Summary Plan Description

2020

Benefits For Hilton U.S. Team Members

(except for Hawaii and Puerto Rico)

- **Health Care**
- **Disability Protection**
- **Life and Accident Insurance**

This Summary Plan Description (SPD) summarizes the major features of the benefits programs for U.S. full-time eligible employees and certain eligible leased employees of Hilton Domestic Operating Company Inc. and its affiliates ("Hilton") as of January 1, 2020. This SPD does not apply to Team Members in Hawaii or Puerto Rico; benefits for these Team Members are described in a separate summary plan description. Certain Team Members whose employment is subject to a collective bargaining agreement are excluded or have modified coverage. You should also refer to any applicable cover letter accompanying this SPD for changes and additions to the SPD that apply to employees at:

- Hilton Baltimore
- Hilton McLean
- Hilton Crystal City
- Doubletree – Crystal City
- Embassy Suites – Crystal City
- Hilton – Vancouver
- Doubletree – San Diego Valley
- Embassy Suites – San Diego La Jolla
- Hilton La Jolla Pines
- Hilton San Diego Bay Front
- La Quinta (Palm Springs)
- Hotel Del Coronado

You should not rely on this information other than as a general summary of the features of the Hilton Health and Welfare Plan (the "Plan").

This SPD is based on legal documents (such as plan documents, insurance contracts and summary booklets and HMO contracts) currently in effect. These documents provide further detail on coverage benefits as well as important exclusions, limitations, and requirements applicable to receive benefits. You may obtain a copy of any of the official legal documents for your coverages online by following the steps below and in the "General Information" section or by contacting the Plan Administrator.

To access any available insurance certificates or Coverage Booklets, follow the instructions below:

1. Access YBR via this website: http://digital.alight.com/hilton
   2. Click on the "Choose a Language" drop-down box from the log on page, select "English" or "Spanish – Español".
   3. Enter your User ID and password on the Logon page.
   4. From the YBR Home page, select the tab titled "Health & Insurance."
   5. From the Health & Insurance page choose the "Coverage Details" drop down, then in the menu items, click on the Plan Information link.
   6. The SPD and available insurance certificates and Coverage Booklets will be displayed on the next screen.

   While every effort has been made to give you correct and complete information about your benefits, in the event of any conflict or inconsistency between this SPD and relevant legal documents with respect to benefits payable, the terms of the legal documents will control. The SPD will govern if the conflict or inconsistency relates to eligibility, except as described in the "State Insurance Mandates and Dependent Coverage" section in the Participation chapter.

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Introduction

WHAT'S INSIDE

This handbook contains important information on many of the benefit programs offered under the Plan. Please read it carefully.

AN OVERVIEW OF YOUR HEALTH AND WELFARE BENEFITS

The Plan offers you a variety of benefits and levels of coverage (Benefit Options) from which you can choose.

(Note: eligibility criteria may vary for each benefit offering):

- Medical Coverage
- Dental Coverage
- Vision Coverage
- Flexible Spending Accounts (FSAs)
    - Health Care FSA
    - Dependent Day Care FSA
- Disability
- Short-term Disability
- Long-Term Disability
- Life Insurance (Basic, Supplemental and Dependent)
- Retiree Life Insurance*
- Accidental Death and Dismemberment (AD&D)
- Employee assistance program (EAP) and work/life benefit
- Business Travel Accident
- Legal Services
- Wellness Programs
- Voluntary Medical Benefits

**This benefit is available only to a closed group of retirees. No new participants are allowed at this time.*

THIRD PARTY ADMINISTRATORS

For purposes of administrating the various Benefit Options under the Plan, the Plan Administrator has retained the services of certain independent third-party administrators and insurance companies, such as Aetna, United Healthcare, Delta Dental and Alight Solutions. Generally the third party administrator does not assume liability for benefits payable under this Plan; some third party administrators, however, may be designated as a "named fiduciary", as that term is defined in ERISA, for purposes of processing claims.

MORE INFORMATION

We encourage you to retain this handbook for future reference. If you have questions about your benefits, please contact the Hilton Benefits Center. You may reach the Hilton Benefits Center at 1.877.442.4772 Monday through Friday from 8:00 a.m. to 6:00 p.m. CT.

The role of the Hilton Benefits Center and the service center representatives with the Plan's insurers and third party administrators is to assist you with questions you may have about this Plan. However, statements made by such representatives do not have a binding effect on the Plan. If you need to bring or appeal a claim under this Plan, you should follow the formal claims and appeals procedures described in this booklet.

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PARTICIPATION

PARTICIPATION

Participation

ELIGIBILITY

Your Eligibility

Generally, you are eligible for health and welfare benefits if:

- you are a regular U.S. Team Member of Hilton; *and*
- you are "full-time", which for purposes of this Plan means you are either:
    - o an hourly or salaried employee who is reasonably expected to work at least 30 hours a week (as determined by Hilton); *or*
    - o an hourly or salaried employee who is not reasonably expected to work at least 30 hours when hired, but who averages 30 or more hours of service during an applicable measurement period, as described in Sections II - V.

Team Member does not include individuals employed by a hotel owner or any other non-affiliated entities (including franchisees). This definition of Team Member shall apply to this SPD and any other communications sent to participants relating to benefits offered under the Plan.

You are eligible for disability insurance, life and AD&D insurance, business travel accident insurance and MetLaw legal services if you are a full-time U.S. Team Member of Hilton (and a corporate salaried Team Member for salary continuation). Except as provided below for Corporate Team Members, coverage will begin following a 90-day waiting period.

Notwithstanding this rule, a newly hired Corporate Team Member must enroll in the Plan within the first 30 days of hire. If coverage is elected, with exception of Health and Dependent Care Flexible Spending Accounts and Health Savings Accounts, coverage will be effective as of the first day of employment, subject to Evidence of Insurability requirements for Life and Accidental Death and Dismemberment coverage. However, medical, dental and vision coverage will be paid on an after-tax basis through the 90th day of employment. Such coverage will be paid on a pre-tax basis starting on the 91st day of employment. Enrollment in Health Savings Accounts and Health and Dependent Care Flexible Accounts, as applicable, must be completed during the first 30 days of hire; however, contributions to Health Savings Accounts and Health and Dependent Care Flexible Accounts would begin on the 91st day. During the first 90 days of employment, contributions to Health Savings Accounts and Health and Dependent Care Flexible Spending Accounts will not be permitted. If a Corporate Team Member wants Life, Accidental Death and Dismemberment, or Disability coverage, the coverage should be elected during this 30-day period, which, other than Basic Life Insurance, is paid on an after-tax basis. To the extent required by applicable tax rules, for the first 90 days of coverage, the cost of Basic Life Insurance coverage, less amounts paid by the Team Member, will be reported to you on your Form W-2 ("C" in Box 12) and on your paycheck (under "Group Term Life"). See the "Life Insurance" section in this SPD for information on how Basic Life Insurance will be taxed at the end of the 90-day period.

The following sections describe in more detail who will be eligible and when you can enroll if you become eligible. Definitions for the capitalized terms are provided in Section V.

I. ELIGIBILITY

A. Non-variable Hour Team Members – Non-variable Hour Team Members are eligible and may enroll in coverage as of the date specified in Section II.

B. Variable Hour Team Members – Variable Hour Team Members are eligible if they average 30 or more Hours of Service during the applicable measurement period below:

(1) New Team Members – the applicable measurement period is your Initial Measurement Period; and

(2) Ongoing Team Members – the applicable measurement period is the most recent Standard Measurement Period.

Team Members who become eligible pursuant to either A or B shall be referred to collectively as "Full-Time Team Members."

See Section II.C. for eligibility rules when you are transitioning between the Initial Stability Period and the Standard Stability Period.

II. ENROLLMENT

A. New Team Members

(1) Non-variable Hour Team Members – Non-variable Hour Team Members will be eligible to enroll in benefit coverage effective on their ninety-first (91st) day of employment.

(2) Variable Hour Team Members – Eligible Variable Hour Team Members will be eligible to enroll in benefit coverage during the Administrative Period following their Initial Measurement Period. Coverage will become effective as of the first day of the Initial Stability Period.

B. Ongoing Team Members – Eligible Ongoing Team Members will be eligible to enroll during the open enrollment period designated by the Plan Administrator. Coverage will become effective as of the first day of the next Standard Stability Period.

Ongoing Team Members who fail to average 30 or more Hours of Service per week during the Standard Measurement Period are not eligible to enroll and will not be offered coverage during the Standard Stability Period. If such Ongoing Team Members were eligible for coverage during the Standard Stability Period that includes the annual enrollment period, they will be offered continuation coverage under COBRA beginning as of the first day of the next Standard Stability Period.

C. Transitioning Team Members – The following rules apply to you when you transition from your Initial Stability Period to your Standard Stability Period:

(1) Coverage During Initial Stability Period - If you averaged 30 or more Hours of Service per week during your Initial Measurement Period and elected coverage, your coverage will continue through the end of your Initial Stability Period.

(a) If you average 30 or more Hours of Service per week during your first Standard Measurement Period, you can elect to continue medical coverage beginning on the first day after the end of your Initial Stability Period and coverage will continue through the end of the Standard Stability Period.

(b) If you do not average 30 or more Hours of Service per week during your first Standard Measurement Period, your coverage will terminate at the end of your Initial Stability Period and you will not be eligible to enroll in coverage unless you average 30 or more Hours of Service per week during a subsequent Standard Measurement Period. If you are enrolled in coverage at the end of your Initial Stability Period, you will be offered continuation coverage under COBRA beginning as of the day following the end of your Initial Stability Period.

(2) No Coverage During Initial Stability Period - If you did not average 30 or more Hours of Service per week during your Initial Measurement Period, you will not be eligible to enroll in coverage during your Initial Stability Period.

(a) If you average 30 or more Hours of Service per week during your first Standard Measurement Period, you will be eligible to enroll in coverage effective as of the first day of your Standard Stability Period, even if that falls within your Initial Stability Period.

(b) If you do not average 30 or more Hours of Service per week during your first Standard Measurement Period, you will not be eligible to enroll in coverage unless you average 30 or more Hours of Service per week during a subsequent Standard Measurement Period.

III. CHANGES IN EMPLOYMENT STATUS

A. Variable Hour Team Member to Non-variable Hour Team Member – If you change employment status from a Variable Hour Team Member to a Non-variable Hour Team Member during your Initial Measurement Period, you will be eligible to enroll as of the earlier of:

(1) The first day of your Initial Stability Period, if you satisfy Section II.C(1); or

(2) The date of your change in employment status (or your 91st day of employment, if later).

B. Non-variable Hour Team Member to Variable Hour Team Member – If you change employment status from a Non-variable Hour Team Member to a Variable Hour Team Member before you begin your first Standard Stability Period, you will remain eligible for coverage until the end of your first Standard Measurement Period (plus Administrative Period), at which time your status as a Full-Time Team Member will be determined based on Hours of Service during the Standard Measurement Period.

III. Leaves of Absence

While you are on an approved leave of absence, you will remain eligible for coverage as long as you remain employed and you make timely contributions, assuming you are otherwise eligible for, and enrolled in, such coverage.

