).
- Preventive care, except as specifically provided in the *Preventive Care* benefit at page 25.

- Rehabilitative care, including speech therapy, physical therapy or occupational therapy except as specifically provided in the Rehabilitative Services benefit in the *Home Health*, *Hospice* and *Rehabilitative Services* benefits at page 25.
- Routine eye and hearing exams. (See, however, the *Vision Benefits* and *Hearing Aid Device Benefits* beginning at page 39.)
- Stem cell rescue, associated high-dose chemotherapy will be provided only under the *Transplant* benefit at page 33. No other benefits related to stem cell rescue and associated high-dose chemotherapy will be provided under this Plan.
- Surgery or treatment for sexual dysfunction / impotence (regardless of cause) or transsexualism.
- Surgery, treatment, programs or supplies intended to result in weight reduction, regardless of diagnosis and no benefits are provided for treatment of complications resulting from such surgery or treatment.
- Treatment and any appliances used in connection with for temporomandibular joint disorders, malocclusions or other abnormalities of the jaw, except as specifically provided in the *Temporomandibular Joint Disorder* benefit at page 30.
- **Mental disorders**, including **mental disorder** treatment for anorexia nervosa, bulima or other eating disorders, except as specifically provided in the *Mental Disorder* benefit at page 32.
- Spinal manipulations, except as specifically provided in the *Spinal Manipulations* benefit at page 30.
- Drugs, except as specifically provided in the *Prescription Drugs* in this *Benefits* section. **Inpatient** benefits are provided for drugs in a **hospital** or **skilled nursing facility**. Preventative injections or immunizations will be covered only if provided in the *Preventive Care* benefit in this *Benefits* section. Food and Drug Administration-approved drugs used for **off-label** indications will be provided only if recognized as effective for treatment:
  - in one of the standard reference compendia;
  - in the majority of relevant **peer-reviewed medical literature** if not recognized in one of the **standard reference compendia**; or
  - by the federal Secretary of Health and Human Services.

  No benefits will be provided for any drug when the Food and Drug Administration has determined its use to be contraindicated.
- Family planning or contraceptive devices; oral contraceptives except as specifically provided in the *Prescription Drug* benefit in the *Benefits* section.
- Eyeglasses and contact lenses except as specifically provided.

General Information

Individual Benefits Management

For certain illnesses or injuries, the UR Coordinator will work with you and your provider to determine the treatment options that will provide the most cost-effective or beneficial care in your specific case. In some instances, the UR Coordinator may authorize benefits that would not normally be covered under this Plan; such authorization must be received in advance of the service being provided. The final decision on the course of treatment will rest with you and your provider.

When provided at equal or lesser cost, the benefits of this Plan will be available for home health care instead of hospitalization or other **inpatient** care when furnished by a licensed home care agency or by a home health or hospice agency. Substitution of less expensive or less intensive services will be made only with your consent and when recommended by your **physician** or health care provider and will be based on your individual medical needs. A written treatment plan may be required for review by the UR Coordinator. Coverage will be limited to the maximum benefit payable for **hospital** or other **inpatient** expenses under this Plan and will be subject to any applicable deductible, **coinsurance** and Plan limitations and exclusions. These benefits will only be provided when your condition is serious enough to require **inpatient** care and you could qualify for the **inpatient** benefits of this Plan; no benefits will be provided for **custodial care**.

How to File a Claim for Benefits

Preferred Providers

The Plan has made special arrangements with providers in the First Choice Health Network for Local 8 participants and Providence Preferred for Local 9 participants..

When you receive care from **preferred provider**s, you receive a higher level of benefits for covered services and your claim will be submitted for you by the **preferred provider**. If you choose to seek medical care outside the **preferred provider** network, your **out-of-pocket** costs will be higher and you may have to submit your own claim.

You should always verify that your **physician** is a **preferred provider** before making appointments. To find out if a provider is preferred, **preferred provider** directories are available from the **Trust Administration Office** or your Local Union Office. You may also obtain provider information on-line:

First Choice Health Network www.fchn.com (*Local 8 members*)

Providence Preferred www.providence.org/oregon/providers (*Local 9 members*)

Using a Claim Form

When a provider or **hospital** does not bill the **Trust Administration Office** directly, you must submit your own claims.

Obtain a claim form from the **Trust Administration Office** or your Local Union Office.

Complete all applicable sections of the "Employee statement." Failure to properly complete the "Employee Statement" may result in a delay in processing your claim.

Attach an itemized bill for all charges relating to the claim.

Note: If the claim for **Medical Benefits** is also submitted as a claim for **Weekly Disability Benefits** connected to your illness or injury, a doctor MUST complete the "Attending Physician's Statement" on the reverse side of the claim form.

Complete a separate form for each patient.

Mail completed form and itemized bills to:

H.E.R.E. Trust
P.O. Box 34355
Seattle WA 98124-1355

Benefit payments will be sent directly to the physician, hospital or other non-preferred service provider, unless evidence such as a paid receipt or cancelled check is sent to show proof that the charges have been paid. Benefits are always paid directly to any preferred provider, regardless of any payment by you or another party.

Deadline for Filing Claims

All claims must be submitted within 15 months of the date of service. However, if your coverage terminates, all claims must be submitted within six months of the date of termination. Claims not submitted within this time limit will not be paid.

Vision Benefits

Routine Eye Examination:

If you and your dependents are eligible under Eligibility Rule A, benefits will be provided for one routine eye examination per calendar year (subject to the limits described below) to determine the need for a new or changed prescription when provided by a physician or optometrist. This eye examination benefit is not subject to the office visit copay.

National Vision Care Centers are the Preferred Optical Provider.

Lenses and Frames:

Benefits for lenses and frames will be provided when prescribed by a physician, optometrist or a licensed optical provider to correct a refractive error. The benefit listed below for medically necessary contact lenses will be provided only for aphakia or if your visual acuity is correctable to 20/70 in the better eye only with the use of contact lenses. If you elect contact lenses and the above provisions do not apply, the Plan will pay up to $40 per lens. You will be responsible for balances over the $40 benefit limit and that balance may vary depending on the type of contact lenses provided.

For lenses and frames obtained from National Vision, payment will be made directly to the provider as specified on the following schedule.

If you choose these other lenses and options not listed below, you will be responsible for any additional cost.

Preferred Optical Provider (National Vision Centers)

Exam – once each calendar year	**Plan Pays**	**You Pay**
	100% of allowed amount	$0
Lenses, each: (for standard plastic or clear glass; maximum of two each calendar year)	**Plan Pays**	**You Pay**
Single Vision	100% of allowed amount	$0
Basic Line Bifocal	100% of allowed amount	$0
Basic Line Trifocal	100% of allowed amount (less $5)	$5
Lenticular or Aphakic (external lens requiring a frame)	100% of allowed amount	$0
Medically necessary contact	100% of allowed amount	$0
Elective contact	Up to $40 per lens	$0

Frame (maximum of one every two calendar years):	**Plan Pays**	**You Pay**
Preferred Frames	100% of allowed amount	$0
Other Frames	Up to $35	Balance over $35

"Allowed amount" means the fee negotiated by National Vision and the Trustees.

"Medically necessary" is determined in the same manner as described under *Medical Benefits — Definition of Terms (Medical Benefits) —*

For exam, lenses and frames obtained from any other optical provider, you will be reimbursed as specified on the following schedule.

Any Other Optical Provider

Exam – once each calendar year	**Plan Pays**	**You Pay**
	$35	Balance over $35
Lenses, each: (maximum of two each calendar year	**Plan Pays** Per lens:	**You Pay** Per lens:
Single Vision	Up to $21	Balance over $21
Bifocal	Up to $32.50	Balance over $32.50
Trifocal	Up to $42.50	Balance over $42.50
Lenticular or Aphakic (external lens requiring a frame) Medically necessary contact	Up to $44.50	Balance over $44.50
	Up to $150	Balance over $150
Elective contact	Up to $40	Balance over $40
Frame: (maximum of one every two calendar years)		
Any Frames	Up to $35	Balance over $35

This benefit is not subject to any deductible requirements

How to File a Claim for Benefits

National Vision providers will file claims for you.

For all other providers, obtain a vision claim form from the **Trust Administration Office** or your Local Union Office.

Complete all applicable sections of the "Employee Statement" portion of the claim form. Failure to properly complete the "Employee Statement" may result in a delay in processing your claim.

Attach an itemized bill for all charges relating to the claim or have your vision care provider complete the backside of the form.

Complete a separate form for each patient.

Mail completed form and itemized bills to:

H.E.R.E. Trust
P.O. Box 34355
Seattle, WA 98124-1355

You must submit claim forms and bills to the **Trust Administration Office** within 90 days after the services were incurred in order for the charges to be covered.

Benefit payments will be issued directly to the vision care provider unless there is evidence such as a paid receipt or cancelled check to show proof that the incurred charges have been paid. However, payments are always made directly to National Vision providers regardless of whether payment is made by you or another party.

Deadline for Filing Claims

All claims must be submitted within 15 months of the date of service. However, if your eligibility under Eligibility Rule A terminates, all claims must be submitted within six months of the date of termination. Claims not submitted within these time limits will not be paid.

Hearing Aid Device Benefits

If you and your dependents are eligible for benefits as described under Eligibility Rule A, benefits for a hearing aid device and related covered services will be provided at 100%, not subject to deductible,(copay applies to professional exam) to a maximum of $1,000 once in any three consecutive calendar years. To receive Hearing Aid Device Benefits, you must be examined by a physician or a certified or licensed audiologist. The physician or audiologist must provide you with a written certification stating that your hearing loss would be lessened by the use of a hearing aid device. Benefits will not be provided without certification. Once you have received certification and a hearing aid device, any subsequent replacement hearing aid device will not require a certification of hearing loss.

Covered Services

1) Otologic examination by a physician, providing a hearing aid is dispensed;
2) Audiological examination and hearing evaluation by a certified or license audiologist including a follow-up consultation, providing a hearing aid device is dispensed;
3) The hearing aid device (monaural or binaural) prescribed as a result of such examination, which includes:
   - iEar molds;
   - iThe hearing aid device;
   - iThe initial batteries, cords and other necessary equipment;
   - iWarranty; and
   - iFollow-up consultation after delivery of the hearing aid device.

Note: Many providers of hearing aid devices allow a 90-day trial use. It is best not to submit the bill for payment until you are satisfied with your hearing aid device.

Limitations and Exclusions

No Hearing Aid Device Benefits are paid for:

- Maintenance of a hearing aid device, for example, new batteries.

- Hearing aid devices that exceed specifications prescribed for correction of hearing loss.
- An examination that does not result in a hearing aid device being obtained.
- Audio care that is related to, or required as a result of, employment.

Hearing Aid Device Benefits are not available:

- when you our your dependent has no obligation to pay.
- more than once during a period of three consecutive calendar years.
- after termination of eligibility under Eligibility Rule except when the hearing aid device was ordered before termination and delivered within thirty days after termination.

Note: If you have a hearing aid device rebuilt, this may be paid in lieu of the regular hearing aid device benefit, provided you are eligible for a hearing aid by means of the three-year rule. The $1,000 limitation will also apply to rebuilt hearing aid devices.

How to File a Claim Benefits

You must obtain a claim form from the **Trust Administration Office** or your Local Union Office.

Complete the claim form Employee Statement section in full and attach an itemized bill for all charges relating to the claim. Your hearing care provider may also submit the claim for you by completing the physician portion of the claim form and itemizing all charges. Mail the completed form and itemized charges to:

H.E.R.E. Trust
P.O. Box 34355
Seattle, WA 98124-1355

Benefit payments will be issued directly to the hearing care provider unless there is evidence such as a paid receipt or cancelled check to show proof that the incurred charges have been paid.

Deadline for Filing Claims

All claims must be submitted within 15 months of the date of service. However, if your coverage terminates, all claims must be submitted within six months of the date of termination. Claims not submitted within this time limit will not be paid

Dental Benefits

If you and your dependents are eligible for benefits as described under Eligibility Rule A and your current bargaining agreement provides coverage for dental care, Dental Benefits cover services necessary for the diagnosis and treatment of the teeth and associated structures. Benefits are paid up to the amounts listed in the schedule.