IV. Rehires and Returns from Leave of Absence

When you are rehired following termination of employment, you will be treated as a New Team Member (*e.g.,* subject to a new Initial Measurement Period) if:

- Variable Hour Team Member: your period of no service lasted 13 weeks or longer; or
- Non-Variable Hour Team Member: your period of no service lasted longer than 12 months.

When you return from an approved leave of absence, you will be treated as an Ongoing Team Member, even if your leave of absence lasted 13 weeks or longer.

If your period of no service was less than 13 weeks long, you will be treated as a continuing employee, as if you had not been gone. However, Hours of Service may not be awarded for the period of no service when averaging your Hours of Service for the Standard Measurement Period that includes the date you return to active service.

Notwithstanding that rule, you will be eligible for benefits upon rehire if you are a Non-Variable Hour Team Member rehired within 12 months of termination of employment.

V. Definitions

A. Administrative Period – the period running from October 4 to December 31, or with respect to a New Team Member, the period running from the day after the Initial Measurement Period through the first day of the month following the month in which the Team Member's anniversary of employment occurs.

B. Hour of Service – each hour for which a Team Member is paid, or entitled to payment, for the performance of duties by Hilton and each hour for which a Team Member is paid, or entitled to payment by Hilton for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

C. Initial Measurement Period – the 11-month period beginning on a Team Member's date of hire over which hours will be averaged for New Team Members who are Variable Hour Team Members.

D. Initial Stability Period – the 12-month period beginning on the first day of the month following the month in which occurs the anniversary of your date of hire.

E. New Team Member – a Team Member who has been employed less than one complete Standard Measurement Period, or a Variable Team Member who has experienced a period of no service equaling or exceeding 13 weeks (or a Non-Variable Team Member who has experienced a period of service that equals or exceeds 12 months) in accordance with Section IV.

F. Non-variable Hour Team Member – a Team Member, including a temporary employee, who is reasonably expected at the time of hire to work 30 or more hours per week, unless the Team Member is a Seasonal Employee.

G. Ongoing Team Member – a Team Member who has been employed at least one complete Standard Measurement Period.

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H. Standard Measurement Period – the period beginning on October 3 and ending on October 2 of the following year during which Hours of Service will be averaged for Ongoing Team Members.

I. Standard Stability Period – the 12-month period beginning each January 1 and ending the following December 31.

J. Seasonal Team Member – a Team Member who performs services on a seasonal basis, as determined by the Plan Administrator in its sole discretion in accordance with applicable guidance. Seasonal Employees may include full-time temporary employees who meet the IRS requirements to be treated as seasonal.

K. Variable Hour Team Member – a Team Member who is not reasonably expected as of the Team Member's start date to be employed on average at least 30 Hours of Service per week during the Initial Measurement Period because the Team Member's Hours of Service are variable or otherwise uncertain.

If you are a non-union Team Member regularly scheduled to work 30 or more hours per week at the time Hilton takes over management or ownership of the property at which you are employed, your service at that property may count toward satisfaction of the eligibility requirements. You will be notified if your service will be counted. Absent such notification, your prior service does not count. Prior service for union Team Members will be determined pursuant to the terms of the collective bargaining agreement.

If you are eligible for benefits and you are placed on furlough and/or your property is partially or fully closed for renovations, due to significant business disruption, or as a result of a national or local disaster or emergency (e.g., hurricane, tornado, earthquake, pandemic), you may be allowed to continue your coverage during the closure under certain conditions and you may be credited with hours of service for eligibility purposes under the Plan during the closure. Hilton has sole discretion to determine which events qualify, which Team Members are affected and the requirements for continued coverage and crediting hours solely for Plan eligibility purposes, and Hilton will attempt to apply those requirements consistently to all affected Team Members, to the extent it deems such application feasible in its sole discretion. In the event any coverage is required to be continued under applicable law, Hilton may determine that such continuation will apply concurrently with or in lieu of coverage continuation under this provision.

Excluded Individuals

The following individuals are not eligible to participate in the Plan: (i) independent contractors, (ii) individuals subject to a consultant or employee leasing agreement, (iii) employees whose employment is covered by a collective bargaining agreement with Hilton (unless the collective bargaining agreement requires otherwise), (iv) individuals employed by a hotel owner other than Hilton or one of its affiliated entities where Hilton manages employees at that hotel but does not actually employ them, unless eligibility is approved by the Plan Administrator, or (v) individuals employed at franchised properties. In addition, even if you are an otherwise eligible Employee, but work at a property that is managed, but not owned, by Hilton and the owner sponsors and offers its own health and welfare benefits, you will not be eligible to participate in the this Plan.

When Coverage Begins

Subject to certain exceptions and if you timely enroll for coverage, your coverage will begin on the date set forth above.

Payroll deductions for your share of the coverage costs will begin as soon as administratively feasible based on your eligibility date and pay cycle. Your contribution for a pay cycle will not be pro-rated by how many days of coverage are provided during that pay cycle.

For the Employee Assistance Program (EAP), coverage begins on the first day of work.

In some cases, certain coverages may start earlier or be subject to additional requirements. For the following coverages, you must be actively at work on the date coverage is scheduled to begin:

- Disability;
- Life Insurance;

- Accidental Death and Dismemberment; and
- Business Travel Accident.

See the chapters on individual benefit options for other requirements.

Preexisting Conditions

Benefits under the LTD program may be limited if you have a disability due to a preexisting condition. See the "Disability" section of this handbook for details.

Your Eligible Dependents

Subject to certain limitations, your eligible dependents may also participate in the Plan. Your eligible dependents include your:

- ***Legal Spouse***. Unless you are legally separated, "Spouse" means the individual recognized as your spouse for federal tax purposes. "Spouse" shall not include an individual legally separated from the Participant under a decree of divorce or separate maintenance nor shall it include, for purposes of the Dependent Day Care Account, an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate residence during the last six months and does not furnish more than one-half of the cost of maintaining the principal residence of the qualifying individual.
- ***Domestic Partner.*** The Plan defines a domestic partnership as a same-sex or opposite-sex relationship where:
  - ✓ Each partner is age 18 or older;
  - ✓ Each partner is a U.S. citizen or a U.S. resident alien (not applicable for STD, LTD, Life and AD&D coverage);
  - ✓ The partners are not blood relatives;
  - ✓ Neither partner is currently, nor have been in the past six (6) months, legally married, or legally separated from each other or someone else, nor does either partner have another domestic partner (not applicable for STD, LTD, Life and AD&D coverage);
  - ✓ The partners maintain an intimate, committed relationship of mutual caring and support;
  - ✓ The partners have lived together for at least six (6) months, during which time the partners were not married to, or legally separated from, each other or someone else before enrollment in any of the coverages;
  - ✓ The partners do and will continue to have the same principal address indefinitely; and
  - ✓ The partners agree to share basic living expenses during their domestic partnership and will permit anyone who is owed money in connection with these expenses to collect from either partner.

Generally, domestic partners are not eligible for pre-tax coverage, including coverage under the Health Care FSA, unless he or she is a dependent for federal income tax purposes. Please see "Domestic Partners: Tax Implications and Other Information" for more details.

For purposes of the Business Travel Accident program, you and your domestic partner must meet the above requirements for at least 12 months before your domestic partner may be covered under the Business Travel Accident program. In addition, proof of the domestic partnership relationship may be required for certain insured benefits. Please contact the Hilton Benefits Center for more information.

- ***Children*** to age 26 (unless otherwise set forth in the applicable benefit option documents), which can include:
  - ✓ Your natural children;
  - ✓ Your stepchildren or except for Life and AD&D coverage, foster children;
  - ✓ Your legally adopted children (including children placed with you for adoption);
  - ✓ Children of your domestic partner who you support and who live with you;
  - ✓ Children who live with you and for whom

you are the legal guardian;

- ✓ A child age 26 or older who, because of a mental or physical disability, lives with you and depends on you for financial support if the child's disability occurred before the child attained age 26. For dependent life insurance and/or Accidental Death and Dismemberment coverage, you must have purchased coverage before his or her 26th birthday for your dependent to be eligible for coverage; and
- ✓ A child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO) (excluding child life and AD&D coverage).

Note: Underlying benefit options may have different dependent eligibility criteria (e.g., the Dependent Day Care FSA, Dependent Life Insurance, Accidental Death and Dismemberment Insurance, and Business Travel Accident Insurance). Please see the dependent eligibility criteria for each section of this handbook for more information).

If you are a new Team Member eligible for health and welfare benefits who has a child that is already age 26 or older with a mental or physical disability, you may enroll your disabled child for health care coverage if the child was disabled before age 26.

Proof of Dependent/Disabled Status

From time to time you will be required to provide documentation as proof of your spouse or dependent's eligibility status, including such items as a marriage certificate, birth certificate, adoption papers or affidavit of domestic partnership. Failure to provide adequate documentation, upon request by the deadline provided in the requesting documents, may result in termination of coverage for the affected individual(s) without any coverage extension under COBRA. In addition, coverage of ineligible dependents is in violation of company policy. Team Members identified as covering ineligible dependents may be subject to legal action and discontinued from Plan coverage.

A disabled child that is continuing coverage beyond any limiting age while he or she is disabled will be required to provide proof of a mental or physical disability, including the Social Security Administration Disability Award Notice, to continue coverage. Contact the Hilton Benefits Center for details.

Qualified Medical Child Support Order (QMCSO)

The Plan also provides medical coverage for your child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is either a National Medical Child Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing Hilton to cover a child as your dependent under the Plan for medical coverage. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid.

If the Plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child. If you have any questions or you would like to receive, free of charge, a copy of the written procedures for determining whether a QMCSO is valid, please contact the Hilton Benefits Center.

Dual Coverage

If your spouse, domestic partner or eligible dependent child also works for Hilton and is eligible for health care coverage and the Health Care and Dependent Day Care FSAs, then he or she can enroll as a Team Member under his or her own coverage or as a dependent under your coverage, but not both.

If you and your spouse or domestic partner are both employed by Hilton and eligible to participate in the Plan, only one of you may enroll your eligible dependent children in the health care benefits. Also, only one of you may cover your eligible children under the dependent life and Accidental Death and Dismemberment insurance programs.

Dependent life insurance does not cover dependents who are also regular, full-time Team Members of Hilton. In that situation, each eligible Team Member is covered as a Team Member under the life insurance program.

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State Insurance Mandates and Dependent Coverage

A number of states have laws requiring health insurance companies to extend eligibility and/or provide coverage that may not be reflected in the eligibility and coverage provisions of the Plan. To determine whether such state-mandated coverage applies to you or your dependents and the terms of such coverage, you may contact the Advocacy Team. Upon contacting the Advocacy Team, you may need to provide details on your personal situation, such as location of your residence and age of your dependents. The Advocacy Team will provide you with information about which insurance carriers to contact (and their contact information), and how to request costs of coverage and enrollment procedures, as applicable. You may contact the Advocacy Team at 1-877-442-4772.

On-Site Medical Clinics

Hilton offers an on-site medical clinic at its McLean, VA location, which provides certain medical services on location to non-union Hilton Team Members. Hilton expects to offer in the future an on-site clinic at its Memphis, TN location to non-union Hilton Team Members as well. Please see the on-site clinic documents for more details regarding eligibility and services.