Your dentist may charge an amount greater than paid under the Schedule of Dental Benefits. You are responsible for the difference between what your dentist charges and what the Plan pays.

Benefits are payable up to $2,000 during each calendar year for you and each of your eligible dependents. For covered dental expenses in connection with orthodontics, the lifetime maximum is $635 for you and each of your eligible dependents.

Orthodontic Benefits

The Plan pays **usual, customary and reasonable** charges up to a maximum lifetime benefit payment of $635. Any payments required by the dentist before treatment begins are your responsibility. To receive benefits, you or your dependent must be eligible under Eligibility Rule A when treatment begins and remain eligible under Eligibility Rule A while benefits are being provided.

Hospital Benefit

If hospitalization is medically necessary for dental treatment, the Plan pays up to $300 for each admission. Your dentist or your physician must certify the medical necessity of the hospitalization.

Schedule of Dental Benefits

Code	Procedure	Trust Allowance
Diagnostic		
120	Periodic Oral Evaluation	**$19**
130	Emergency Oral Exam	**25**
140	Ltd. Oral Eval- Problem Focused	**25**
150	Comprehensive Oral Evaluation	**23**
210	Xray – Complete Series	**48**
220	Intraoral Periapical First Film	**7**
221	Intraoral Periapical –Two Films	**11**
223	3-Intraoral X-rays	**18**
230	Intraoral Periapical Each Add.	**4**
240	Intraoral-Occlusal Single 1st Film	**22**
270	Bitewing – Single Film	**10**
271	Bitewings – Single Film	**10**
272	Bitewings – Two Films	**16**
273	Bitewings – Three Films	**16**
274	Bitewings – Four Films	**19**
330	Panoramic X-Rays	**46**
460	Pulp Vitality Test	**16**

All exams are limited to 2 per calendar year. One complete series of x-rays, including a panoramic x-ray, will be covered once during any 36-consecutive month period

Code	Procedure	Trust Allowance
Preventive		
1110	Prophylaxis – Adult	$34
1120	Prophylaxis – Child	34
1203	Fluoride – Child	16
1204	Fluoride – Adult	16
1510	Space Maintainer-Fixed-Unilat	113

Prophylaxis is limited to 2 per calendar year; fluoride treatment is limited to 1 per calendar year

Restorative		
2110	Amalgam – One Surface – Prime.	$29
2120	Amalgam – Two Surface – Prime.	43
2130	Amalgam – Three Surface – Prime.	62
2131	Amalgam – Four Surface – Prime.	76
2140	Amalgam – One Surface – Perm.	32
2150	Amalgam – Two Surface – Perm.	49
2160	Amalgam – Three Surface – Perm.	67
2161	Amalgam – Four Surface – Perm.	85
2330	Resin – One Surface, Anterior	45
2331	Resin – Two Surface, Anterior	69
2332	Resin – Three Surface, Anterior	102
2335	Resin – Four or More Surface, Ant.	134
2392	Comp Resin – One Surface – Post	48
2393	Comp Resin – Two Surface – Post	74
2394	Comp Resin – Three Surface – Post	110
2920	Recement Crown	27
2930	Prefab Stainless Steel Crown-Prim	87
2931	Prefab Stainless Steel Crown-Perm	87
2940	Fillings – Sedative	27
2951	Pin Ret-Per Tooth-Add to Crown	21
2952	Cast Post & Core in Add to Crown	123
2954	Prefab Post & Core – Add to Crown	108

Code	Procedure	Trust Allowance
Crowns		
2710	Resin Crown	$154
2740	Porcelain Crown	349
2750	Porcelain With Gold Crown	365
2751	Porcelain w/ Base Metal Crown	365
2752	Porcelain Fused To Noble Metal Crown	365
2790	Gold Full Cast	322
2791	Full Cast Predominant Base Metal	305
2792	Full Cast Noble Metal Crown	305
2781	¾ Cast Metallic	308
2950	Crown Buildup	84
Endodontics		
3100	Endo Exam	$27
3110	Pulp Cap-Dir (Excld Final Restor)	22
3220	Viltal Pulpotomy	50
3310	Root Canal Therapy – Anterior	235
3320	Root Canal Therapy – Bicuspid	316
3330	Root Canal Therapy – Molar	391
3350	Apexification	66
Periodontics		
4100	Periodontic Exam	$23
4210	Gingivectomy or Gingivoplasty/Q	155
4240	Gingival Flap Procedure Per Quad	187
4249	Crown Lengthening-Hard Tissue	155
4260	Osseous Surgery	348
4263	Bone Repl Gft-First Site in Quad	179
4271	Free Soft Tissue Grafts	181
4321	Provisional Splinting-Extracoronal	139
4341	Perio. Scaling and Root Planning	82
4910	Periodontal Maintenance (1 per cal year)	60
Prosthodontics (removable)		
5110	Complete Dentures – Maxillary	$542
5120	Complete Dentures – Mandibular	542
5130	Immediate Upper Denture	542
5140	Immediate Lower Denture	542
5211	Upper Partial W/O Clasps Acrylic	278
5213	Max. Partial Denture	581
5214	Mand. Partial Denture	581
5410	Complete Denture Adjustment	20
5422	Lower Partial Denture Adjustment	20
5510	Repair Broken Complt Dent Base	47
5520	Repl Miss/Brkn Tth-Comp Dent E	38
5610	Repair Resin Denture Base	47
5640	Replace Broken Teeth – Per Tooth	38
5650	Add Tooth to Partial Denture	62
5710	Rebase Complete Maxil Denture	271
5711	Rebase Complete Mand Denture	271
5740	Reline Upper or Lower Partial	139
5750	Reline Upper Complete Dent	155
5751	Reline Lower Complete Dent	155
5760	Relining Up or Low Part Dent-Lab	155

Code	Procedure	Trust Allowance
Prosthodontics (removable)		
5810	Interim complete denture (maxillary)	$193
5820	Interim partial denture (maxillary) (Includes any necessary clasps and rests)	193
5850	Tissue Conditioning	62
5860	Overdenture Complete	542
Prosthodontics (fixed)		
6210	Cast Gold Pontic	$325
6240	Porcelain	370
6241	Pontic – Porcelain w/ Base Metal	297
6242	Prontic – Porcelain Fused to Noble	326
6750	Crown – Porcelain Fused to Gold	279
6751	Crown – Porcelain w/ Base Metal	379
6752	Crown – Porcelain Fused to Noble Metal	379
6790	Crown – Gold Full Cast	335
6792	Crown – Full Cast Noble Metal	316
6930	Recement Bridge	49
Oral Surgery		
7140	Extraction – Single Tooth	$42
7210	Surgical Extraction – Erupted	68
7220	Extraction – Soft Tissue Impacted	98
7230	Extraction – Partial Bony Impacted	135
7240	Surg Extraction-complete Bony Im	179
7241	Surg Ext of Tooth-Comp Bony Dif	195
7250	Root Recovery	78
7291	Transseptal Fiberotomy	65
7310	Alveoplasty Per Quad	98
7510	Incision and Drain of Abscess-Intra	41
7960	Frenulectomy Separate Procedure	48
Miscellaneous Services		
9940	Nightguard (maximum one per lifetime)	$150

The **Trust Administration Office** will determine a maximum amount consistent with the amounts listed in the schedule. The determination will take into account the nature and complexity of the procedure involved, the exclusions, and other applicable restrictions.

Exclusions

Benefits are not payable for:

- Expenses resulting from occupational injuries or diseases.
- Services prescribed by other than a Doctor of Dental Surgery, Doctor of Medical Dentistry, a legally qualified physician, a Dental Hygienist, or a licensed Denturist.
- Charges for service for any replacement of an existing partial or full removal denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, unless evidence satisfactory to the **Trust Administration Office** is presented that:
  - The replacement or addition of teeth is required to replace one or more additional natural teeth extracted while your or your dependent is eligible under eligibility Rule A.
  - The existing denture or bridgework cannot be made serviceable and has been in place five or more years.
  - The existing denture is an immediate temporary denture and replacement by a permanent denture is required, and takes place within twelve months from the date of installation of the immediate temporary denture.

- Charges for expenses incurred prior to your effective date, including charges for prosthetic devices started prior to effective date but inserted after the effective date. Expense incurred after eligibility under Eligibility Rule A ends, except prosthetic devices that were fitted and ordered before eligibility ended and were delivered to you or your dependent within thirty days after the date eligibility ended, provided that you or your dependent was certified for the prosthetic device before eligibility ended.
- Charges for sealants are not covered.
- Charges for services and supplies that are partially or wholly cosmetic in nature, bonding veneer and personalization or characterization of dentures.
- Charges for the replacement of a lost or stolen prosthetic device.
- Charges for any service or supplies that are for orthodontic treatment, or correction of malocclusion, except as specifically provided in this *Dental Benefits* section.
- Any treatment or supply or appliance for conditions related to Temporomandibular and Maxillary Skeletal Dysphasia, unless specifically provided for in the Schedule of Dental Benefits.
- Charges that would not have been made in the absence of this coverage or charges that neither you nor your dependent is required to pay.
- Charges for services or supplies that are furnished, paid for or otherwise provided for by reason of the past or present service of any person in the armed forces of a government, or that are caused by loss of war.
- Charges for services or supplies that are paid for or otherwise provided for under any law of a government except when the payments or the benefits are provided under a plan specifically established by a government for its own civilian employees and the dependents.
- Charges for services and supplies that are not necessary or are not recommended and approved by the attending physician or dentist or charges to the extent that they are unreasonable.
- Charges for missed appointments.
- Charges for treatment related to change in vertical dimension or to restore occlusion.
- Implants.
- An injury or illness to or of you or your dependent that, in the judgment of the Trustees, is or appears to be the responsibility of one or more persons and for which payment is or may be made by a third party (including, but not limited to, automobile, liability, uninsured or underinsured motorist, business or commercial liability, homeowners' liability, and umbrella liability insurance, and medical payment for PIP coverage, regardless who maintains the insurance or coverage). See *General Plan Provisions – Trustees May Advance Medical or Dental Benefits When Injury or Illness may be the Responsibility of a Third Party* at page 59.

How to File a Claim for Benefits

Obtain a dental claim form from the **Trust Administration Office** or your Local Union Office.

Complete all applicable sections of the "Employee Statement." Failure to properly complete the "Employee Statement" may result in a delay in processing your claim.

Attach an itemized bill for all charges relating to the claim or have your dentist complete the backside of the form.

Complete a separate form for each patient.

Mail completed form and itemized bills to:

H.E.R.E. Trust
P.O. Box 34355
Seattle, WA 98124-1355

You must submit claim forms and bills to the **Trust Administration Office** within 90 days after the services were incurred in order for the charges to be covered.

Benefit payments will be issued directly to the dentist unless there is evidence such as a paid receipt or cancelled check to show proof that the incurred charges have been paid.

Deadline for Filing Claims

All claims must be submitted within 15 months of the date of service. However, if your coverage terminates, all claims must be submitted within six months of the date of termination. Claims not submitted within this time limit will not be paid.

Life Insurance Benefits

The life insurance benefit provided by LifeWise Assurance Company offers financial protection to your beneficiary if you die. A benefit will be paid to your beneficiary (subject to applicable state law) in the event of your death regardless of the cause, time, or place while you are covered under this Plan.

Your Life Insurance Amount

Your Life insurance benefit is $7,500.

Beneficiary

Your beneficiary is the person or persons you name to receive your life insurance benefits after your death. You designate your beneficiary when you first enroll, and you may change your beneficiary any time by filing the appropriate form with the **Trust Administration Office**. The beneficiary who receives your death benefit is the most current beneficiary on file with the **Trust Administration Office**. In community property states, your spouse will receive 50% of your benefit unless he or she signs a notarized statement waiving the right to the benefit.