Participation

COST OF COVERAGE

The chart below highlights who pays for the benefit coverages and on what basis they are paid. Depending on the benefit chosen, either Hilton or you may pay for all of the coverage, or you may share the cost of the coverage with Hilton. In addition, it shows you how you pay for each benefit coverage – on a pre-tax or after-tax basis. The benefits marked in the "Employer Pays" column require no enrollment; coverage for those benefits is provided automatically.

Coverage	Employer Pays	You Pay	You and Employer Pay	You Pay Pre- or After-Tax[1]
Medical[2]			X	Pre-Tax
Dental			X	Pre-Tax
Vision		X		Pre-Tax
Health Care FSA		X[3]		Pre-Tax
Dependent Day Care FSA		X		Pre-Tax
Employee Assistance Program	X			N/A
Disability				
■ Basic STD	X	X[4]		N/A / After-Tax
■ STD Buy-up Option		X		After-Tax
■ LTD		X		After-Tax
Life Insurance[5]				
■ Basic	X			N/A
■ Supplemental		X		After-Tax
■ Dependent		X		After-Tax
Accident Insurance				
■ AD&D		X		After-Tax

[1] Even though the above chart indicates payment on a pre-tax basis, you will be required to pay on an after-tax basis for medical and prescription drug coverage if you failed to enroll within the required period, but actually enrolled within 30 days after the end of the required enrollment period. Benefits for domestic partners may also be on an after-tax basis. In addition, newly-hired Corporate Team Members must, within the first 30 days of employment, enroll in the Plan. If coverage is elected by such Corporate Team Members, medical, dental and vision coverage will be effective as of the first day of employment and paid on an after-tax basis through the 90th day of employment and paid on a pre-tax basis starting on the 91st day of employment. During the first 90 days of employment, contributions to Health Savings Accounts and Health and Dependent Care Flexible Spending Accounts will not be permitted. All company-provided benefits under the Plan and contributions to Health Savings Account and Health and Dependent Care Accounts, if elected and as applicable, will start following the end of the 90-day waiting period.

[2] Some Team Members who choose not to elect medical coverage under this Plan may be entitled to an opt-out credit. You will receive additional information about this credit if it applies to you.

[3] Certain Team Members may be eligible for a Company-provided contribution to their Health Care FSA if they elect certain medical coverage. If you are eligible, this benefit will be reflected on your Confirmation of Enrollment.

[4] Some states require employees to pay for state short-term disability coverage. Check with your local Human Resources department. Enrollment is automatic in these states.

[5] Payment of retiree life insurance premiums varies between Hilton and the retiree depending on the terms of the policy at the time of retirement.

[6] These benefits are only available to Non-Variable Hour Team Members.

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Coverage	Employer Pays	You Pay	You and Employer Pay	You Pay Pre- or After-Tax[1]
■ Business Travel[6]	X			N/A
Group Legal[6]		X		After-Tax

Pre-Tax vs. After-Tax

As shown in the chart above, you pay for coverage under certain benefits with pre-tax dollars deducted from your paycheck each pay period. Using pre-tax dollars reduces your taxable income for federal, Social Security and (in most cases) state income tax purposes, making more of your paycheck available for you and your family. Using pre-tax dollars to pay for Plan benefits will not, however, reduce your coverage level for any Plan benefit that is based on your income (e.g., your coverage level of basic life insurance).

You pay for coverage under other benefits on an after-tax basis. This means that you pay for the cost of coverage with your already-taxed dollars (your take-home pay). Your after-tax contributions are also deducted from your paycheck each pay period. IRS rules determine how each benefit you receive is taxed.

If Hilton pays for your life insurance benefits, your coverage is tax-free if your coverage does not exceed $50,000. If Hilton-provided coverage exceeds $50,000, you are taxed on the cost of the coverage over $50,000, which is added to your Form W-2 for tax purposes.

Please note: Using pre-tax dollars can affect any Social Security benefits you may eventually receive. This is because you do not pay Social Security (FICA) taxes on pre-tax dollars. If you earn less than the Social Security "taxable wage base" ($137,700 for 2020) after making contributions to the Plan, your pre-tax contributions to the Plan will lower the portion of your wages that is subject to Social Security taxes. As a result, your Social Security taxes will be lower, which may, in turn, cause your Social Security benefits to be slightly lower when you retire or if you become disabled. The amount of benefit reduction will depend on the amount of your pre-tax contributions and how long you participate in the Plan before you retire. If you have any concerns, or if you need additional information, contact your local Social Security Administration office or consult your financial advisor about the effects of your participation in the Plan.

Please note that coverage under the Plan is subject to payment of any required contribution unless, in the case of a child who is eligible for coverage pursuant to a QMCSO, payment of the required contribution is made by a state agency.

Remember that income tax laws change frequently, and these changes affect different individuals in different ways. Therefore, Hilton cannot assure you that it will be to your advantage to participate in the Plan.

Domestic Partners: Tax Implications and Other Information

If you choose to cover your domestic partner as a dependent under your medical, dental and/or vision coverage, there are important tax implications related to the cost of coverage of which you should be aware. While the Plan permits a domestic partner to be covered as an eligible dependent, the federal government has not changed its definition of dependent under Internal Revenue Code Section 152 to recognize domestic partners. Many domestic partners do not qualify as dependents for federal income tax purposes. Generally, to be a dependent for federal income tax purposes, your domestic partner must live in your home with you for the full tax year, be in a relationship with you that does not violate local law, be a citizen of the U.S. or a resident of the U.S. and, for your taxable year, be over 50% supported by you.

If your domestic partner does not qualify as your legal dependent, you must pay for your domestic partner's medical, dental and/or vision coverage on a post-tax basis. Accordingly, Hilton will include in your reportable income the value of any medical, dental and vision insurance coverage that you pay for on a pre-tax basis or that Hilton provides for such domestic partner. You will then be taxed on the amount reported. If you believe that your domestic partner meets the requirements to be a dependent for federal income tax purposes such

that income should not be imputed to you, please submit to the Hilton Benefits Center a completed Affidavit of "Dependency" for Tax Purposes. Copies of the Affidavit may be obtained from the Hilton Benefits Center.

Please note that you must make a similar determination with respect to your domestic partner's children.

You should check with your tax advisor for assistance in determining whether your domestic partner and/or their children are tax dependents under federal and/or state law.

REDUCING THE AMOUNT YOU PAY FOR MEDICAL COVERAGE

You can reduce the amount you are required to pay for medical coverage in 2020 by certifying that you have undergone a wellness status review as described below.

Wellness Review Credit*

The medical plans may offer prevention and wellness programs to reduce your risk of developing life-threatening illnesses. If you certify that you have undergone at least one of the following wellness reviews no later than December 1, 2020, you will receive a one-time a Wellness Review Credit of $300 applied toward the payment of your medical coverage premium for the 2020 Plan year.**

- You have undergone a complete physical examination by your primary care physician or other medically licensed practitioner qualified to conduct such examinations; or

- You have submitted to the following tests conducted by your primary care physician or other medically licensed practitioner qualified to conduct such tests: cancer screening (includes mammogram and colonoscopy) and prenatal screening (if applicable).

If you satisfy the credit requirements, your credit will appear as a reduction to your medical premium in your paycheck within10 weeks. Participation in the Wellness Review Credit program is voluntary and will not affect your health insurance eligibility.

** The Wellness Review Credit does not apply to all Team Members and may vary based on eligibility or location.*

*** Please note that the Plan enrollment materials will specify the ways in which you may certify your completion of the wellness review. In no case should you provide or submit any personal health care information directly to Hilton. Some Team Members who are represented by a bargaining unit may automatically receive the credit. Please contact your HR department for more details about eligibility.*

Participation

ENROLLMENT

When to Enroll

The Plan has four types of enrollment opportunities:

- Initial enrollment: You must enroll before your 91st day of eligible full-time employment if you are a Non-variable Hour Team Member *(see definition above*) and during the Administrative Period if you are a Variable Hour Team Member.

    - A newly hired Corporate Team Member must enroll in the Plan within the first 30 days of hire. If coverage is elected, medical, dental and vision coverage will be effective as of the first day of employment and paid on an after-tax basis through the 90th day of employment. Such coverage will be paid on a pre-tax basis starting on the 91st day of employment. Enrollment in Health Savings Accounts and Health and Dependent Care Flexible Accounts, as applicable, must be completed during the first 30 days of hire;
    however, contributions to Health Savings Accounts and Health and Dependent Care Flexible Accounts would begin on the 91st day. During the first 90 days of employment, contributions to Health Savings Accounts and Health and Dependent Care Flexible Spending Accounts will not be permitted. Corporate Team Members must elect Life, Accidental Death and Dismemberment, and Disability coverage during this 30-day period; however, coverage will not be effective until the 91st day of employment. All company-provided benefits under the Plan will start following the end of the 90-day waiting period.

- Annual Enrollment: During annual enrollment—you must enroll during the enrollment period designated in the enrollment materials;

- Changes During the Year: Within 31 days after you have a change in status or experience another event that allows you to make a mid-year election change (60 days may be allowed for very limited types of events related to state Medicaid assistance); and

- After-Tax "Grace Period" for Medical Coverage Only: You must enroll within 30 days after the expiration of certain enrollment periods described below.

How to Enroll

Upon becoming initially eligible and before each annual enrollment, you will receive enrollment information that will let you know how and when to enroll for coverage. To obtain medical coverage, you will be required to provide a valid Social Security number for yourself and each dependent that you wish to cover, as well as the date of birth for each covered person. While a Social Security Number is required for all dependents, newborns should be enrolled within the first 31 days of birth even if a Social Security number has not been provided for the child. Upon receipt of the Social Security number, you should input the number into the system on or before the newborn's first birthday. If you have additional questions about this process, please contact the Hilton Benefits Center.

The elections you make will stay in effect until you change them upon an event permitting a mid-year change in elections or during a subsequent annual enrollment period. If you transfer your employment to a new property (or if you are a Corporate Team Member and your address/zip code changes and the change impacts your available benefits), your coverage will be changed to the lowest cost plan offered to Team Members at your new address/zip code. However, you may be able to select other coverage, if you do so within 30 days of the address/zip code change. See the "Changing Coverage During the Year" section for information on mid-year enrollment and changes.

Annual Enrollment

Each fall, the Plan has an enrollment period for benefits for the following Plan year (January 1 –

December 31). You must review your annual enrollment materials to know whether you need to take action or not. Every year can be different. Most annual enrollments are "active," requiring you to take action and make elections in order to have coverage. Some annual enrollments are "passive," meaning some or all of your previous benefit elections will remain in effect and you will not be required to make elections in order to have coverage.

If you elected Supplemental and Dependent Life Insurance or Supplemental Accidental Death & Dismemberment Insurance for the prior Plan year, no action is required if you want to continue your current elections for the next Plan year. If you want to make changes to your elections for the following Plan year, you must take action during Annual Enrollment, or in accordance with the change in status event rules. This passive enrollment only applies to Supplemental and Dependent Life Insurance and Accidental Death & Dismemberment Insurance. You must make an election for all other coverages for each Plan year in which you wish to participate in these programs.

IMPORTANT: For the Health Care and Dependent Day Care FSAs and Health Savings Account (HSA), you will need to make an election for each Plan year in which you wish to participate in these programs. Your elections for these FSAs and HSA **will not** automatically continue from Plan year to Plan year, even if the annual enrollment is "passive" for other benefits.

During annual enrollment, you may elect coverage under any of the applicable benefit programs. The elections you make during annual enrollment generally take effect on the following January 1, the start of the new Plan year. See the "Coverage During Absences" section for special rules regarding annual enrollment while on an unpaid leave of absence.

During annual enrollment, you may have the opportunity to:

- Switch from one medical option or dental option to another (if several options are offered in your location), add or drop dependents, or decline or add medical (including prescription drug), dental or vision coverage for the next calendar year.
- With respect to the Health Care and Dependent Day Care FSAs, enroll for coverage and authorize the amount you want to deduct from your pay on a pre-tax basis, subject to certain maximums and IRS regulations.
- With respect to income protection—disability, life and accident coverage—you may be able to enroll for coverage (if not automatically provided) or increase or decrease the level of life insurance coverage for you or your dependents, subject to certain conditions. Certain other restrictions may apply. Please see the "Disability" and "Life and Accident" sections of this handbook for further details.

If you are on a leave of absence at the time of annual enrollment, your elections may be affected. Please see the "Paid and Unpaid Absences" section of this handbook for further details.

Special Exception When Adding Dependent(s) Does Not Affect Premium

- If you select family medical coverage during annual enrollment but mistakenly fail to include one or more of your dependents, you may add such dependent(s) to coverage, on a prospective basis only. In order for this exception to apply, adding such dependent(s) cannot cause an increase in your premium. No other changes are permitted in this circumstance, unless you experience one of the enumerated change in status events.

Medical Coverage Enrollment – After-Tax Basis

If you miss the deadline to enroll for medical coverage upon your initial eligibility or due to a mid-year event that allows you to change or enroll for medical coverage, you may still enroll for medical coverage only during the 30-day period that begins on the day immediately after your applicable enrollment period expires. Any enrollment during this additional 30-day period will be on an after-tax basis. You must contact the Hilton Benefits Center to enroll for coverage during this period. You will not be able to enroll electronically. If you timely enroll during this

"grace period", coverage will be effective on the day immediately following your enrollment.

Special Circumstances: Re-employment

If you leave Hilton and subsequently return to Hilton, the following rules will apply:

- You will be treated as a New Team Member (*e.g.,* subject to a new Initial Measurement Period) if:
  - Variable Hour Team Member: your period of no service lasted 13 weeks or longer; or
  - Non-Variable Hour Team Member: your period of no service lasted longer than 12 months.
- If you are reemployed less than 13 weeks (12 months if you are non-variable) following your employment termination, you will be treated as if your employment did not terminate and will again be offered coverage upon your return.
- If you are rehired within 30 days and within the same year, your prior elections will be reinstated if you are rehired into a benefits eligible position, but if you are rehired more than 30 days after you terminate, you will be eligible to make new elections. If you are rehired within 30 days but in the year following the year in which you terminated employment, you will need to make new coverage elections.

If you terminate and are rehired in the same year, special rules will apply to reimbursements from your Health Care Flexible Spending Account. For more information, see "How Your Flexible Spending Accounts Work" in the "Flexible Spending Accounts" section of this handbook.

Changing Coverage During the Year

As a general rule, you will be allowed to make coverage changes only if the event results in you, your spouse, or your dependents gaining or losing coverage eligibility under an employer-sponsored plan. Your change in coverage must be consistent with the event (sometimes called a "change-in-status" event or "life" event). For example; if you have a baby, you can change your level of medical coverage from employee only to employee plus family.

The Plan Administrator, in its sole discretion, shall determine whether an event permits an election change and, if so, whether the election change is consistent with the event, in accordance with rules established by the IRS.

Election Period for Changing Coverages and Effective Date of Coverage

If you experience an event permitting you to change any of your health and welfare coverages, you must notify the Hilton Benefits Center and make your election changes within 31 days after the event (60 days for a loss of eligibility for Medicaid or State Child Health Plan or a gain of eligibility for premium assistance under Medicaid or State Child Health Plan), or any longer period specified in the table below. If timely made, coverage changes made due to a mid-year event are generally effective on the first of the month following a timely election change. Three exceptions are:

- For enrollment of a child pursuant to a QMCSO, coverage will be effective as soon as administratively possible after the Plan Administrator determines the QMCSO is valid;
- For HIPAA special enrollment of a child as a result of birth, adoption or placement for adoption, coverage will be effective as of birth or the date on which you acquired the child; and
- For coverages that require you or your dependent, as applicable, to satisfy EOI, coverage will be effective on the later of the first day of the month following a timely election change or the day on which the insurance company approves your EOI. If you are on a leave of absence when the insurance company approves your EOI, coverage will be delayed until the day you are actively at work subject to the rules in the "Coverage During Unpaid Absences" section in the Participation chapter.

Participation

If you do not make a timely election, you will not be able to make a mid-year election and will have to wait until annual enrollment (or a subsequent election change event) to make any election changes.

The Plan reserves the right to require, at any time, appropriate documentation of your change in status or other event.

Important Notes Regarding Mid-Year Election Changes

- If you experience a change in status that allows you to decrease your Health Care FSA contributions, you cannot make an election change that will result in decreasing your annual contribution amount below what you have already contributed through the date the change will become effective. For example, if you elect an annual contribution amount of $1,000 and have contributed $600, you cannot elect to decrease your annual contribution amount to $500.

- For changes in status resulting in either you or a dependent becoming ineligible, coverage automatically ends as of the event resulting in your or your dependent's ineligibility (except that health coverage extends through the end of the month for dependents losing eligibility due to reaching age 26). The mid-year election change will stop the premium deduction that relates to the cost of coverage.

- If you become divorced or legally separated or a dependent child is no longer eligible for coverage, your spouse or child will lose eligibility for medical coverage under the Plan on the day the event occurs (except that coverage extends through the end of the month for dependents losing eligibility due to reaching age 26). Please see "Medical Coverage Continuation Rights (COBRA)" later in this section for more information on COBRA for such individuals.

- Certain HIPAA special enrollment rights require that you decline enrollment in the Plan due to other coverage in order to be eligible for enrollment due to a later event. The types of events to which this requirement applies are marked in the table further below titled "Allowable Mid-Year Change Events".

- Even if your spouse or dependent do not have a Social Security number at the time of the mid-year change, you must contact the Hilton Benefits Center to make your election changes within 31 days after the event (60 days for a loss of eligibility for Medicaid or State Child Health Plan or a gain of eligibility for premium assistance under Medicaid or State Child Health Plan), or any longer period specified in the table further below titled "Allowable Mid-Year Change Events". If you do not make a timely election, you will not be able to make a mid-year election and will have to wait until Annual Enrollment (or a subsequent election change event) to make any election changes. You must provide the Social Security number of your spouse and dependent, as applicable, in accordance with the instructions provided by the Hilton Benefits Center.

Participation

Paid and Unpaid Absences

As noted above, the beginning of an unpaid absence is a change in status permitting election changes. To assist you in determining whether your furlough or leave of absence is paid or unpaid, triggering your right to make an election change, the following chart identifies which leaves of absences or furlough periods (sometimes referred to as an "LOA" or "Furlough") will be considered paid and unpaid.

Paid Absence[1]	Unpaid Absence
▪ Family and Medical Leave Act (FMLA) plus paid time off ▪ Sick leave ▪ Bereavement ▪ Jury duty ▪ Leave subject to salary continuation[2] ▪ Involuntary military leave with pay differential[3] ▪ Furlough	▪ FMLA and no other income source ▪ FMLA and basic STD, buy-up and/or state mandated disability pay ▪ Non-FMLA medical leave without salary continuation ▪ STD with basic STD, buy-up and/or state mandated disability pay ▪ Personal leave of absence and no other income source ▪ Voluntary military leave[3] ▪ Furlough

[1] If any of these paid LOAs become unpaid, election changes may be made.

[2] The Salary Continuation Program is available to corporate Team Members only.

[3] Continuation of elective disability, life insurance and AD&D coverages are subject to the terms of insurance policies and Hilton's military leave policy and may not continue during a military leave. Please contact the Hilton Benefits Center for details.

Coverage During Unpaid Leave of Absences and Paid or Unpaid Furloughs

In the event you qualify for an unpaid leave of absence under Hilton's leave of absence policy (like an FMLA leave or personal leave) or are on a paid or unpaid furlough, the following describes how your coverages may be impacted during your LOA or Furlough and what happens when you return from a LOA or Furlough.

Continue to Participate in All or Some of Your Coverages For the Same Plan Year	The coverages in effect when you begin your LOA or Furlough will automatically continue during your LOA or Furlough, provided any required contributions are timely made. You will be directly billed for coverage provided during your LOA or Furlough and will pay for your coverages with after-tax dollars.[1] As discussed in the Flexible Spending Accounts section, any YSA Card will be suspended during an unpaid LOA or Furlough. In addition, for an unpaid LOA or paid or unpaid Furlough you can choose to terminate any dependent child care election and spend down any remaining contributions for eligible expenses incurred while on leave. If you return from a LOA or Furlough and payment for coverage received during your LOA or Furlough is not received after the 30-day grace period for the second billing period expires, coverage will terminate retroactively to the beginning of the period for which payment was not made. If coverage terminates and you incur services during that period, your services will not be covered.
Terminate All or Some of Your Coverages	You may choose to terminate your participation in any of your coverages, as long as you make a timely election within 31 days of the beginning of your approved LOA or Furlough by notifying the Hilton Benefits Center. You must make election changes via YBR or by calling the Hilton Benefits Center if you wish to continue some, but not all, of your coverages during your LOA or Furlough. If you send payment for some, but not all, of your coverages without first dropping the coverages for which payment is not remitted, you will lose **ALL** coverage.

Participation

Return From LOA in Same Plan Year	When you return from a LOA or Furlough in the same Plan Year, you will be enrolled in the following coverage: - any coverage in effect at the time of your return will continue upon your return at the same level unless you choose to drop **ALL** coverages within 31 days of your date of return.[2] - If your coverage dropped due to nonpayment during your LOA or Furlough, the elections in place at the time your LOA or Furlough began (for life and AD&D coverage, subject to evidence of insurability requirements).[3] When you return from a LOA or Furlough, your payroll withholding will begin for the coverage in effect after your return. However, you must also make payment on an after-tax basis for the portion of the month before your return if you continued your coverage through the end of the preceding month. Failure to remit that amount by the end of the applicable grace period will result in loss of coverage for the portion of the month before your return from **LOA/FURLOUGH**. If you do not pay for the portion of the month before your return by the end of the applicable grace period, you will have a gap in coverage and services incurred during that period will not be covered. If you have questions about the payment due, you should contact the Hilton Benefits Center for details. If annual enrollment occurs during your LOA or Furlough, your coverage may be affected as described below. Exceptions apply for the FSAs—please see the "Flexible Spending Accounts" section for more information.