You may want to name a contingent beneficiary to receive your benefits if your primary beneficiary does not survive you. If no designated beneficiary survives you, or if none has been designated, payment will be made to the following surviving relatives: your surviving spouse, if no surviving spouse, in equal shares to your children who survive you; if none survive, to your parents, equally or the survivor; if neither survives, in equal shares to your brothers and sisters who survive you; or, if none survive, to the executors of your estate.

Life Insurance For Your Dependents

In the event your covered dependent dies, the following benefit will be payable to you:

	Amount of Benefit
Your wife or husband	$3,000
Each of your children (age 14 days to age 19)	$2,000

Waiver of Life Insurance Premium

Your life insurance benefit will continue without further payment of life insurance premium if you become totally disabled, provided:

- you are insured under this policy at least 12 months or from the policy effective date; and
- you are under the age of 60 at the time of total disability; and
- you provide satisfactory written proof of total disability within 3 months after you have been continuously disabled for six months; and
- your disability has continued without interruption for at least 6 months; and
- you are still disabled when you submit the proof of disability.

Disabled or totally disabled means any disability which results from a sickness or injury that completely prevents you from engaging in any occupation for wage or profit for which you are or become reasonably qualified by due to education, training, or experience.

The premium will be waived for 12 months from the date notice is received for a disability that has continued for at least 6 months. Premium will continue to be waived for subsequent 12-month periods, provided you:

- remain totally disabled; and
- provide satisfactory written proof of continuing total disability during the last 3 months of each 12-month period.

You are responsible for obtaining initial and continuing proof of disability. You will be covered for the amount of life insurance in force as of the date of disability. The amount of life insurance in force will be subject to termination of benefits as a result of retirement.

LifeWise Assurance Company may, at its own expense, require a physical examination of you at reasonable intervals during the period of claimed total disability. This Waiver of Premium benefit shall end immediately and without notice if you refuse to be examined.

Termination of Waiver of Life Insurance Premium

Waiver of premium will end on the earliest of the following dates:

- the date you are no longer disabled;
- the date you do not submit to examination when required by LifeWise Assurance Company;
- the date you fail to give proof of continuing disability; or
- the date you attain age 65.

LifeWise Assurance Company will waive the life premiums for your dependent when you are disabled if:

- the dependent's insurance was in force before you became disabled; and
- your life insurance premiums are being waived.

Your dependent's life insurance continued under this provision will continue until:

- your premiums are no longer being waived;
- you fail to meet the terms of the policy;
- you are no longer disabled;
- the dependent benefits provided under this policy terminate; or
- you die.

You and your dependent(s) may convert the life insurance under the Conversion Privilege if this waiver of premium ends and the insurance doesn't continue in force under the plan.

Conversion Privilege

When all or part of an insured's life insurance ends, as outlined below, you and your dependents may apply for an individual policy without submitting evidence of insurability.

Conversion upon Termination of Eligibility

When all or part of the Life Insurance Benefit ends due to:

1) termination of your employment;
2) termination of your membership in a class of eligible employees (that is, you cease to be covered under Eligibility Rule A or Eligibility Rule B;)
3) your death; or
4) your dependent's change of status,

you or your dependents may convert the Life Insurance Benefit to an individual policy of life insurance.

The largest amount that can be converted is the benefit amount that was in force on the date the Life Insurance Benefit terminated.

Conversion upon Termination or Amendment of Policy

If the Life Insurance Benefit terminates or is amended to terminate the Life Insurance on any class of insureds, each insured meeting the following conditions may convert. The insured must be:

1) insured under the Life Insurance Benefit at the date of termination; and
2) continuously insured under the Life Insurance Benefit for at least five years on the date this insurance ends.

The amount converted cannot exceed the lesser of:

1) the life amount ending, less any amount for which the insured becomes eligible under any group life policy within 31 days after this insurance ends; or
2) $2,000.

Conditions

1) Written application and payment of the first premium is made to LifeWise Assurance Company within 31 days after this insurance ends.
2) The individual policy shall be any one of the level premium plans then issued by LifeWise Assurance Company, except a policy containing term insurance, disability or supplementary benefits.
3) The individual policy shall be in an amount not in excess of the amount of the Life Insurance terminated under this policy.
4) The individual policy effective date shall be 31 days after this insurance ends.

5) The initial premium will be based on:
   1. the form of the policy;
   2. the amount of the policy;
   3. the class of risk to which the insured then belongs; and
   4. the insured's attained age on the date the individual policy takes effect.

Insurance Continued Under Group Policy

If you or your dependent have converted to an individual policy and again become insured under the Life Insurance Benefit provided by LifeWise Assurance Company, the individual policy must be returned to LifeWise Assurance Company before your or your dependent may be insured under this policy.

31-Day Continuance of Death Benefit

If an insured dies during the 31 days in which the application for an individual policy may be made, LifeWise Assurance Company will pay to the named beneficiary the amount of life insurance which the insured could have converted. The death benefit is payable whether or not application was made for the individual policy. The individual policy, if the insured had applied for it, will not become effective.

Assignment

You may assign all rights in and to the life insurance. An assignment will transfer your interest and any beneficiary to the assignee. Any such assignment will remain in force until changed by the assignee. No assignment will be in effect until a copy is filed with the **Trust Administration Office**. LifeWise Assurance Company is not responsible for the validity or sufficiency of any assignment. The Beneficiary provisions will not apply for coverage that has been assigned.

How to File a Claim for Benefits

Obtain a claim form from the **Trust Administration Office** or your Local Union Office.

Complete the form according to the instructions.

Return the form to the **Trust Administration Office** with a certified copy of the death certificate to:

H.E.R.E. Trust
P.O. Box 34355
Seattle, WA 98124-1355

Summary Only

This is a summary of the Plan's Life Insurance Benefit. For complete details on life insurance and related provisions, including but not limited to limitations and exclusions, please refer to the insurance contract with LifeWise Assurance Company on file with the **Trust Administration Office**.

Accidental Death and Dismemberment Benefit

This Plan provides benefits to your beneficiary if you die or to you in the event of loss of limbs or sight, if your death or loss is caused by an accidental injury. Your benefits for accidental death are in addition to the Plan's Life Insurance Benefit. The following benefits are payable if the injury occurs while covered under the Plan and your death or loss occurs within 365 days of the injury.

Schedule of Benefits

For Loss of	Amount of Benefit
Life	$7,500
Both hands	$7,500
Both feet	$7,500
One hand and one foot	$7,500
Sight of both eyes	$7,500
One hand and sight of one eye	$7,500
One foot and sight of one eye	$7,500
One hand	$3,750
One foot	$3,750
Sight of one eye	$3,750

Only one of the amounts, the largest, is payable for all losses resulting from a single accident. Loss means, for hands and feet, dismemberment by severance through or above wrist or ankle joints, and for eyes, entire and irrecoverable loss of sight.

Exclusions

No benefits will be paid for any loss by:

- Suicide, or its attempt, while sane or insane, or intentionally self-inflicted injuries.
- Disease, or bodily or mental infirmity, or its medical/surgical treatment.
- War, or any act of war, that is declared or undeclared.
- Attempt or commission of assault or felony.
- Ptomaine or bacterial infection except for infections occurring through an accidental cut or wound.
- Participation in a riot.

How to File a Claim for Benefits

Obtain a claim form from the **Trust Administration Office** or your Local Union Office.

Complete the form according to the instructions.

Return the form to the **Trust Administration Office** with a certified copy of the death certificate to:

H.E.R.E. Trust
P.O. Box 34355
Seattle, WA 98124-1355

Deadline for Filing AD&D Claims

The employee must give written proof of loss to LifeWise Assurance Company within 90 days after the date of loss.

Failure to furnish proof within the time frame required will not void or reduce a claim if the proof is furnished as soon as it is reasonably possible to do so. Except in the event of legal incompetence, this extension of the time limit shall in no event exceed one year.

Summary Only

This is a summary of the Plan's accidental death and dismemberment benefits. For complete details on accidental death and dismemberment benefits and related provisions, including but not limited to limitations and exclusions, please refer to the insurance contract with LifeWise Assurance Company on file with the **Trust Administration Office**.

Definition of Terms

The following are definitions of terms used in this Plan Booklet:

- Allowed Amount means
  - the fee negotiated by the PPO, if a service or supply is provided by a **preferred provider**; or
  - if no PPO agreement exists, the **usual, customary and reasonable** charge.
- **Chemical Dependency**: **Chemical Dependency** means alcohol and/or drug addiction under the terms of the International Classification of Disease, volume 9 CM categories 303.0 through 304.9.
- **Chemical Dependency Treatment Facility**: An approved chemical abuse treatment facility is a facility that provides treatment for chronic alcoholism and/or drug addition and that is operating under the direction and control of the State Department of Social and Health Services.
- **Chiropractor:** A **chiropractor** is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. (For coverage of a **chiropractor**'s services, see page 30).
- **Copay**: The amount, in addition to the rate you are required to pay for certain services and supplies provided under this Plan. You are responsible for the payment of any **copay** directly to the provider of the service or supply.
- **Cosmetic Surgery**: **Cosmetic surgery** is surgery that is performed primarily:

- to improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or
- to prevent or treat a mental or nervous disorder through a change in bodily form.

- **Custodial Care:** Care that is designed primarily to assist you in activities of daily living, including institutional care that serves primarily to support self-care and provide room and board. **Custodial care** includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications that are ordinarily self-administered.
- **Dentist:** A **dentist** is a legally qualified dentist practicing within the scope of his or her license. (For coverage of a **dentist**'s services, see page 39.)
- **ERISA** means the Employee Retirement Income Security Act of 1974, as amended.
- **Experimental or Investigational Service or Supply**: An experimental or investigational service or supply is any service or supply (including any treatment, drug, equipment or device) that, at the time ordered, comes within any one of the three following categories:
  - The service or supply has not received a required approval by the Food and Drug Administration or other agency of the United States for general public use for treatment of your condition.
  - The Centers for Medicare and Medicaid Services ("CMS") will not reimburse the expense or the service or supply under Medicare because CMS has determined (as published in its Coverage Issues Manual or any update) that the service of supply is not reasonable and necessary for the diagnosis or treatment of illness or injury. This category does not include organ transplants specifically described as covered on page 33.
  - The service or supply has not been scientifically demonstrated by the medical profession to be effective and efficient in terns of the condition being treated, or it is rendered by an institution or provider in the United States that has not demonstrated proficiency in the provision of the service or supply.

    As is the case with any provision in the Plan, the Board of Trustees has the full and exclusive authority, in its discretion, to interpret and apply this definition of experimental or investigational service or supply.
- **Hospital**: Means an establishment which:
  - Holds a license as a hospital (if required in the state);
  - Operates primarily for the reception, care and treatment of sick or injured persons as **inpatient**s;
  - Provides around the clock nursing service;
  - Has a staff of one or more **physician**s available at all times;
  - Provides organized facilities for diagnosis and surgery;
  - Is not primarily a nursing, rest or convalescent home or a **skilled nursing facility** or a similar establishment; and
  - Is not, other than incidentally, a place for treatment of Drug addiction.

    The nursing service must be by registered or graduate **nurse**s on duty or call. The surgical facilities may be either at the **hospital** or at a facility with which it has a formal arrangement.

    Confinement in a special unit of a **hospital** used primarily as a nursing, rest or convalescent home or Skill Nursing Facility will not be deemed to be a confinement in a **Hospital**. "**Hospital**" also includes a licensed ambulatory surgical center. The center must have permanent facilities and be equipped and operated primarily for the purpose of performing surgical procedures. The type of procedures performed must permit discharge from the center in the same "working day". The center will not qualify as a "**Hospital**" if:
  - Its primary purpose is performing abortions;
  - It is maintained as an office by a **Physician** for the practice of medicine; or
  - It is maintained as an office for the practice of **dentist**ry.