Annual Enrollment During a LOA/Furlough and Return From a LOA/Furlough in Different Plan Year	If the annual enrollment period occurs while you are on a LOA or Furlough, you will be sent annual enrollment information and may make election decisions for the upcoming Plan year. It is your responsibility to ensure that Hilton has the most updated information for you during your LOA or Furlough period. If you fail to provide your contact information, Hilton will not be responsible for any consequences that may result from your failure to receive annual enrollment information. Any new elections for disability, life and accident coverages will be delayed until you return to work as an eligible Team Member or until you satisfy any required EOI, whichever is later.
	The elections you make during annual enrollment may or may not take effect in the following year as described below:
	- Your annual enrollment elections will become effective on the next January 1st, provided:
	  - you timely pay for your benefits for all months between annual enrollment and January 1st and for the January following annual enrollment,
	  - your coverage was dropped for nonpayment before annual enrollment but you timely pay for the benefits elected during annual enrollment in January, or
	  - you elect or default to no coverage following annual enrollment.
	- Your annual enrollment elections will NOT become effective on the next January 1st or thereafter, if:
	  - Your coverage is dropped for nonpayment between annual enrollment and January 1st, or
	  - Your coverage is dropped for nonpayment of the January contribution amount.
	However, you will not be allowed to add or increase the amount of your life, AD&D or disability coverages while you are on a LOA or Furlough. You must return to active work before you can elect to increase your coverage amounts.
	If you are eligible for annual enrollment but do not make any election changes or if your annual enrollment elections do not become effective under the rules above, your elections in effect at the time your LOA or Furlough began will be reinstated upon return from LOA or Furlough (except for the Health Care and Dependent Day Care FSAs).

Participation

	Health Care and Dependent Care FSA elections must be made within 31 days of your return from LOA/Furlough.
Other Mid-Year Events	If you also experience another event permitting a mid-year change in coverage during your LOA or Furlough period, such as a change in status and/or a HIPAA special enrollment event (discussed below), you may change your coverages in accordance with the rules for that event.
Unpaid Military Leave	Keep in mind that, subject to the terms of the underlying insurance policies, coverage (and your obligation to pay for coverage) will continue unless you drop coverage. If your coverage is no longer needed you must drop coverage as described above. If you continue coverage and later experience another event permitting a mid-year change in coverage during your leave, such as a change in status and/or a HIPAA special enrollment event (discussed below), you may change your coverages in accordance with the rules for that event. For more information regarding your rights under USERRA, please contact the Hilton Benefits Center.

[1] You must make election changes via YBR or by calling the Hilton Benefits Center if you wish to continue some, but not all, of your coverages during your LOA or Furlough period. If you send payment for some, but not all, of your coverages without first dropping the coverages for which payment is not remitted, you will lose **ALL** coverage.

[2] When you return from a leave of absence, your payroll withholding will begin for the coverage in effect after your return. However, you must also make payment on an after-tax basis for the portion of the month before your return. Failure to remit that amount by the end of the applicable grace period will result in loss of coverage for the period before your return from **LOA/FURLOUGH**. If you have questions about the payment due, you should contact the Hilton Benefits Center for details.

[3] If the coverage you had when you started your LOA or Furlough is no longer offered, you will be enrolled in the coverage deemed closest to your prior coverage. If you wish to elect different coverage, you must notify the Hilton Benefits Center within 31 days of your return from your LOA or Furlough to make the change.

Participation

Allowable Mid-Year Change Events

The following chart lists the election changes under the elective health and welfare programs that would be considered consistent with some of the events described above. In addition, enrollment in the disability and life coverages may be subject to additional EOI requirements. As noted above, the Plan Administrator, in its discretion, has the authority to determine whether an election change is permitted.

Event	Medical, Dental, Vision	Health Care FSA and Dependent Care FSA	STD Buy-Up and LTD	Life and Accident Insurance [1]
Marriage or Establishment of Domestic Partnership [2]	*If covered, you can add dependent, or you can drop coverage for yourself and dependents. If opted out, enroll self and dependent.*	*Health Care FSA--Start or increase contributions (does not apply for Domestic Partnership)* *Dependent Care FSA--Start or increase contributions if your spouse or domestic partner is a qualifying individual*	*Enroll for or drop Coverage*	*- Enroll or increase, drop or decrease supplemental life coverage, 1x annual earnings up to $1,000,000* *- Enroll spouse or domestic partner for dependent life coverage, 1 increment not to exceed $25,000* *- Enroll or increase, drop or decrease accident coverage*
Divorce; Legal Separation; Annulment; End of Domestic Partnership [2]	*- Drop spouse or domestic partner and any children who gain coverage under ex-spouse's/partner's plan* *- Enroll yourself and children for coverage if you lose other coverage under spouse's/partner's plan*	*Health Care FSA—Add, increase, decrease or drop contributions (does not apply for or Domestic Partnership)* *Dependent Care FSA—Add, increase, drop or decrease contributions*	*Add or Drop Coverage*	*- Enroll, increase, drop or decrease supplemental life coverage* *- Drop spouse or domestic partner and any children from dependent life coverage* *- Enroll or increase, drop or decrease accident coverage*
Birth; Adoption or Placement for Adoption; Child gains eligibility [2]	*Enroll or increase coverage for newly-eligible dependent (and any other dependents who were not previously covered under IRS "tag-along" rule).*	*Health Care FSA--Start or increase contribution* *Dependent Care FSA--Start or increase contributions if your new child dependent is a qualifying individual* *Drop or decrease contributions if spouse ceases to work following birth or adoption*	*Enroll for Coverage*	*- Enroll or increase supplemental life coverage* *- Enroll child for dependent life coverage* *- Enroll or increase accident coverage*

Participation

Event	Medical, Dental, Vision	Health Care FSA and Dependent Care FSA	STD Buy-Up and LTD	Life and Accident Insurance [1]
Death of Spouse, Domestic Partner, or Child [2]	*Coverage for that person ends* *Add coverage for dependents if coverage lost under deceased spouse's/partner's employer's plan*	*Health Care FSA — decrease contributions (does not apply for Domestic Partnership)* *Add or increase contributions if spouse dies* *Dependent Care FSA — Drop or decrease contributions if the deceased was a qualifying individual* *Add or increase upon death of spouse/partner*	*- Drop coverage* *- Enroll for coverage*	*- Enroll or increase, decrease or drop* supplemental life coverage* *- Full benefit payable to you under dependent life coverage* *- Drop or decrease accident coverage; possible benefit payable to you*
Loss of Child's Eligibility; Termination of Adoption Proceedings	*Coverage for that person ends*	*Health Care FSA — decrease contributions* *Dependent Care FSA — Drop or decrease contributions if the child was a qualifying individual*	*- Drop coverage*	*- Increase, decrease or drop dependent or supplemental life coverage* *- Drop or decrease accident coverage;*
Gain or Loss of Entitlement for Medicare or Medicaid	*Gain entitlement: Drop coverage for affected individual(s).* *Lose entitlement: Add coverage for yourself or that individual and other dependents.*	*Add, increase, drop or decrease*	*No changes*	*No Changes*
Gain Eligibility for premium assistance under Medicaid or State Child Health Plan [2]	*Elect coverage for self or dependent who has become eligible for premium assistance.*	*No changes*	*No changes*	*No changes*
Loss of Coverage due to Loss of Eligibility under Medicaid or State Child Health Plan [2]	*You may elect coverage for employee or dependent who has lost Medicaid or State Child Health Plan coverage.*	*No changes*	*No changes*	*No changes*
Court-Ordered Coverage for Child (QMSCO)	*As dictated by court order*	*Health Care FSA -- As dictated by court order* *Dependent Care FSA — No changes*	*No changes*	*No changes*

Participation

Event	Medical, Dental, Vision	Health Care FSA and Dependent Care FSA	STD Buy-Up and LTD	Life and Accident Insurance [1]
Loss of Outside Medical Coverage*[2] [3] *because: *- You or dependent lost eligibility;* *- You or dependent exhaust COBRA under another employer's group health plan;* *- Employer contributions toward the other group health plan terminate.*	*Elect coverage for self and affected dependents.*	*Health Care FSA - Start or Increase contributions* *Day Care FSA – No changes*	*No changes*	*No changes*
***Change in Employment Status or Coverage (other than a loss of coverage)*[2]** *- Start/end employment* *- Unpaid LOA* *- Change in worksite or home residence resulting in loss of coverage (e.g., leaving HMO service area)* *- Change from Variable Hour to Non-Variable Hour during an initial measurement period* *- Any other employment change resulting in loss or gain in coverage*	*You can add coverage for yourself and dependent(s), or you can drop coverage for yourself and dependent(s). If opted out, enroll self and dependent(s). For change in residence only, you may change coverage options.*	*Health Care FSA--Add, increase, drop or decrease contributions (does not apply for Domestic Partnership)* *Dependent Care FSA — Start, increase, decrease or end contributions if consistent with change*	*Make changes consistent with event.*	*Make changes consistent with event.*
***Change in spouse or dependent work schedule or employment status resulting in a loss of benefit coverage*[2] [3]**	*You may add coverage for yourself and any affected dependents*	*Health Care FSA; Add or increase contributions* *Dependent Care FSA – add, increase, drop or decrease contributions*	*Make changes consistent with event.*	*Make changes consistent with event.*

Participation

Event	Medical, Dental, Vision	Health Care FSA and Dependent Care FSA	STD Buy-Up and LTD	Life and Accident Insurance [1]
Significant[4] increases or significant decreases in cost of coverage (includes significant cost changes under your spouse's employer plan) Note: cost increase or decrease applies by plan (*e.g.,* an increase in medical does not allow changes in other plans)	*Significant decrease in cost of your coverage: you can enroll yourself and dependents in that coverage option.* *Significant decrease in cost of spouse's plan: you can drop yourself and dependents if you enroll in spouse's plan.* *Significant increase in cost of your coverage: you can select another coverage option providing similar coverage (e.g., change from the medical EPO option to an HMO option). If no option provides similar coverage, then you can drop coverage.* *Significant increase in cost of spouse's coverage: you can add coverage for yourself and your dependent(s).*	*Health Care FSA - no changes.* *Dependent Day Care FSA: election changed allowed only if the cost change is imposed by a dependent day care provider who is not your relative.*	*Make changes consistent with event.*	*Make changes consistent with event.*
Significant[4] Coverage Curtailment (With or Without Loss of Coverage) (e.g., a significant increase in the deductible, the copay or coinsurance amounts; elimination of your coverage option, or an HMO ceasing to be available in your area)	*Select another coverage option providing similar coverage. If no option provides similar coverage, then you can drop coverage.*	*Health Care FSA - no changes.* *Dependent Day Care FSA - Add, increase, drop or decrease if your or your spouse's coverage is curtailed*	*Make changes consistent with event.*	*Make changes consistent with event.*
Addition or Significant[4] Improvement of Benefit Package Option	*Switch to the new or improved option if currently enrolled; if not enrolled for coverage, you can elect coverage under the new or improved option for yourself and dependent(s).*	*Health Care FSA - no changes.* *Dependent Day Care FSA - No changes.*	*Make changes consistent with event.*	*Make changes consistent with event.*
Addition or Significant [4] Improvement of Benefit Package Option under your spouse's plan	*You may drop coverage for yourself, spouse and/or dependent(s) who become covered under new/improved option under spouse's plan*	*Health Care FSA - no changes* *Dependent Day Care FSA - Drop or decrease if coverage added or increased under spouse's new option*	*May drop coverage if coverage added under spouse's new option*	*May drop coverage if coverage added under spouse's new option*

Participation

Event	Medical, Dental, Vision	Health Care FSA and Dependent Care FSA	STD Buy-Up and LTD	Life and Accident Insurance [1]
Loss of coverage under any group health coverage sponsored by a governmental or educational institution.	*You may elect coverage for the individual who has lost such coverage.*	*Health Care FSA - no changes.* *Dependent Day Care FSA - No changes.*	*No Changes*	*No Changes*
You gain eligibility for another employer's plan	*You may drop coverage for yourself and dependents*	*Health Care FSA - no changes.* *Dependent Day Care FSA - You may add, increase, drop or decrease contributions*	*You may make changes consistent with the elections made under the other employer plan. Proof of elections may be required.*	*You may make changes consistent with the elections made under the other employer plan. Proof of elections may be required.*
Open Enrollment Period for other Employer Plan Differs from the Hilton Plan's and period of coverage is not on a Calendar Year	*You may make changes consistent with the elections made under the other employer group health plan. Proof of elections may be required.*	*Health Care FSA - no changes.* *Dependent Day Care FSA - Add, increase, drop or decrease contributions.*	*You may make changes consistent with the elections made under the other employer plan. Proof of elections may be required.*	*You may make changes consistent with the elections made under the other employer plan. Proof of elections may be required.*
Other Employer's Plan Allows Changes for Any Event Listed in this Chart *The election change must be on account of and correspond with the change in coverage under the other employer's plan. In addition, either (1) the plan of the other employer must permit elections specified under the Regulations and an election must actually be made under such plan; or (2) the employee's plan must permit elections for a period of coverage different from that under the other employer plan ("Election Lock" rule).*	*You may decrease or revoke election for yourself and dependents if you or your dependents have elected or received corresponding increased coverage under other employer plan.*	*Health Care FSA - no changes.* *Dependent Day Care FSA - Add, increase, drop or decrease contribution.*	*You may decrease or revoke election for yourself and dependents if you or your dependents have elected or received corresponding increased coverage under other employer plan.*	*You may decrease or revoke election for yourself and dependents if you or your dependents have elected or received corresponding increased coverage under other employer plan.*

Participation

Event	Medical, Dental, Vision	Health Care FSA and Dependent Care FSA	STD Buy-Up and LTD	Life and Accident Insurance [1]
Change in Employment Status from Non-variable Hour to Variable Hour. *Allowed if: (i) t*he employee has been in an employment status under which the employee was reasonably expected to average at least 30 hours of service per week and there is a change in that employee status so that the employee will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the employee ceasing to be eligible under the Plan; and (ii) for changes to medical coverage, the revocation of the election of coverage under the Plan corresponds to the intended enrollment of the employee and any related individuals who cease coverage due to revocation in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.	*Medical only: You may drop coverage for yourself and your dependents, provided that you enroll in another plan that provides minimum essential coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.* *Dental and Vision: No changes*	*No changes.*	*Drop coverage.*	*Drop coverage.*
Enrollment in a Qualified Health Plan [5] ***Allowed if:*** *(i) the employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and (ii) the*	*Medical only: You may drop coverage for yourself and your dependents, provided that you enroll in a Qualified Health Plan the day immediately following the last day of the original coverage.*	*No changes.*	*No changes.*	*No changes.*

Participation

Event	Medical, Dental, Vision	Health Care FSA and Dependent Care FSA	STD Buy-Up and LTD	Life and Accident Insurance [1]
revocation of the election of coverage under the Plan corresponds to the intended enrollment of the employee, and any related individuals who cease coverage due to revocation, a Qualified Health Plan with the new coverage effective no later than the day immediately following the last day of the original coverage.				

[1] *Conversion rights may apply for certain events. Check with the applicable insurance carrier.*
[2] *If you have a HIPAA special enrollment right, you and your eligible dependents may enroll in the benefit options under the plan that you and your eligible dependents are eligible for, provided the change in coverage level is consistent with the event.*
[3] *For the HIPAA special enrollment right to apply, you must have declined Plan medical coverage because of the outside coverage.*
[4] *Whether a change is "significant" is determined in the sole discretion of the Plan Administrator.*
[5] *A "Qualified Health Plan' means an insurance policy that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements, including having a certification by each Marketplace in which it is sold.*

Participation

WHEN COVERAGE ENDS

Your Coverages

Your coverages end upon the first of the following to occur:

- Your employment with Hilton ends (e.g., you retire, quit or are terminated);
- You are no longer eligible to participate (e.g., you do not work, on average, 30 hours per week);
- You fail to timely pay your required contributions;
- You elect to terminate coverage;
- You go out on strike or are locked out;
- You knowingly make, or cause or permit to be made, false statements in order for you or another person to obtain Plan services or payment to which you or the other person are not entitled;
- Hilton terminates the benefit program in whole or in part; or
- Hilton terminates coverages for the eligible class to which you belong.

Termination of your coverages will be effective on the day the triggering event occurs. For example, if your employment with Hilton ends on May 17, your coverages will end on that same day. As of May 18, you do not have coverage, subject to your COBRA and life insurance conversion or continuation rights.

Your Dependent's Coverage

Your dependent's coverage ends upon the first of the following to occur:

- You fail to submit requested documentation of dependent status in connection with a dependent coverage verification;
- When your coverage ends; or
- Your dependent no longer meets the eligibility requirements.

Termination of coverage due to attaining age 26 is effective on the last day of the month that includes the dependent's 26th birthday.

If you intend to leave Hilton, be sure to check with the Hilton Benefits Center about your benefit status as soon as possible. In addition, you or your dependent may be able to elect COBRA coverage for continued medical, dental or vision coverage after coverage ends or you may convert certain life insurance coverages to individual policies if you no longer qualify for group coverage through the Plan.

ADMINISTRATION

Administration

COORDINATION OF BENEFITS

The following Coordination of Benefits (COB) rules are intended to supplement any COB provisions contained in the benefit booklet or insurance certificate issued by the Claims Administrator or insurer. These rules and the benefit booklet provisions should be read together, but in the event of a conflict the terms of the benefit booklet will govern.

This COB provision applies when you have health care coverage under more than one plan. Spouses who have primary insurance with another carrier (other than a government program) are not eligible for medical coverage under the Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the SPD, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network provider can bill you for any remaining coinsurance and/or deductible under the higher of the Plans' allowable amounts. This higher allowable amount may be more than the Plan's maximum allowable amount.

COB Definitions

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non group insurance contracts and Subscriber contracts; health maintenance organization (HMO) contracts; uninsured arrangements of group or group-type coverage; coverage under group or non group closed panel plans; group-type contracts; medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; limited health benefit coverage; benefits for non-medical components of long term care policies; hospital indemnity coverage benefits or other fixed indemnity coverage; school accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a primary plan or secondary plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including deductibles and coinsurance, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a provider by law or in

accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the provider may charge up to the higher contracted fee.

The following are not Allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement will be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the secondary plan to determine its benefits.
5. The amount of any benefit reduction by the primary plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and network provider arrangements.
6. The amount that is subject to the primary high-deductible health plan's deductible, if the Claims Administrator has been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 – Non-Dependent or Dependent**.** The Plan that covers you as an employee or retiree is the primary plan, and the Plan that covers you as a dependent is the secondary plan. However, if you are a Medicare beneficiary and, as a result of

federal law, Medicare is secondary to the Plan covering you as a dependent and primary to the Plan covering you as other than a dependent (e.g., a retired Employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an Employee or retiree is the secondary plan and the other Plan covering you as a dependent is the primary plan.

Rule 2 – Dependent Child Covered Under More Than One Plan**.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
   - the Plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
   - if both parents have the same birthday, the Plan that has covered the parent the longest is the primarypPlan.
2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   - If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   - If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
   - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of 1. above will determine the order of benefits; or
   - If there is no court decree assigning responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
     - The Plan covering the Custodial parent;
     - The Plan covering the spouse of the Custodial parent;
     - The Plan covering the non-custodial parent; and then
     - The Plan covering the spouse of the non-custodial parent.
3. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.
4. For a dependent child covered as a child of an employee and also covered as a spouse under the dependent's spouse's plan, the plan that has covered the dependent for the longest period of time is Primary.

Rule 3 – Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The Plan also covering you as a retired or laid-off employee is the secondary plan. The same would hold true if you are a dependent of an active employee and you are a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 – COBRA. If you are covered under COBRA or under a right of continuation provided by other federal law and are covered under another Plan, the Plan covering you as an employee, Member, Subscriber or retiree or covering you as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or other federal continuation coverage is the secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non- dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an employee or as a retired employee and is covered under his or her own Plan as an employee, member, subscriber or retiree); or (b) as a dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a dependent of an employee, member or subscriber or retired employee and is covered under the other plan as a dependent of an employee, member, subscriber or retiree). If Medicare coverage is in effect prior to the COBRA

coverage effective date, COBRA coverage can continue for up to 18 months. If Medicare coverage goes into effect after the COBRA coverage effective date, COBRA coverage will terminate.

Rule 5 – Longer or Shorter Length of Coverage. The Plan that covered you longer is the primary plan and the Plan that covered you the shorter period of time is the secondary plan.

Rule 6 – If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the primary plan.

Effect On The Benefits of This Plan

When a member is covered under two or more Plans which together pay more than this Plan's benefits, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is primary. However, when this Plan is secondary under the Order of Benefit Determination Rules, benefits payable by this Plan will be reduced by the combined benefits of all other Plans covering you or your dependent.

When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan. If this Plan is secondary, the combined benefits of this Plan and the other Plan will never exceed what would have been provided by this Plan if primary. No benefits will be provided by this Plan when the amount paid by the other Plan is equal to or greater than the amount this Plan would have paid if Primary.

If you are enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB will not apply between that Plan and other closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Claims Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts the Claims Administrator need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by This Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:

1. the Plan has paid or for whom the Plan have paid; or
2. any other person or organization that may be responsible for the benefits or services provided for the member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

This Plan will pay Benefits primary to Medicare for the following Medicare-eligible individuals:

- Subscribers with active current employment status age 65 or older and their spouses age 65 or older; and
- Individuals with end-stage renal disease, for a limited period of time.

The Plan will pay benefits second to Medicare when you become eligible for Medicare, even if you don't elect it under all other circumstances.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they

don't accept Medicare) will be the Allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total Allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

SUBROGATION AND REIMBURSEMENT

The following subrogation and reimbursement rules are intended to supplement any COB provisions contained in the benefit booklet or insurance certificate issued by the Claims Administrator or insurer. These rules and the benefit booklet provisions should be read together, but in the event of a conflict the terms of the benefit booklet will govern.

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of covered persons or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Beneficiary") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, workers' compensation, underinsured motorist, and medical payment provisions (collectively "Coverage").