    Hospital also includes a licensed treatment facility when treatment for chemical dependency is rendered.
- **Inpatient**: **Inpatient** refers to services a patient receives while confined in a **hospital** as a registered bed patient.
- **Medical Emergency**: The sudden and unexpected onset of a condition or exacerbation of an existing condition requiring **medically necessary** care to safeguard your life or limb immediately after the onset of the emergency. For the purpose of benefit determination, consideration will be given to the symptoms of the condition and to the actions that would have been taken by a prudent person under such circumstances.

- **Mental Disorder**: **Mental disorder** includes only those disorders listed in the Internal Classification of Diseases as psychoses, neuroses, personality disorders, eating disorders and other nonpsychotic **mental disorders**.
- **Medically Necessary**: A service or supply that meets all of the following criteria:
  - It is required to diagnose or treat your condition.
  - It is consistent with the symptoms or diagnosis and treatment of the condition.
  - It is the most appropriate supply or level of service that is essential to your needs
  - When applied to an **inpatient**, it cannot safely be provided on an **outpatient** basis, including diagnostic studies.
  - It is not an investigational service or supply
  - It is not primarily for the convenience of you or your provider.

  The fact that a service or supply is furnished, prescribed, recommended or approved by a **physician** or other provider does not, of itself, make it **medically necessary**. A service or supply may be **medically necessary** in part only.
- **Nurse:** A registered **nurse** (R.N.) is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license.
- **Optometrist:** An **optometrist** is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license.
- **Out-of-Pocket**: The amount that you are responsible to pay during a Calendar year after the Plan has paid its share of charges. After you have reached the **out-of-pocket** limit, the Plan will pay most benefits at 100% of the **allowed amount** for the remainder of the calendar year. Some benefits are not subject to the **out-of-pocket** provision, as specified in the Benefits section; these benefits will always remain payable at the percentage level given in the Payment Schedule or in the applicable benefit section. **In addition, the following do not count towards the out-of-pocket limit:** your annual deductible; any **copays**; the difference between the **allowed amount** and the provider's actual charge; any benefit penalty required when the preadmission approval provision is not satisfied; and any balances that remain after benefit limits have been expended.
- **Off-label drug:** Means the drug has not been approved by the Food and Drug Administration for use other than conditions indicated on the drug manufacturer's labeling or package insert.
- **Outpatient**: Outpatient refers to services a patient receives in a physician's office, at home, or in a hospital outpatient department.
- **Peer-reviewed medical literature**: Means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.
- **Physician**: A licensed practitioner of the healing arts who practices within the scope of his or her license. For purposes of this Plan, a physician may be a medical doctor (MD) or an osteopathic physician (DO). If the practitioner performs services covered under the Plan and within the scope of his or her license, a physician may also be a licensed: dentist (DDS), podiatrist (DPM), psychologist (PhD), optometrist, or chiropractor. Before you receive treatment from any practitioner other than an MD or DO, check with the **Trust Administration Office** to find out if the expenses will be recognized as covered expenses.
- **Plan Administrator** means the Board of Trustees of the Hotel Employees Restaurant Employees Health Trust.
- **Preferred Provider**: A **Preferred provider** is a **physician**, **hospital** or health care provider who has entered into a special agreement with First Choice or Providence Preferred to provide efficient, cost-effective healthcare.
- **Psychologist:** A **psychologist** is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license.
- **Skilled Nursing Facility**: A **skilled nursing facility** is an institution recognized as such by Medicare and approved by Medicare for payment.
- **Standard reference compendia** means:
  - The American Hospital Formulary Service-Drug Information;
  - The American Medical Association Drug Evaluation;
  - The United States Pharmacopoeia-Drug Information; or
  - Other authoritative compendia as identified from time-to-time by the federal Secretary of Health and Human Services.

- **Trust**: **Trust** means the trust established and maintained under the Agreement and Declaration of Trust of the Hotel Employees Restaurant Employees Health Trust, as amended from time-to-time.
- **Trust Administration Office**: means the office of the contract plan administrator designated by the Board of Trustees. See *Contact Information* below.
- **Usual, Customary and Reasonable**: **Usual, customary and reasonable** means a provider's charges for services or supplies essential to the care of an individual to the extent they are:
  - the usual fee that the provider of service most frequently charges to the majority of his or her patients for a similar service or medical procedure.
  - the fees that fall within the customary range of fees charged in a locality by most providers of a similar training and experience for the performance of a similar service or medical procedure.
  - if unusual circumstances or medical complications require additional time, skill and experience in connection with a particular service or medical procedure, the reasonable fee charged for the service or medical procedure.

  If you owe charges in excess of the **usual, customary and reasonable** fee, the excess amount will be your responsibility.

Benefit Claims and Appeal Procedures for Medical, Dental, Vision, Hearing Aid Device, and Weekly Disability Benefits Claims

I. Scope

These Benefit Claims and Appeal Procedures for Medical, Dental, Vision, Hearing Aid Device, and Weekly Disability Benefits (these "Procedures") apply only to claims for Medical, Dental, Vision, Hearing Aid Device, and Weekly Disability Benefits under the Hotel Employees Restaurant Employees Health Trust Plan (the "Plan") and appeals of denials of those claims.

II. Contact Information

The Procedures may require you to file claims with the **Trust Administration Office**, the Utilization Review (UR) Coordinator or MNHCRx (claims for prescription drugs). Appeals are filed with the **Trust Administration Office**. Their contact information is as follows:

Trust Administration Office:

Telephone	(206) 441-7574 or (800) 331-6158
Fax	(206) 441-9110
Street Address	Hotel Employees Restaurant Employees Health Trust c/o Welfare and Pension Administration Service, Inc. 2815 Second Avenue, Suite 300 Seattle, Washington 98121
Mailing Address	Hotel Employees Restaurant Employees Health Trust c/o Welfare and Pension Administration Service, Inc. P.O. Box 34203 Seattle, WA 98124

UR Coordinator:

Members of HERE Local 8 (Washington) use the UR Coordinator at First Choice Health Network, Inc.:

Telephone	Seattle (206) 292-8255 Inside Washington (800) 231-6935 Outside Washington (800) 345-5767

Members of HERE Local 9 (Oregon), use the UR Coordinator at Providence Preferred:

Telephone	(800) 793-9338

NMHCRx

Telephone	1 (800) 880-1188

III. Authorized Representative

Your authorized representative may act on your behalf under these Procedures, for example by filing your claim for benefits or your appeal of a denied claim.

No person (including a treating health care professional) will be recognized as your authorized representative until the **Trust Administration Office** receives your written appointment of the authorized representative signed by you. If, however, the claim involves a request for **Urgent Care** (defined below), a health care professional, with knowledge of your medical condition, may act as your authorized representative without your having to complete a written appointment.

Protection of Your Health Information. If you appoint an authorized representative in connection with your claim for Medical, Dental, Vision or Hearing Aid Benefits, the Plan cannot disclose your protected health information to your representative unless you provide a written disclosure authorization to the **Trust Administration Office.**, Therefore, you should complete, sign and return a disclosure authorization form at the same time you provide your appointment of your authorized representative. You may obtain a disclosure authorization form by calling the **Trust Administration Office**.

IV. Claims Procedures

A. What is a "claim"?

A claim for benefits is a request for Medical, Dental, Vision, Hearing Aid Device, or Weekly Disability Benefits made in accordance with the claims procedures described in these Procedures.

B. What is NOT a "claim"?

- Simple or general inquiries about the Plan's provisions that are unrelated to any specific benefit claim.
- Request for a determination regarding the Plan's coverage of a treatment or service that your physician has recommended, but treatment or service has not yet been provided and the treatment or service is for non-urgent care that does not require prior authorization from the Plan. In this case, you may request a determination from the **Trust Administration Office** regarding the Plan's coverage of the treatment or service. However, any determination from the **Trust Administration Office** is not a guarantee of payment because the request is not a claim and, therefore, not subject to the requirements and timelines described in these Procedures.
- Request for a prescription to be filled under the terms of the Plan is not a claim under these Procedures. If, however, your request for a prescription to be filled is denied, in whole or in part, you can file a claim and appeal the denial by following these Procedures.

C. How Claims are Filed

In many cases, your provider or hospital will file a claim on your behalf.

When a provider or hospital does not bill the **Trust Administration Office** directly, you must submit your own claims on the Trust's claim forms. See *How to File A Claim* under *Weekly Disability Benefits* (page 20), *Medical Benefits* (page 36), *Vision Benefits* (page 39), *Hearing Aid Device Benefits* (page 39), or *Dental Benefits* (page 44). You may obtain a claim form from your Local Union, or by calling the **Trust Administration Office**. See *Section I — Contact Information*, above.

A request for Medical, Dental, Vision, Hearing Aid Device or Weekly Disability Benefits is considered a "claim" only if all the information required by its claim form is included.

D. Where to File Claims

Urgent Care Claims and Pre-Service Claims. File **Urgent Care Claims** and **Pre-Service Claims** (defined below) by calling the appropriate UR Coordinator **Post-Service Claims and Claims for Weekly Disability Benefits.** File claim forms for Medical, Dental, Vision or Hearing Aid Benefits that have already been provided or for Weekly Disability Benefits with the **Trust Administration Office** by mail at its mailing address or by personal delivery at its street address. See *Section I — Contact Information*, above.

E. When to File Post-Service Claims or Claims for Weekly Disability Benefits

File **Post-Service Claims** within 15 months of the date of service. However, if your coverage terminates, submit all claims within six months of the date of termination. Claims not submitted within this time limit will not be paid

File claims for Weekly Disability Benefits within 15 months of date of disability. However, if your coverage terminates, submit all claims within 6 months of the date of termination. Claims not submitted within this time limit will not be paid.

F. Medical, Dental, Vision and Hearing Aid Benefits

Claims procedures for Medical, Dental, Vision and Hearing Aid Benefits will vary depending on whether your claim for

benefits is a **Pre-Service,** an **Urgent Care,** a **Concurrent Care, or** a **Post Service Claim**. Read each section below carefully to determine which procedure applies to your request for benefits.

1. Pre-Service Claims

A **Pre-Service Claim** is a claim for medical care or treatment, which requires approval by the Plan, in whole or in part, ***before*** medical care or treatment is obtained so that you might receive full Plan benefit coverage. Under the Plan, examples of when to submit a **Pre-Service Claim** include, but are not limited to:

- A request to the UR Coordinator for preauthorization for admission to a hospital or a surgery that will be performed in a setting other than your doctor's office
- A request to the UR Coordinator for authorization of emergency hospital admissions or emergency surgeries
- A request to the UR Coordinator for preauthorization of benefits that would not normally be covered under the Plan

If your provider does not file a **Pre-Service Claim** properly, you and your medical provider will be notified as soon as possible, but not later than *5 days* after receipt of the claim. This notice will advise you of the proper procedures for filing the claim. Your provider and you will only receive notice of an improperly filed **Pre-Service Claim** if the claim includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a "claim."

For properly filed **Pre-Service Claims**, you and your medical provider will be notified of a decision within *15 days* from the receipt of the claim, unless additional time is needed to make a decision. If necessary, an extension of up to *15 days* may be required due to matters beyond the control of the Plan. You will be notified of the circumstances requiring an extension of time and the date a decision may be made available to you.

If an extension is necessary because the Plan requires additional information from you, the extension will specify the information required. In this case, you or your medical provider will have *45 days* from receipt of the notification to submit the additional information. If that information is not provided within 45 days, your claim will be denied. During the period in which you are allowed to provide 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 either until 45 days have elapsed or the date you respond to the request, whichever occurs sooner. Once your response is received (within the earlier or 45 days or the date of your response), the Plan has 15 days to make a decision on a **Pre-Service Claim**.

2. Urgent Care Claims

An **Urgent Care Claim** is any claim for medical care or treatment that, if handled within the time period(s) of a **Pre-Service Claim** as described above,

- could seriously jeopardize the life or health of the individual or his ability to regain maximum function, or
- in the opinion of the physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment requested in the claim. An example of an **Urgent Care Claim** might be a request for prior approval of a diagnostic test for appendicitis.

Whether your claim is an **Urgent Care Claim** is determined by the Plan by applying the judgment of a prudent layperson possessing an average knowledge of health and medical claims processing. Any claim made by a medical provider, who has knowledge of your medical condition and determines that it is an **Urgent Care Claim** will be treated as an **Urgent Care Claim**.

If you are requesting pre-certification of an **Urgent Care Claim**, the response times differ, depending on whether your request contains sufficient information for making a determination. If the request contains sufficient information, the UR Coordinator will respond to you and your medical provider with a determination, by telephone, as soon as possible, taking into account the medical urgency of the patient's condition, but not later than *72 hours* after the UR Coordinator receives the claim. The determination will be confirmed in writing.

If an **Urgent Care Claim** is received without sufficient information to determine whether or not benefits are covered ***or*** payable or to what extent benefits are covered or payable, the UR Coordinator will notify you and your medical provider as soon as possible, but not later than *24 hours* after the UR Coordinator receives the claim, of the specific information necessary to complete the claim. You and/or your physician must provide the specified information within 2 working days. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided no later than 48 hours after the UR Coordinator receives the specified information, but only if the information is received within the required time frame.

3. Concurrent Claims

A **Concurrent Claim** is a claim that is reconsidered after an initial approval was made and, after reconsideration, results in a reduction, termination or extension of a benefit. An example of a **Concurrent Claim** is an inpatient hospital stay that

was originally authorized for 5 days and is reviewed after 3 days to determine if the full 5 days is still appropriate. In this example, a decision to reduce, terminate or extend the inpatient stay is made concurrently with the provision of medical treatment. Reconsideration of a benefit with respect to a **Concurrent Claim** that involves the *termination or reduction* of an approved benefit (other than by a Plan amendment or termination) will be made by the **Trust Administration Office** or the UR Coordinator, depending on which approved the benefit initially, as soon as possible but, in any event, in time to allow you to appeal the decision before the benefit is reduced or terminated.

Any request by a claimant to *extend* approved **Urgent Care** treatment will be acted upon by the UR Coordinator 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. A request to *extend* approved treatment that does not involve **Urgent Care** will be decided according to the timeframes for **Pre-Service Claims** (by the UR Coordinator) or **Post-Service Claims** (by the **Trust Administration Office**), whichever apply.

4. Post-Service Claims

The following procedure applies to **Post-Service Claims**, which are all claims for Medical Benefits that are not described in Sections 1 through 3 above and all claims for Dental, Vision and Hearing Aid Benefits. An example of a **Post-Service Claim** is any claim submitted for payment ***after*** you have received medical services or treatment.

In most cases, your health care provider will submit a claim on your behalf.

If you need a claim form, you may obtain one from your Local Union, or by calling the **Trust Administration Office**. See *Section I — Contact Information*, above.

Complete and file a claim form as follows:

- Complete all applicable sections of the "Employee statement." Failure to properly complete the "Employee Statement" may result in a delay in processing your claim.
- Attach an itemized bill for all charges relating to the claim. If, however, the claim is for Vision, Dental or Hearing Aid Benefits, you may instead have your vision care provider, dentist or hearing care provide complete and sign the backside of the form.
- Complete a separate claim form for each patient.
- File the completed claim form and itemized bills with the **Trust Administration Office** by mail at its mailing address or by personal delivery at its street address. See *Section I — Contact Information*, above.

Usually, you will be notified of the decision on your **Post-Service Claim** within *30 days* from the Plan's receipt of the claim. This period may be extended one time by the Plan for up to *15 days* if the extension is necessary due to matters beyond the control of the Plan. 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 Plan expects to make its decision available.

G. Weekly Disability Benefits

Obtain a time loss form from your Local Union, or by calling the **Trust Administration Office**. Complete the employee's portion of the form completely and sign it. The physician who is treating you for the disabling condition must complete the doctor portion of the form. Your employer must complete the employer portion of the form. File the form with the **Trust Administration Office** by mail at its mailing address or by personal delivery at its street address.

Usually, you will be notified of the decision on your claim for **Weekly Disability Benefits** within *45 days* from the Plan's receipt of the claim. This period may be extended one time by the Plan for up to *30 days* if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 45-day period. The Plan may extend the period for a second time for up to 30 more days if the extension is necessary due to matters beyond the control of the Plan. If the second extension is necessary, you will be notified before the end of the initial extension. Any extension notice will:

- describe the special circumstances requiring an extension of time and the date by which the Plan expects to render its decision; and
- specifically explain the standards on which entitlement to a Weekly Disability Benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and shall afford you at least 45 days from the date you receive the extension notice within which to provide the specified information.

If the period for deciding a your claim for **Weekly Disability Benefits** is extended due to a your failure to submit necessary information, the period is tolled (suspended) from the date the extension notice is sent to you until the date you respond to the request for additional information.

H. Notice of Decision

If your claim for benefits is denied, in whole or in part, you will be provided with a written notice of denial of the claim (an "adverse benefit determination") that will include:

- 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 complete your claim and an explanation of why that 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, protocol or other similar criterion was relied upon in deciding your claim — either a copy of the rule, guideline, protocol or criterion or a statement that it is available, upon request, at no charge
- If the adverse benefit determination was made because the treatment or service was not medically necessary or 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.
- If the adverse benefit determination is based on medical necessity, or because the treatment is experimental or investigational, or other similar exclusion or limit — an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that it is available free of charge upon request.
- In the case of an **Urgent Care Claim**, the notice will describe the expedited review process that applies to **Urgent Care Claims**. For **Urgent Care Claims**, the required determination may be provided orally, followed with a written notification.

For **Urgent Care Claims**, you will receive notice of the determination even when the claim is approved.

V. Appeal of a Denied Claim

A. What Your Request for Review Must Contain

If your claim is denied, in whole or in part, or if you disagree with the decision made on your claim, you may appeal the denial by filing a request a review. ***Your request for review must:***

- be made in writing (unless the request is for review of an **Urgent Care Claim**);
- state the reason(s) for disputing the denial (adverse benefit determination);
- include any pertinent material not already furnished to the Plan; and
- submitted within *180 days* from the date you receive the notice of denial.

If you fail to file a request for review that meets all of the above, you waive your right to appeal the denial (adverse benefit determination) of your claim.

B. Where to File Your Request for Review

To appeal an adverse benefit determination of any claim, file your request for review with the Board of Trustees in care of the **Trust Administration Office** by mail to the **Trust Administration Office**'s mailing address or by personal delivery at its street address. See *Section I — Contact Information*, above. If you are appealing an adverse benefit determination on an **Urgent Care Claim**, call the **Trust Administration Office** to file your claim with the Board of Trustees.

C. Appeal Process

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 initial decision to deny your claim; it was submitted, considered, or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for providing 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, who gave advice to the Plan on your claim, without regard to whether the advice of those experts was relied upon in deciding your claim.

A different person will review your appeal from the one who originally denied your claim. The reviewer will not give deference to the initial adverse benefit determination. The decision on appeal will be made on the basis of the record, including any additional documents and comments you submit.

If your claim was initially 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 with appropriate training and experience in a relevant field of medicine will be consulted.

D. Who Decides the Appeal

The Board of Trustees will decide your appeal of a denial of a claim.

For purposes of these Procedures, the "Board of Trustees" means the Board of Trustees of the Hotel Employees Restaurant Employees Health Trust, and any committee of members of the Board of Trustees to whom the Board of Trustees, under the governing provisions of the Plan or the Hotel Employees Restaurant Employees Health Trust Agreement and Declaration of Trust, has allocated the Board of Trustees responsibilities under these Procedures.

E. Timing of Notice of Decision on Review

Pre-Service Claim: The Board of Trustees will mail you a notice of its decision on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receiving your request for review.

Urgent Care Claim: The Board of Trustees will notify you of its decision on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after it receives your request for review. The Board of Trustees may provide oral notice, but must provide written notice not later than 3 days after the oral notice.

Post-Service Claim: The Board of Trustees will mail you a notice of its decision on review within a reasonable period but no later than 60 days after it receives your request for review.

Claim for Weekly Disability Benefits: The Board of Trustees will mail you a notice of its decision on review within a reasonable period but no later than 60 days after it receives your request for review.

F. Notice of Decision on Review

The decision on any review of your claim will be provided to you in writing. The notice of a denial of your claim on review (adverse benefit determination) will include:

- The specific reason(s) for the adverse benefit determination
- Reference to the specific Plan provision(s) on which the benefit determination is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents relevant to your claim
- 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, protocol or other similar criterion was relied upon by the Plan — either a copy of the rule, guideline, protocol or criterion or a statement that it is available, upon request, at no charge
- If the determination is based on medical necessity, or because the treatment is experimental or investigational, or other similar exclusion or limit — an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that it is available free of charge upon request. The denial of a claim to which you have waived the right to request review (that is, you have failed to file your request for review within the required time limit), or the Board of Trustees' denial of your claim on review, is final and binding upon all parties, including you, subject only to any civil action you may bring under ERISA.

G. Voluntary Appeal

1. Right to Voluntary Appeal

If the Decision on Review denies your claim, in whole or in part, or if you disagree with the Decision on Review you may — but are not required to — pursue a further, voluntary appeal of the Decision on Review. If you elect to pursue your claim in court rather than through a voluntary appeal, the Plan will not assert a failure to exhaust administrative remedies. Any statute of limitations applicable to pursuing your claim in court will be tolled during the period of the voluntary appeal process. Your decision whether or not to file a voluntary appeal will have no effect on your rights to any other benefits under the Plan. No fees or costs are imposed on you as part of the voluntary appeal process. At your request, the Plan will provide you sufficient information relating to the voluntary appeal to enable you to make an informed judgment about whether to submit a voluntary appeal. Your authorized representative may act on your behalf. See *Section III*.

2. What Your Voluntary Appeal Must Contain

Your voluntary appeal must:

- be made in writing;
- state the reason(s) for disputing the Decision on Review;

- include any pertinent material not already furnished to the Plan; and
- be submitted within *30 days* from the date you receive the Notice of Decision on Review.

If you fail to file an appeal that meets all of the above, you waive your right to a voluntary appeal.

3. Voluntary Appeal Procedure

File your voluntary appeal with the Board of Trustees in care of the **Trust Administration Office** by mail at **Trust Administration Office**'s mailing address or by personal delivery at its street address. See *Section I — Contact Information*, above.

The Board of Trustees will decide your voluntary appeal. The decision will be made on the basis of the record, including any additional documents and comments you submit.

The Board of Trustees will mail you a notice of its decision on your voluntary appeal not later than 120 days after receiving your voluntary appeal.

VI. Limit on When You May Begin a Lawsuit (Civil Action)

You may not begin a lawsuit to obtain benefits until after the following events have occurred:

- You requested a review of the denial of your claim under *Section V. Appeal of a Denied Claim* and the Board has reached and issued its Notice of Decision on Review under *Section V.F.*; or
- You requested a review under *Section V. Appeal of a Denied Claim*, but have not received Notice of Decision on Review under *Section V.F.* within the time frames described in *Section V.E.*.

Benefit Claims and Appeal Procedures for Life Insurance Benefit, Waiver of Life Insurance Premium and Accidental Death and Dismemberment Benefit Claims

Note: for purposes of *Benefit Claims and Appeal Procedures for Life Insurance Benefit, Waiver of Life Insurance Premium and Accidental Death and Dismemberment Benefit Claims*, "we" and "us" refer to LifeWise Assurance Company.

Life Insurance and AD&D Benefits

Claim for Benefits:

If you or your designated beneficiary would like to present a claim for benefits for yourself or your insured dependents, you should obtain a claim form(s) from the **Trust Administration Office** your Local Union Office or the insurance carrier. The applicable section of such form(s) should be completed by (1) you or the designated beneficiary and (2) your employer or the **Trust Administration Office**.