Plan beneficiary, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Beneficiary agrees the Plan shall have an equitable lien on any funds received by the Plan Beneficiary and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan beneficiary agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Plan beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to reimburse the Plan for all benefits paid or that will be paid. If the Plan Beneficiary fails to reimburse the Plan out of any judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Plan beneficiary agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan beneficiary is entitled, regardless of how classified or characterized.

If a Plan beneficiary receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Plan beneficiary may have against any party causing the sickness or injury to the extent of such payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of the Plan Beneficiary commence a proceeding or pursue a claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the Plan.

If the Plan beneficiary fails to file a claim or pursue damages against:

a) the responsible party, its insurer, or any other source on behalf of that party;

b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

c) any policy of insurance from any insurance company or guarantor of a third party;

d) worker's compensation or other liability insurance company; or,

e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages;

then the Plan beneficiary authorizes the Plan to pursue, sue, compromise or settle any such claims in the Plan Beneficiary's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Beneficiary assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Beneficiary is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Beneficiary's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan beneficiary, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan beneficiary.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits shall be excess to:

a) the responsible party, its insurer, or any other source on behalf of that party;

b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

c) any policy of insurance from any insurance company or guarantor of a third party;

d) worker's compensation or other liability insurance company; or

e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages.

Wrongful Death Claims

In the event that the Plan beneficiary dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

It is the Plan beneficiary's obligation to:

a) cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

b) provide the Plan with pertinent information regarding the sickness, disease, disability or injury, including accident reports, settlement information and any other requested additional information;

c) take such action and execute such documents as the Plan may require to facilitate

enforcement of its subrogation and reimbursement rights;

d) do nothing to prejudice the Plan's rights of subrogation and reimbursement;

e) promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

f) not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan beneficiary may have against any responsible party or Coverage.

If the Plan beneficiary and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Beneficiary.

Offset

Failure by the Plan beneficiary and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Plan Beneficiary satisfies his or her obligation.

Minor Status

In the event the Plan Beneficiary is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

LIFE INSURANCE AFTER YOU LEAVE

This section provides a brief description of the conversion, portability, and continuation rights you may have for certain insured benefits. For more information about your rights, as well as terms, limitations and restrictions, please refer to your certificate of coverage for the specific insured benefit.

Conversion Rights

These rights apply to employee basic and supplemental life insurance; and dependent life insurance. You or your dependent may convert to an individual policy if you cease to be employed by Hilton, you become ineligible for coverage, or group life insurance (limited rights apply in this circumstance) is terminated under the Plan. To timely convert to an individual policy, you or your dependent must apply for conversion with the appropriate insurance company listed in the "General Information" section at the end of this handbook and pay the first premium within 31 days after your coverage ends.

Portability Rights

These rights apply to employee basic life insurance, supplemental life insurance and dependent life coverage. If you have basic life insurance coverage or supplemental life insurance coverage (including dependent coverage) and your coverage ends, you may elect to continue group coverage for yourself and/or your dependent under a portability plan by paying the premiums due directly to the insurance company instead of converting the coverage to an individual policy. You must apply within 31 days after your coverage ends. Generally, your portability rights are in lieu of your conversion rights

Administration

Continuation Rights—Minnesota Residents

If you are a Minnesota resident, you may elect to continue your or your dependent's life insurance for a certain period following certain terminations from employment. You will have a 60-day period during which to make the election. Please contact the insurance company for more details.

HEALTH CARE COVERAGE CONTINUATION RIGHTS (COBRA)

COBRA

A federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) allows you and your covered dependent (including your covered spouse, child, domestic partner or child of your domestic partner) to continue your medical, dental and vision care, EAP benefits and Health Care FSA coverage (on an after-tax basis) in certain situations when coverage would otherwise end. Upon a qualifying event (described below), you and your covered dependents may be able to continue these coverages. If otherwise eligible, you and each of your covered dependents have an independent right to elect COBRA continuation coverage.

Although your eligibility may end for the reasons stated in the "Participation" section above, you and your dependents may continue using EAP benefits for the shorter of (i) 18 months following termination of your employment or (ii) the date you (or they) obtain coverage under another employer sponsored medical plan.

When to Elect COBRA

If you and/or your dependents choose continuation coverage through COBRA, you and your covered dependents are offered coverage on the same basis as other participants, except you or your affected dependents pay the entire cost plus a 2% administrative fee (or a 50% administrative fee in the case of an 11-month extension due to disability). COBRA coverage is intended to extend the coverage that is in effect for you and your covered dependents on the day before your qualifying event. COBRA coverage does not create new classes of covered individuals. To be eligible for continuation of coverage, Hilton provided health care coverage must be in effect on the date before the qualifying event. For your dependents to be eligible for continuation of coverage, they must also be enrolled for coverage on the day before the qualifying event.

As noted above, if you elect COBRA coverage, you will receive the same coverage that was in effect on the day before the qualifying event. However, you may change your coverage choices during the annual enrollment period that falls during your COBRA continuation coverage period. If your covered dependents elect COBRA, these same rights apply.

COBRA coverage takes effect on the date coverage is lost on account of the qualifying event if a timely election is made. While Hilton will notify its COBRA Administrator of your qualifying event in the case of your termination from employment (or service, as applicable), reduction in hours or death, it is your (or your covered dependent's) responsibility to notify the COBRA administrator of any other qualifying event (e.g., divorce, termination of domestic partnership, child reaching age 26). In addition, you may add a newborn or an adopted child during the COBRA continuation period in accordance with the HIPAA "special enrollment" rules outlined earlier. Your newborn or adopted child's coverage begins immediately.

Reporting a Qualifying Event

You or your affected covered dependent must notify the Hilton Benefits Center either in writing or orally within 60 days after the date on which coverage is lost on account of any of the following qualifying events:

- You divorce or become legally separated, or your domestic partnership ends;
- Your child no longer meets the definition of a dependent (e.g., due to age limit); or
- You (or your covered dependent) are determined to have been disabled under the Social Security Act when coverage ended or at any time during the first 60 days of receiving COBRA continuation coverage.

When you or your affected covered dependent contact the Hilton Benefits Center, be sure to inform the Hilton Benefits Center of the specific event, the date of the event and who is affected.

Administration

Please note that you may be required to provide documentation concerning the qualifying event.

The COBRA Administrator sends you and/or your affected covered dependent a notice and election form, including the cost of coverage, within 14 days of receiving this notification.

Hilton informs the COBRA Administrator within 30 days of the loss of your coverage on account of any of the following qualifying events:

- Reduction in hours that makes you ineligible for coverage;
- You are laid off;
- You do not return from an FMLA leave of absence;
- Your termination of employment (or service, as applicable) for any reason other than gross misconduct;
- You become entitled to Medicare; or
- Your death.

The COBRA Administrator sends you and/or your affected covered dependents a notice and election form, including the cost of coverage, within 44 days after one of these qualifying events occur.

Snapshot of COBRA Coverage

Here is a snapshot of who is eligible for COBRA continuation coverage, under what circumstances, and how long COBRA continuation coverage continues for health care coverage. If one of the events listed in the chart occurs, you and your enrolled dependents may apply for COBRA coverage.

Qualifying Event	Who Is Eligible for COBRA	Maximum COBRA Period*
Termination of your employment (or service, as applicable) for any reason except gross misconduct	You and your enrolled dependents	18 months
Reduction in hours of employment (including a military leave of absence)**	You and your enrolled dependents	18 months
You become laid off	You and your enrolled dependents	18 months
You do not return from an FMLA leave of absence	You and your enrolled dependents	18 months
You or your covered dependent becomes disabled	You and your enrolled dependents	18 months up to 29 months***
Your death	Your enrolled dependents	36 months
Divorce, legal separation or termination of domestic partnership (unless a QMCSO provides otherwise)	Your enrolled dependents	36 months
Your child no longer meets the definition of dependent under the Plan	Your covered dependent	36 months

**The maximum COBRA period is measured from the date you lose coverage on account of the qualifying event. If your qualifying event is termination of employment or reduction in hours of employment and you became entitled to Medicare less than 18 months before the date coverage ended, the maximum COBRA period for your enrolled dependents lasts until 36 months after the date you became entitled to Medicare. If eligible for COBRA under the Health Care FSAs, the maximum COBRA period is through the end of the calendar year in which the qualifying event occurs. See "Health Care Flexible Spending Account" below for details.*

***Note that in the event you become entitled to COBRA coverage due to a loss of coverage triggered by a military leave of absence covered by the USERRA, you will receive continued coverage at the same cost paid by active Team Members for the first 30 days of your military leave. Also, your continuation coverage period is 24 months, not 18 months.*

****See "COBRA Coverage for Disabilities" below for details.*

Administration

Deciding Whether or Not to Continue Coverage

You have 60 days from the day coverage would otherwise end (or from the day the notice is sent to you, if later) to choose continuation coverage.

In order to continue your health care coverage, you and/or your covered dependents must pay the full cost of coverage, plus a 2% fee for administrative costs (or a 50% administrative fee in the case of an 11-month extension due to disability).

Your first payment (due within 45 days of your election) must include your COBRA contribution for the entire period from the date coverage ended through the month of the payment. Subsequent contributions are due on the first of the month, whether or not you receive a bill. If the COBRA Administrator does not receive your monthly contribution within 30 days of the first of the month, coverage is canceled as of the last day of the month in which you paid a contribution. If you do not choose to continue coverage, you should make the appropriate election on the election form and return it to the COBRA Administrator. In that case, your health care coverage ends on the day on which the qualifying event occurred.

When Continuation Coverage Ends

Continuation coverage ends when any of the following events occur:

- You (or a covered dependent) reach the end of the applicable maximum COBRA period for coverage;
- You (or a covered dependent) do not pay a monthly contribution within 30 days of its due date;
- Upon you or your covered dependent's written request to cancel coverage;
- You (or a covered dependent) become entitled to Medicare after the COBRA event;
- You (or a covered dependent) subsequently become covered under another group medical or dental plan that does not contain a preexisting condition rule; or
- Hilton ceases to provide any group health plan coverage.

Please inform the Hilton Benefits Center of any changes in address or in personal circumstances so that you and your covered dependents can receive the necessary information concerning your rights to continuation of coverage. However, if you are already receiving COBRA, please contact the COBRA Administrator to update any changes in address or in personal circumstances.

COBRA Coverage for Disabilities

As shown in the chart above, COBRA coverage can be extended from 18 months up to 29 months if you (or another qualified beneficiary) are totally disabled when you (or the other qualified beneficiary) become eligible for COBRA coverage or become disabled during the first 60 days of COBRA coverage. Monthly contributions for continuation coverage increase to 150% (from 102%) of the monthly amount for each of the 11 additional months of continuation coverage. (Any covered dependents can also continue their COBRA coverage during this extension period.)

To be eligible for this extension, the individual must:

- Receive a determination of disability from the Social Security Administration (SSA) that the individual was disabled on the date coverage ended, or became disabled during the first 60 days of COBRA coverage, and
- Notify the Hilton Benefits Center prior to expiration of the original 18 month coverage period and within 60 days after the later of:
  - ✓ The date of the SSA's determination of disability; or
  - ✓ The date of the qualifying event.