Following completion, the claim form(s) and all additional documentation (including a death certificate for Life Insurance Benefits or for the life insurance benefit under the AD&D Benefit) must be filed with the **Trust Administration Office**, so it may verify your or your dependents' eligibility for benefits. It will then forward the claim form(s) to the insurance carrier. The individual authorized to process and pay the claims will compute benefits due, and will issue draft(s) in settlement. Drafts will be made payable to you or your beneficiary, unless you have assigned your benefits to another party.

A decision will be made by us no more than 90 days after receipt of due proof of loss. The time for decision may be extended for up to 90 days provided that, prior to the extension period, we notify you in writing that an extension is necessary due to matters beyond the control of the Plan, we identify those matters and give the date by which we expect to render our decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request.

Our written decision will include:

- specific reasons for the decision,
- specific references to the plan provisions on which the decision is based,
- a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary,
- a description of the review procedures and time limits applicable to such procedures, and
- a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to you. This written decision will:

- give the specific reason or reasons for denial;
- make specific reference to policy provisions on which the denial is based;
- provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
- provide an explanation of the review procedure.

Appealing Denial of Claim

On any denied claim you or your representative may appeal to us for a full and fair review by filing a timely request for review. You:

- must request a review upon written application within 60 days of receipt of claim denial;
- may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
- may submit written comments, documents, records and other information relating to your claim.

If you do not appeal a claim denial, you lose your right to bring a civil action under ERISA section 502(a).

A decision will be made by us no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision and specific references to the plan provisions on which the decision is based.

You have the right to bring a civil action under section 502(a) of ERISA only after on of the following events occur:

- your appeal is denied, and you have received a written denial on appeal; or
- your appeal is not decided within the timeframes above.

Claim Procedures for Waiver of Life Insurance Premium Claims

Claim for Benefits:

If you would like to present a claim for waiver of premium for Life Insurance benefits, you should obtain a Waiver of Premium claim form from the **Trust Administration Office**, your Local Union Office or LifeWise Assurance Company. The applicable section of such form(s) should be completed by (1) you; (2) your employer or the **Trust Administration Office**, if applicable; and (3) the attending physician or hospital.

Following completion, file the claim form with the **Trust Administration Office**, so it may verify your eligibility. It will forward the claim form to the insurance carrier. The individual authorized to evaluate claims will determine if premiums should be waived and, if so, issue approval of waiver of premium to you.

We will make a decision no more than 45 days after we receive your claim. The time for decision may be extended for two additional 30-day periods provided that, prior to any extension period, we notify you in writing that an extension is necessary due to matters beyond the control of the Plan, we identify those matters and give the date by which we expect to render our decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request.

- The written decision will include:
  - specific reasons for the decision,
  - specific references to the Plan provisions on which the decision is based,
  - a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary,
  - a description of the review procedures and time limits applicable to such procedures,
  - a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal, and,
    (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or
    (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the

determination, applying the terms of the plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

Appealing Denial of Claim:

On any wholly or partially denied claim, you or your representative may appeal to us for a full and fair review by filing a timely request for review. You:

- must request a review upon written application within 180 days of the claim denial;
- may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
- may submit written comments, documents, records and other information relating to your claim.

If you do not appeal a claim denial, you lose your right to bring a civil action under ERISA section 502(a).

We will make a decision no more than 45 days after we receive your appeal. The time for decision may be extended for one additional 45-day period provided that, prior to the extension, we notify you in writing that an extension is necessary due to special circumstances, identify those circumstances and give the date by which we expect to render our decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request. The written decision will include specific references to the plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.

You have the right to bring a civil action under section 502(a) of ERISA only after on of the following events occur:

- your appeal is denied, and you have received a written denial on appeal; or
- your appeal is not decided within the timeframes above.

General Plan Provisions

Trustees May Advance Medical or Dental Benefits When Injury or Illness may be the Responsibility of a Third Party

Definitions

For purposes of this section, *Trustees May Advance Medical or Dental Benefits When Injury or Illness May be the Responsibility of a Third Party*, the following terms are defined:

- "Amount Advanced" means the full amount of Medical or Dental benefits that the Trustees advance on your or your dependent's behalf for supplies or services for a Covered Injury or Illness.
- "Covered Injury or Illness" means an injury or illness to or of you or your dependent that, in the judgment of the Trustees, is or appears to be the responsibility of one or more persons and for which payment is or may be made by a third party (including, but not limited to, automobile, liability, uninsured or underinsured motorist, business or commercial liability, homeowners' liability, and umbrella liability insurance, and medical payments for PIP coverage, regardless who maintains the insurance or coverage).
- "Recovery" means any recovery by you or your dependent or on behalf of you or your dependent related to your, his or her Covered Injury or Illness regardless of the source of the recovery and regardless how you, your dependent or any other party characterizes the recovery or source of recovery.

Trustees May Advance Benefits

The Plan excludes Medical and Dental benefits for supplies or services for any Covered Injury or Illness. See *Medical Benefits — Benefits — Limitations and Exclusions* at page 33 and *Dental Benefits — Schedule of Dental Benefits — Exclusions* at page 43. The Trustees, in their discretion, may advance Medical or Dental benefits on your or your dependent's behalf for supplies or services for a Covered Injury or Illness pending the resolution of your or your dependent's claims against third parties in connection with a Covered Injury or Illness, on the terms and subject to the conditions in this section *Trustees May Advance Medical or Dental Benefits When Injury or Illness may be the Responsibility of a Third Party*.

Trustees' Rights to Request Agreement, Instruments and Actions

If the Trustees request, you and your dependent must:

- sign and deliver to the Trustees a legally enforceable agreement affirming the Trustees' rights and your and your dependent's obligations under this section *Trustees May Advance Medical or Dental Benefits When Injury or Illness may be the Responsibility of a Third Party*, including, but not limited to, the Trustees' rights of reimbursement and subrogation (the "Reimbursement and Subrogation Agreement"); and

- sign and deliver to the Trustees all other instruments and take any other actions the Trustees' deem necessary or appropriate to secure their rights.

If the Trustees make such a request, you and your dependent must satisfy the request before they will advance any benefits or additional benefits on an existing matter.

Until the Trustees receive the fully signed Reimbursement and Subrogation Agreement, you or your dependent's claims for supplies or services for a Covered Injury or Illness will not be considered filed and the Trustees will not advance benefits. A claim will be untimely and will not be paid if the period for filing claims passes before the Trustees receive your Reimbursement and Subrogation Agreement. See *Medical Benefits — How to File a Claim for Benefits* at page 36 and *Dental Benefits — How to File a Claim for Benefits* at page 44.

Trustees' Lien

The Trustees have a lien on any Recovery you, your dependent or your, his or her representative (including an attorney) receive to secure payment of the Advanced Amount to the Trustees, and you, your dependent or representative is deemed to hold any Recovery in trust for the benefit of the Trustees until the Advanced Amount is paid to the Trustees.

Trustees' Right to Require Payments into Trust Account

At the request of the Trustees, the Recovery up to the Advanced Amount shall be paid into a **trust** account and held there until the Trustees' claim is resolved by mutual agreement or court order. The individual or entity that will hold the funds in **trust** must be identified to the Trustees. The obligation to place the Advanced Amount in **trust** is independent of the obligation to reimburse the Trustees. If the Recovery up to the Advanced Amount is not placed in **trust**, you or your dependent and your or your dependent's representative shall be personally liable for any loss the **Trust** suffers as a result. If there are multiple parties or Recoveries, payments will be made from each successive Recovery until the Advance Amount has been paid in the **trust**.

Trustees' Right to Subrogation

Trustees have the right to subrogate themselves for the Amount Advanced to the extent of any and all:

- payments made or to be made by the person or persons whom the Trustees consider responsible for the Covered Injury or Illness, or their insurers (whether pursuant to a judgment, settlement or otherwise) — regardless whether the payment is designated as payment for damages including, but not limited, to pain and/or suffering, loss of income, medical benefits or any other specified damages;
- payments made or to be made under any auto or recreational vehicle insurance, including, but not limited to, uninsured/underinsured motorist coverage, in connection with or relating to the Covered Injury or Illness; or
- payments made or to be made under any business or homeowners medical liability insurance in connection with or relating to the Covered Injury or Illness; or
- attorney fees paid or to be paid in connection with any claim, demand, lawsuit or other proceeding by your or your dependent against any third party in connection with or relating to the Covered Injury or Illness.

Under their right of subrogation the Trustees may use your right (or your dependent's right) to recover money from a third party. Thus, among other things, the Trustees have the right:

- to commence an action against a third party in your name to effect the Trustees' right of subrogation; and
- to join as a party in any action (including a lawsuit, an arbitration or other means of dispute resolution) against a third party that you or your dependent commences.

Trustees' Right to Reduce or Deny Medical or Dental Benefits

The Trustees have the right to reduce or deny Medical or Dental benefits they otherwise would pay or provide under the Plan to the extent of any and all:

- payments made, to be made or that should be made by any person or persons whom the Trustees consider responsible for the Covered Injury or Illness, or their insurers (whether pursuant to a judgment, settlement or otherwise) — regardless whether the payment is designated as payment for damages including, but not limited, to pain and/or suffering, loss of income, medical benefits or any other specified damages;
- payments made, to be made or that should be made under any auto or recreational vehicle insurance, including, but not limited to, uninsured/underinsured motorist coverage, in connection with or relating to the Covered Injury or Illness; or
- payments made, to be made or that should be made under any business or homeowners medical liability insurance in connection with or relating to the Covered Injury or Illness; or
- attorney fees paid, to be paid or that should be paid in connection with any claim, demand, lawsuit or other proceeding by your or your dependent against any third party in connection with or relating to the Covered Injury or Illness.

The Medical or Dental benefits the Trustees have a right to reduce or deny are not limited to the Medical or Dental benefits with respect to an injury or illness for which a person is responsible. The Trustees have the right to reduce or deny benefits until the amount of benefits they would otherwise pay or provide under the Plan exceeds the Amount Advanced.

Trustees' Right to be Reimbursed for or Recover Amount Advanced

You must reimburse the Trustees for, and the Trustees have the right to recover, the Amount Advanced to the extent of any and all:

- payments made by any person or persons whom the Trustees consider responsible for the Covered Injury or Illness, or their insurers (whether pursuant to a judgment, settlement or otherwise) — regardless whether the payment is designated as payment for damages including, but not limited, to pain and/or suffering, loss of income, medical benefits or any other specified damages;
- payments made under any auto or recreational vehicle insurance, including, but not limited to, uninsured/underinsured motorist coverage, in connection with or relating to the Covered Injury or Illness; or
- payments made under any business or homeowners medical liability insurance in connection with or relating to the Covered Injury or Illness; or
- attorney fees paid in connection with any claim, demand, lawsuit or other proceeding by your or your dependent against any third party in connection with or relating to the Covered Injury or Illness.

Your and Your Dependent's Obligations

You and your dependent must cooperate with the Trustees in protecting and enforcing their rights under this section *Trustees May Advance Benefits When Injury or Illness may be the Responsibility of a Third Party* and do nothing to impair those rights.

If you or your dependent make or file a claim, demand, lawsuit or other proceeding against any third party in connection with or relating to an illness or injury of or to you or your dependent with respect to which the Trustees have advanced Medical or Dental benefits under this section *Trustees May Advance Medical or Dental Benefits When Injury or Illness may be the Responsibility of a Third Party*, you or your dependent must (1) as part of such claim, demand, lawsuit or other proceeding, and on behalf of the Trustees, seek payment or reimbursement for the Amount Advanced, and (2) promptly notify the Trustees in writing (A) of the claim, demand, lawsuit or other proceeding, when made or filed; (B) of any settlement you, he or she intends to make of the claim, demand, lawsuit or other proceeding, before you make the settlement; (C) of any request or motion for any judgment or award against a third party, when you make the request or motion; and (D) of any judgment or award against a third party or payment by or on behalf of a third party, when the judgment, award or payment is entered or made.

You or your dependent must promptly notify the Trustees of the existence of any right to indemnification with respect to any injury or illness to you or your dependent, when you or your dependent first knows of that right.

You or your dependent must pay your, his or her attorney's fees. The Trustees do not pay for and are not responsible for your or your dependent's attorney's fees. Your or your dependent's attorney's fees do not reduce the amounts that the Trustees may recover, be reimbursed for or by which the Trustees may reduce or deny benefits they would otherwise pay or provide.

Overpayment of Benefits

You must reimburse the Trustees for, and the Trustees have the right to recover from you, your dependent or any other person, the amount of any overpayment of any type of benefit paid to or on behalf of you or your dependents. The Trustees also have the right to reduce or deny benefits they otherwise would pay or provide under the Plan to the extent of any overpayment of benefits.

Coordination of Benefits

Benefits subject to this provision. All of the Medical, Dental, Vision and Hearing Aid Device Benefits of this Plan are subject to this *Coordination of Benefits* section.

Definition of terms. Whenever used in this *Coordination of Benefits* section, the following terms shall be defined as specified:

- **Allowable expense** means the **allowed amount** for any necessary medical, dental, vision and hearing aid device service or supply when the service or supply is covered at least in part under any of the plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered as an allowable expense. The difference between

the cost of a private **hospital** room and the cost of a semiprivate **hospital** room is not considered an allowable expense under the above definition unless the covered person's stay in a private **hospital** room is considered **medically necessary** under a least one of the plans involved.

- Claim determination period means calendar year.
- **Plan** means:
  - any plan established or maintained by one or more employers, one or more labor organizations, or jointly by one or more employers and one or more labor organizations that provides medical, surgical, hospital, dental, optical, prescription drug, or audio benefits, or hospital indemnity benefit of over $200 per day, or similar benefits; or
  - any group or individual insurance policy, contract, or plan that provides medical, surgical, hospital, dental, optical, prescription drug, audio, or blanket disability benefits, or a hospital indemnity benefit of over $200 per day, or a similar policy, contract, or plan provided through an insurer, a health care service contractor, or a health maintenance organization;

  Each of the plans under which a person is covered, and each of the benefits within the plan shall be considered separately in administering this coordination of benefits provision. The term "plan" does not include accident-only coverage for preschool, grammar school, high school, or college students, including athletic injuries, either on a 24-hour basis or a "to and from school" basis.

General Provisions

Benefits will be provided under this Plan to the extent that you or your dependent could not have received benefits for the same services under any other plan had claim been made. If the other plan has a coordination of benefits provision and if the benefits provided under this Plan and all other plans under which you or your dependent ("the person" for purposes of this *Coordination of Benefits* section) is covered would exceed the allowable expenses for the claim being processed, then this *Coordination of Benefits* section will apply. This means that the benefits of this Plan and all other plans under which the person is covered will be reduced so that the sum of the benefits of all plans shall not exceed the total allowable expenses for that claim. The benefits of the other plan include all benefits that would have been payable had claim been duly made under that plan. When this provision operates to reduce the total amount of benefits otherwise payable for a person covered under this Plan during any claim determination period, such benefit that would be payable in the absence of this *Coordination of Benefits* section shall be reduced proportionately, and the amount reduced will be applied toward any allowable expenses incurred during the claim determination period.

Which plan pays first. The primary plan pays benefits first. The secondary plan pays benefits second (after the primary plan has paid). If the other plan does not have a coordination of benefits (COB) provision, that plan is the primary plan.

Note: If a Medical Benefit would be payable under this Plan for repair or accidental injury (trauma) to natural teeth under *Medical Benefits — Benefits — Repair of Teeth* at page 29 this Plan is always secondary to any dental plan you have.

If the other plan contains a COB provision, the primary plan is determined in the following order:

- The plan that covers the person as an active employee or as a subscriber (for example, the subscriber under an individual policy of health insurance).
- If the person is a dependent child whose parents are married to each other and not legally separated, the plan of the parent whose birthday (month and day) occurs earlier in the calendar year. **Exception:** If the parents have the same birthday, the plan of the older parent is the primary plan.
- If the person is a dependent child whose parents are married to each other, but are legally separated:
  - If a court decree establishes financial responsibility for the health care of the child, the plan that covers the child as the dependent of the parent with the financial responsibility.
  - The plan of the parent whose birthday (month and day) occurs earlier in the calendar year. **Exception:** If the parents have the same birthday, the plan of the older parent is the primary plan.
- If the person is a dependent child whose parents are (a) divorced from each other or (b) are not and have never been married to each other:
  - If a court decree establishes financial responsibility for the health care of the child, the plan that covers the child as the dependent of the parent with the financial responsibility.
  - If the parent with custody is not married, the plan of the parent with custody.
  - If the parent with custody is married, then:
    - ➢ The plan of the parent with custody.
    - ➢ The plan of the spouse of the parent with custody.

- ➢ The plan of the parent without custody.
- ➢ The plan of the spouse of the parent without custody.

- If (a) one plan covers the person as an active employee or subscriber or as his or her dependent and (b) the other plan covers the person as a former, retired or laid-off employee or his or her dependent, the plan covering the person as an active employee, subscriber or his or her dependent is the primary plan.
- The plan that has covered the person for the longer period of time.

Limitation on Payments. In no event shall the covered person recover under this Plan and all other plans combined more than the total allowable actual expenses of benefits offered by this Plan and the other plans. Nothing contained in this section shall entitle the person to benefits in excess of the total maximum benefits of this Plan during the claim determination period. The person shall refund to the Trustees any excess they may have paid.

Payments to Other Plans. If a payment that should have been made under this Plan was made by another plan, the Trustees have the right, exercisable alone and in their sole discretion, to pay to the other plan any amount the Trustees determine is necessary to satisfy the provision of this *Coordination of Benefits* section. Any amount paid shall be considered benefits under this Plan, and, to the extent of such payments, the Trustees shall be fully discharged from liability.

Right of Recovery. Whenever payments have been made by the Trustees in excess of the maximum amount of payment necessary to satisfy the provisions of this *Coordination of Benefits* section, the Trustees shall have the right to recover such excess payments from you, the covered person, the provider, and the other plan.

Many people subscribe to more than one group or individual health care plan in order to protect themselves against the high costs of medical care. To keep the cost of your health care benefits as low as possible, the Plan will coordinate benefit payments with your other group or individual health care plans so that you will receive up to, but not more than the **allowed amount** for covered benefits. This prevents people from collecting more than the actual cost of services, which can substantially increase rates.If you or your dependents are covered under another group or individual plan, it is your responsibility to make sure that identical, itemized bills are submitted to the **Trust Administration Office** and to the other plan at the same time.

Authority to Interpret and Apply Plan and to Determine Eligibility

Except as provided in the following paragraph, the Board of Trustees has the full and exclusive authority, in its discretion, to interpret and apply the Plan, this Plan Booklet and all other Plan documents, to determine eligibility for coverage under the Plan (i.e., eligibility for coverage under Eligibility Rule A or Eligibility Rule B), to determine eligibility for Medical, Dental, Vision or Hearing Aid Benefits, and to make all factual determinations concerning eligibility for coverage under the Plan or for those Benefits.

The Life Insurance Benefits and Accidental Death and Dismemberment Benefits of this Plan are insured by LifeWise Assurance Company pursuant to insurance contracts with the Board of Trustees. LifeWise Assurance Company has the full and exclusive authority to interpret and apply those insurance contracts, the *Life Insurance Benefits* and *Accidental Death and Dismemberment Benefits* of this Plan Booklet and to determine eligibility for Life Insurance Benefits and Accidental Death and Dismemberment Benefits.

ERISA Disclosures

Name of Plan

Hotel Employees Restaurant Employees Health Trust Plan

Name, Address, and Telephone Number of Plan Administrator and Plan Sponsor

This Plan is sponsored and administered by a joint labor-management Board of Trustees. The name, address, and telephone number is:

Board of Trustees
Hotel Employees Restaurant Employees Health Trust
2815 Second Avenue, Suite 300
P.O. Box 34355
Seattle, WA 98124-1355
(206) 441-7574
(800) 331-6158

Information as to whether a particular employer or employee organization participates in the Plan, and if so, such employer or employee organization's address, may be obtained by participants upon written request to the Board of Trustees. The. Board of Trustees may impose a reasonable charge to cover the cost of providing this information. Participants and beneficiaries may wish to inquire as to the amount of the charges, before requesting information.

Source of Contributions

This Plan is funded through employer contributions, the amount of which is specified in the underlying collective bargaining agreements (between participating employers and labor organizations), and special agreements (between employers, and the, Board of Trustees for non-collectively bargained employees). Self-payments are permitted under certain circumstances (and, in certain circumstances, are required to maintain specified benefits and benefit maximum).

Employer Identification Number (EIN)

91-0590441

Plan Number

501

Plan Year

The financial records of the Plan are kept on a Plan Year basis ending on each May 31.

Name and Address of Trustees

Employer Trustees

Michael Bashaw (Chairman)
Paramount Hotels, LLC
Plaza 600 Building
600 Stewart Street, Suite 601
Seattle, WA 98101

Jill Ridlehoover
The Westin Hotel
1900 5th Avenue
Seattle, WA 98101

Lee Kaufman
Doubletree Hotel
18740 Pacific Highway S
Seattle, WA 98188

Howard Cohen
Best Western Executive Inn
200 Taylor Avenue N.
Seattle, WA 98109

John Taffin
WestCoast Hotels
201 W North River Drive, Suite 100
Spokane, WA 99201

Brad Hutton
Hilton Portland Executive Towers
921 SW 6th Avenue
Portland, OR 97204

Labor Trustees

Richard F. Sawyer (Secretary)
H.E.R.E. Local #8
2800 1st Avenue, Suite 3
Seattle, WA 98121

Erik VanRossum
H.E.R.E. Local No. 8
1322 S. Fawcett, Room #20
Tacoma, WA 98402

Jeff Richardson
H.E.R.E. Local No. 9
1125 S.E. Madison, #209
P.O. Box 14629
Portland, OR 97293

Elizabeth Freeman
H.E.R.E. Local #8
2800 1st Avenue, Suite 3
Seattle, WA 98121

Omar Perestrejo
H.E.R.E. Local #8
2800 1st Avenue, Suite 3
Seattle, WA 98121

Enrique Fernandez
H.E.R.E. Local #19
1415 Koll Circle Suite 105
San Jose, CA 95112

Name and Address of Agent for Service of Legal Process

The agent for service of legal process is:

Board of Trustees
Hotel Employees Restaurant Employees Health Trust
2815 Second Avenue, Suite 300
Seattle, WA 98121

Service of legal process may also be made upon any one of the Trustees or the Board of Trustees as plan administrator.

Type of Plan

Plan may be described as a welfare benefit plan that provides medical, prescription drug, dental vision, hearing, disability, death and accidental death and dismemberment benefits.

Type of Administration

This Plan is administered by the Board of Trustees, with the assistance of Welfare and Pension Administration Service, Inc., a contract administration organization.

Collective Bargaining Agreements

This Plan is maintained pursuant to collective bargaining agreement. Copies of such agreements may be obtained by participants upon written request to the Board of Trustees. Such agreements are also available for examination at the **Trust Administration Office** upon ten (10) days advance written request. The Board of Trustees may impose a reasonable charge to cover the cost of furnishing the agreements. Participants and beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

Participation, Eligibility and Benefits

The eligibility rules that determine which employees and beneficiaries are entitled to benefits are set forth on pages 5 to 11. The benefits to which eligible employees and beneficiaries are entitled are found on pages 19 through 48.

Circumstances Which May Result in Ineligibility or Denial of Benefits

The circumstances that may result in disqualification, ineligibility, denial, or loss of benefits.

Once covered, a person may become ineligible, for example, as a result of one or more of the following circumstances:

- The employee's failure to work the required hours to maintain eligibility, or failure to make a required employee contribution.
- The failure of the employee's employer to report the hours and pay contributions on his or her behalf to the Trust Fund.
- In the case of beneficiaries who are dependents of an eligible employee, they may become ineligible when they no longer dependents as defined in the Plan. See page 7. *Eligibility and Enrollment — Benefits For Employees Who Work Required Hours Under Eligibility Rule A — Eligibility for Your Dependents* page 6.
- If the employee or dependent has elected or is receiving continuation of group health plan coverage ("COBRA coverage"), COBRA coverage terminates at the end of the maximum coverage period, or upon the occurrence of an event requiring earlier termination. See *Eligibility and Enrollment — Continuation of Benefits under COBRA* at pages 12 to 19.

A person who is eligible may nonetheless be denied benefits as a result, for example, of one or more of the following circumstances:

- The failure of the employee or beneficiary to file a claim for benefits within 90 days of the date he or she incurred the expense for which benefits are payable;
- The failure to file a complete and truthful benefit application;
- The person fails to cooperate with the Trustees to protect and secure its first and third party payments. See General Plan Provisions — Trustees May Advance Medical or Dental Benefits When Injury or Illness may be the Responsibility of a Third Party page 59.
- Where the employee or beneficiary has other group insurance coverage, it is possible that benefits payable under this Plan may be reduced or denied due to "coordination of benefits" between the two plans because other insurance is available. See *Coordination of Benefits* at page 61.

- If the employee or dependent ceases to be covered by this Plan but is entitled to elect continuation of group health plan coverage ("COBRA coverage"), he or she fails properly to elect COBRA coverage within the applicable 60-day election period. See *Eligibility and Enrollment — Continuation of Benefits under COBRA* at page 12.

Amendment of Trust Agreement and Plan

As provided in the Trust Agreement, the Board of Trustees has the authority to make amendments to the Trust Agreement and Plan, including amendments that affect the eligibility rules and the amount and nature of benefits. Amendments may be made on a prospective or retroactive basis.

Termination of Trust and Plan

As provided under the Trust Agreement, the Board of Trustees may terminate the Trust and Plan at any time. As provided in the Trust Agreement, the Trust and Plan also terminate automatically when all collective bargaining agreements and special agreements requiring payment of contributions to the Trust have expired, have been terminated, and negotiations for extension thereof have ceased. For purposes of these termination rules, a collective bargaining agreement or special agreement covering employees involved in a strike or lockout shall not be deemed to have expired until the strike or lockout has continued for more than six months.

If the Trust and Plan terminate, the Board of Trustees will apply the assets remaining in the Trust to pay, or provide for payment, of any and all obligations of the Trust, and will apply any remaining assets in the Trust for the continuation of the benefits provided under the Plan until the assets have been exhausted.

Contributions Held in Trust

The employer contributions and employee self-payments are received and held in trust by the Board of Trustees. The Board of Trustees pays Weekly Disability Benefits, Medical Benefits, Vision Benefits, Hearing Aid Benefits and Dental Benefits from the Trust.

Death Benefits and Accidental Death and Dismemberment Benefits are paid by LifeWise Assurance Company and guaranteed and under a contract or contracts of insurance issued by LifeWise Assurance Company.

The address for LifeWise Assurance Company is:

LifeWise Assurance Company
P.O. Box 2272
Seattle, WA 98111-2272

Procedures Governing Claims for Benefits

See *How to File a Claim for Benefits* under *Weekly Disability Benefits* (page 20), Medical *Benefits* (page 36), Vision Benefits (page 39), *Hearing Aid Device Benefits* (page 39) *Dental Benefits* (page 44), *Life Insurance Benefits* (page 45) and *Accidental Death and Dismemberment Benefits* (page 48). See *Benefit Claims and Appeal Procedures* at page 51.

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

- Examine without charge, at the **Trust Administration Office** and 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 U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the **Trust Administration Office**, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The **Trust Administration Office** may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report; the **Trust Administration Office** 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 Plan Booklet 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 the Medical Benefits of the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan when you lose group health plan 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 a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people responsible for the operation of the Plan. The people who operate the 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 benefit under the Plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 a copy of the Plan documents or the latest annual report from the **Trust Administration Office** 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 Trustees 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 **Trust Administration Office**. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, but only after you have completed the claims and appeals procedures described under *Benefit Claims and Appeal Procedures for Medical, Dental, Vision, Hearing Aid Device, and Weekly Disability Benefits Claims* at page 51 or *Benefit Claims and Appeal Procedures for Life Insurance Benefit, Waiver of Life Insurance Premium and Accidental Death and Dismemberment Benefit Claims* at page 57. If you fail to complete the claims and appeals procedures, you may lose your right to file 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 the 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 a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the **Trust Administration Office**.

If you have any questions about this statement or your rights under ERISA, you should contact the nearest area 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.

Hotel Employees Restaurant Employees Health Trust Plan

Notice of COBRA Qualifying Event

When to Use this Notice: Use this Notice to notify the **Trust Administration Office** when (1) there is a divorce or (2) a child ceases to be an eligible dependent under the terms of the Plan.

Instructions: Complete, date, sign and mail, fax or personally deliver this Notice to the **Trust Administration Office** within 60 days after the date of the divorce or the date the child ceases to be a dependent. If the Notice is mailed, faxed or delivered after this date, no COBRA coverage will be offered to the spouse or child and coverage for the spouse or child will cease at the date provided in the Plan.

Required Documentation: If the spouse has become divorced, provide a copy of the decree of divorce. If a child has lost dependent status because he or she attained age 19 or married, provide a copy of the child's birth certificate or marriage certificate.

However, if you cannot provide the decree or certificate by the 60-day deadline above, complete and provide this Notice to the **Trust Administration Office** by the deadline and submit the decree or certificate as soon as possible. Your Notice will be timely. However, COBRA continuation coverage will not become effective until after the decree or certificate is received, reviewed and accepted.

---

1. Event Description (Check one and complete):

❑ **Employee and spouse divorced.**

Name of Spouse: _____ Social Security No. _____

Address of Spouse: _____ Telephone No. _____

Date of Divorce: _____

Is a copy of the divorce decree enclosed? ❑ Yes ❑ No

❑ **Employee's child ceased to be an eligible dependent under the terms of the Plan**

Name of Spouse: _____ Social Security No. _____

Address of Spouse: _____ Telephone No. _____

Reason child ceased to be eligible dependent: ❑ attained age 19 ❑ married ❑ no longer dependent on covered employee, spouse or non-covered legal parent for support ❑ stepchild no longer lives at home with employee ❑ other (see Plan booklet — describe)

Date child ceased to be a dependent: _____

Is a copy of the child's birth or marriage certificate enclosed? ❑ Yes ❑ No ❑ N/A

---

2. Status, Signature and Date:

I am the ❑ employee ❑ spouse or former spouse of employee ❑ former dependent child

Signature: _____

Print Name: _____ Date: _____

Addresses and Fax Number of Trust Administration Office

Mailing Address: Hotel Employees Restaurant Employees Health Trust, P.O. Box 34203, Seattle, WA 98124.

Fax Number: Hotel Employees Restaurant Employees Health Trust (206) 441-9110.

Street Address: Hotel Employees Restaurant Employees Health Trust, 2815 Second Avenue, Suite 300, Seattle, WA 98121.

For Plan Use Only

Date Notice received: _____ If mailed, date of postmark: _____

Divorce decree enclosed? ❑ Yes ❑ No ❑ N/A

Child's birth or marriage certificate received? ❑ Yes ❑ No ❑ N/A

Hotel Employees Restaurant Employees Health Trust Plan

Notice of COBRA Second Qualifying Event (Divorce, Death or Loss of Dependent Status) or SSA Disability Determination

[This Notice is 2 pages]

When to Use this Notice: Use this Notice only when your or your family member is already receiving COBRA coverage, to extend the maximum period of COBRA coverage to:

- a total of 36 months when (a) the covered employee and spouse divorce; (b) a child ceases to be a dependent under the terms of the Plan; or (c) the covered employee dies; or
- a total of 29 months when the Social Security Administration has determined that a qualified beneficiary was disabled on any day of the first 60 days after the covered employee's termination of employment or reduction in hours.

Instructions: Complete, date, sign and mail, fax or personally deliver this Notice to the **Trust Administration Office** by the deadline below. If the Notice is mailed, faxed or delivered after the deadline, COBRA coverage will not be extended past the original 18-month period.

Deadline If you are notifying the **Trust Administration Office** of divorce, employee's death or child's loss of eligibility as a dependent, mail, fax or deliver the completed Notice within 60 days after the divorce, death or date the child ceased to be a dependent (for example, the date the child attained age 19 or married). If you are notifying the **Trust Administration Office** of a disability determination by SSA, mail, fax or deliver the Notice (a) 60 days after the date of Social Security Administration's disability determination and (b) before the initial 18-month COBRA coverage period ends.

Required Documentation:
If the spouse has become divorced, provide a copy of the decree of divorce. If a child has lost dependent status because he or she attained age 19 or married, provide a copy of the child's birth certificate or marriage certificate. If the covered employee has died, provide a copy of the death certificate. If a qualified beneficiary has been determined to be disabled, provide a copy of the Social Security Administration's determination.

However, if you cannot provide the decree, certificate or determination by the deadline above, complete and provide this Notice to the **Trust Administration Office** by the deadline and submit the decree, certificate or determination as soon as possible. Your Notice will be timely. However, continuation coverage will not be extended until a copy of the decree, certificate or determination has been received, reviewed and accepted.

---

1. Identify the Employee:

Print name of employee: _____ Social Security No. _____

Address of employee: _____ Telephone No. _____

---

2. Event Description *(Check one and complete)*:

❑ **Employee and spouse have become divorced**

Print name of spouse: _____ Social Security No. _____

Address of spouse: _____ Telephone No. _____

Date of divorce: _____

Print name(s) of dependent child(ren) receiving continuation coverage:

_____

Address of spouse and dependent child(ren): ❑ same as employee's address ❑ different address (provide address)

_____

Is a copy of the decree of divorce enclosed? ❑ Yes ❑ No

❑ **Employee's child has ceased to be an eligible dependent under the Plan**

Print name of child: _____ Social Security No. _____

Reason child ceased to be eligible dependent (check one): ❑ attained age 19 ❑ married ❑ no longer dependent on covered employee, spouse or non-covered legal parent for support ❑ stepchild no longer lives at home with employee ❑ other (explain)

Address of child: ❑ same as employee's address ❑ different address (provide address)

_____ Telephone No. _____

Is a copy of the child's birth or marriage certificate enclosed? ❑ Yes ❑ No ❑ N/A

❑ **Covered employee has died**

Date of employee's death: _____

Print name of spouse receiving continuation coverage: _____ Social Security No. _____

Print name(s) of dependent child(ren) receiving continuation coverage:

_____

Address of spouse and dependent child(ren):

_____ Telephone No. _____

Is a copy of the death certificate enclosed? ❑ Yes ❑ No

❑ **Social Security Administration has determined qualified beneficiary to be disabled**

Print name of disabled qualified beneficiary: _____ Social Security No. _____

Address of disabled qualified beneficiary: _____ Telephone No. _____

Date disability began (as determined by the Social Security Administration): _____

Date of Social Security Administration's determination: _____

Is a copy of the Social Security Administration's determination enclosed? ❑ Yes ❑ No

---

3. Status, Signature and Date:

I am the (check one): ❑ employee ❑ spouse or former spouse ❑ former dependent child

❑ other (explain) _____

Signature: _____ Date: _____

Print Name: _____

Addresses and Fax Number of Trust Administration Office

Mailing Address: Hotel Employees Restaurant Employees Health Trust, P.O. Box 34203, Seattle, WA 98124.

Fax Number: Hotel Employees Restaurant Employees Health Trust (206) 441-9110.

Street Address: Hotel Employees Restaurant Employees Health Trust, 2815 Second Avenue, Suite 300, Seattle, WA 98121.

For Plan Use Only

Date Notice received: _____ If mailed, date of postmark: _____

Divorce decree enclosed? ❑ Yes ❑ No ❑ N/A

SSA determination enclosed? ❑ Yes ❑ No ❑ N/A

Child's birth or marriage certificate received? ❑ Yes ❑ No ❑ N/A

Covered employee's death certificate received? ❑ Yes ❑ No ❑ N/A