If the SSA determines that the individual is no longer totally disabled, continuation of coverage will cease. The individual must notify the Hilton Benefits Center within 30 days of any such finding. Coverage will terminate on the earlier of the first day of the month that is at least 30 days after the SSA's findings or at the end of the 29-month period.

Administration

Health Care Flexible Spending Account

You and your covered dependents are also permitted to elect COBRA continuation coverage for the Health Care FSA upon a qualifying event, provided you have not received reimbursement for amounts that exceed the balance in your Health Care FSA as of the date the qualifying event occurs (i.e., you have not "overspent" your Health Care FSA). In this case, you would continue contributions on an after-tax basis. The COBRA rules discussed in this section are the same, except that the maximum period for which you may continue after-tax contributions to your Health Care FSA is the remainder of the Plan year in which the qualifying event occurs.

Administration of COBRA

If you have any questions about COBRA or if you are required to notify Hilton of any event to trigger Hilton's COBRA obligations, please contact the Hilton Benefits Center. Upon any required notification by you, the Hilton Benefits Center will contact the COBRA Administrator to send you any necessary paperwork. Alight Solutions has been engaged as the Plan's COBRA Administrator to assist with the sending and receiving of COBRA information, including the collection of COBRA premiums if elected by participants.

State Continuation Coverage

Certain states, such as California, provide for continuation coverage extending beyond the date your federal COBRA coverage ends. You should contact your insurer at the address listed in the coverage booklet provided by the insurer for more information. You may contact the Advocacy Team at 1-877-442-4772.

Other Coverage Options Besides COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

CLAIMS AND APPEALS

CLAIMS AND APPEALS

This section reviews what you need to do to file claims for the different benefit options in the Plan. If you have any questions about filing claims, please call the appropriate administrator or carrier as listed in the General Information section of this booklet.

What Is a Claim?

There are two general types of claims: a claim regarding eligibility or enrollment, and a claim for benefits.

Claim Regarding Eligibility or Enrollment. This is a claim involving eligibility under a benefit program or enrollment in a benefit program. The U.S. Appeals Committee, to which the Plan Administrator has delegated authority to decide eligibility claims, generally determines these types of claims. If you are denied disability or life coverage because you did not satisfy an insurance requirement for coverage (e.g., Evidence of Insurability), any inquiries or claims should be directed to the Claims Administrator (the insurance company for the coverage).

Claim for Benefits. A claim for benefits is the more common type of claim and is a request that benefits be paid under the applicable program or, with respect to the Health or Dependent Day Care FSAs, a request that expenses be reimbursed.

Do You Need to File a Claim?

You may or may not need to file a claim to receive benefits. For example, if you participate in an EPO or HMO benefit option, you will generally not need to file claims for medical coverage. For a CDHP medical coverage option or a PPO dental option if you receive in-network services, you do not need to file a claim—the provider should do that for you. However, if you receive non-network medical or dental services you will be responsible for filing your own claims.

For more information regarding the claims filing process see the coverage booklet or insurance certificate for your benefit option or contact the Claims Administrator as listed in the General Information section of this booklet. The following chart summarizes these requirements for the various benefit options. In the event of a conflict between the claim procedures below and those shown in the Claims Administrator's Coverage Booklet, the terms of the Coverage Booklet will control.

Timely Filing

You should make every reasonable effort to file claims promptly after you incur services. In most cases you have up to 12 months from the date of service to file your claim. Claims filed or received after 12 months are not generally eligible for payment.

If You Are a...	Do You Need to File a Claim?
Medical	
If you receive medical or prescription drug services from a network provider	No
If you receive medical or prescription drug services from a non-network provider	Yes*
Dental	
If you receive dental services from a network provider	No
If you receive dental services from a non-network provider	Yes*
Vision	
Network provider	No
Non-network provider	Yes*
Disability	

Claims and Appeals

If You Are a...	Do You Need to File a Claim?
STD participant	Yes
LTD	Yes, unless you filed an STD claim with the appropriate Claims Administrator. See the "Disability" Section of this chapter for details.
Life and Accident	
Life & Accident	Yes

**Unless your provider submits the claim on your behalf.*

IF A CLAIM IS DENIED

If your claim for benefits under the Plan is denied, you may have it reviewed in accordance with the following claims review procedures. The procedures will vary depending on the type of benefit claim it is.

Insured benefits of the Plan are listed below:

- Short-term disability
- Long-term disability
- Vision
- Life insurance
- Accidental Death & Dismemberment (AD&D)
- EAP
- Business Travel Accident

Denial of Insured Benefit Claims

If your claim for an insured or third-party benefit is denied under the Plan, you should refer to the applicable policy or Certificate of Coverage provided by the carrier, or contact the insurance carrier (see the General information section) for more information on the applicable claims procedures.

Denial of Non-Insured Benefit Claims

If the benefit is not provided through an insurance contract, you must file an appeal with the Claims Administrator (see the General Information section) if you choose to appeal the denial.

If your first level appeal is denied, you may choose to file a second level appeal (if applicable) with the Claims Administrator. *Contact the Claims Administrator listed in the General Information section to determine whether a second level appeal is allowed*. With the exception of medical claims for which an external review process may be applicable, the decision of the Claims Administrator is final.

Non-insured benefits of the Plan are listed below:

- Medical
- Prescription drugs
- Dental
- Health Care FSA
- Dependent Care FSA

Eligibility or Enrollment Claims Process

These procedures apply to claims for eligibility or enrollment in a benefit program.

Filing a Claim

If you believe that you or your dependent is eligible or entitled to enroll under the Plan or a specific benefit program, you may file a claim in writing with the U.S. Appeals Committee.

Initial Claim Decision

When a claim is received, the U.S. Appeals Committee must notify you of its benefit determination within 90 days of the receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. You will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.

The U.S. Appeals Committee will send you a written notice of an adverse determination. A denial of a claim will include:

- The reason(s) for the denial;
- References to the specific plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the plan's appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on appeal.

Appealing an Eligibility or Enrollment Claim Denial

If you (or your duly authorized representative) believe that a denial is incorrect, you may request a full review by the U.S. Appeals Committee within 60 days after your receipt of denial of your claim. In connection with your appeal, you or your representative may submit written comments, documents, records and other information relating to the claim. You also have the right to request copies of all relevant documents (free of charge). The relevant documents that must be made available to you include documents, records and other information that:

- Were relied on in deciding your claim;
- Were submitted, considered or generated in the course of deciding your claim; or
- Demonstrate that the decision complied with the Plan's administrative procedures or safeguards.

The U.S. Appeals Committee will furnish you with a written decision providing the final determination of the claim. The U.S. Appeals Committee's review will take into account all comments, documents, records and other information related to the claim, regardless of whether such items were considered in the initial claim decision. The U.S. Appeals Committee's decision on appeal usually will be made within 60 days after receiving your appeal, unless special circumstances require an extension of an additional 60 days. If the period is extended, the U.S. Appeals Committee will notify you in writing of the extension within 60 days of receiving your appeal. The U.S. Appeals Committee's decision on review will be final and binding on you, your dependents and any other interested party. Your appeal notice will include:

- The specific reason or reasons for the appeal decision;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that you have the right to request access to and copies of all relevant documents free of charge; and
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA following an adverse determination on appeal.

Group Health Plan Claims and Appeals

These procedures apply to the health care coverage programs (medical, prescription drug, dental, vision and Health Care FSA), which are all referred to as "medical benefit" claims. Some medical plan options are fully insured by an insurance carrier, while other options are self-insured by Hilton. With regard to the self-insured options, the coverage booklets made available by the insurance carriers or Claims Administrators online, or upon request (the "Benefit Summaries" or "Coverage Booklets") may provide more detail with regard to the applicable benefit Claims and Appeal procedures. The procedures set forth in the applicable Benefit Summary or Coverage Booklet will control. The separate HMO documents provided by the insurance carrier will govern the terms of the insured HMOs. Contact the insurance carrier directly to obtain Claims and Appeals information about the fully-insured HMO benefits. See the General information section for contact information..

Generally, the steps below describe your appeal procedures, regardless of the type of claim. A claim is not deemed "filed" for purposes of these claims review procedures until it is filed in accordance with the applicable claims filing procedures established by the applicable Claims Administrator (see General Information section) and it is received by the Claims Administrator.

The following provides additional detail about how your claims appeals are processed for all benefits that are not insured:

- Each level of appeal will be independent from the previous level (in other words, the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal)
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information. In addition, you have a right to request documents or other records relevant (as defined by ERISA) to your claim
- You cannot file suit in federal court until you have exhausted these appeals procedures

Step 1: Notice of denial is received from Claims Administrator. **I**f your claim is denied, you will receive written notice from the Claims Administrator that your claim

is denied. You will receive notice of the decision within 30 days of receipt of your claim. In addition, the Claims Administrator may request an extension of time in which to review your claim for reasons beyond the Claims Administrator's control. If the reason for the extension is that you need to provide additional information, you will be given 45 days in which to obtain the requested information. The time period during which the Claims Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the applicable information gathering period.

Step 2: Review your notice of denial carefully. Once you have received your notice from the Claims Administrator, review it carefully. The notice will contain:

a. The reason(s) for the denial and the Plan provisions on which the denial is based;

b. A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;

c. A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following a denial of your final appeal and a description of the external review process and how to initiate the review process. Note that external review applies only to medical claims that involve medical judgment or rescissions. External review does not apply to claims for eligibility and enrollment, dental, vision, or health care FSA; and
A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and that a copy of that rule, guideline or protocol will be provided free of charge upon request (not applicable to claims for eligibility and enrollment);

d. If the denial is based on a medical necessity, experimental treatment or a similar Plan exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request; and

e. If the claim was an urgent care claim, a description of the expedited appeal process. The notice may be provided to you orally; however, a written or electronic notification will be sent to you not later than three days after the oral notification.

Step 3: If you disagree with the decision, file a first level appeal with the Claims Administrator. If you do not agree with the decision of the Claims Administrator and you wish to appeal, you must file a written appeal with the Claims Administrator within 180 days of receipt of the Claims Administrator's letter referenced in Step 1. You should submit all information referenced in Step 2 with your appeal. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

Step 4: You receive a notice of the first level appeal from the Claims Administrator. If the claim is again denied, you will be notified by the Claims Administrator within the time period described in the Claims and Appeals Procedures Table, depending on the type of claim.

Step 5: Review your first level appeal notice carefully. You should take the same action you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Claims Administrator (see Step 2).

Step 6: If you still disagree with the Claims Administrator's decision, file a second level appeal with the Claims Administrator, if permitted. If you still do not agree with the Claims Administrator's decision and you wish to appeal, you must file a written second (and final) level appeal to the Claims Administrator within 60 days after receiving the first level appeal denial notice from the Claims Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

Step 7: Review your second level appeal notice carefully. If the Claims Administrator denies your second level appeal, you will receive notice within the time period described in the Claims and Appeals Procedures Table, depending on the type of claim. The notice will contain the same type of information that was referenced in Step 2 above, including your right to bring a civil action following a denial of your final appeal.

External Review Process for Medical and Prescription Drug Claims

External review is available for claims involving medical judgment or rescissions after you have exhausted internal review procedures. If you choose to request an external review, you must submit your request within four months after you receive a final decision from the Claims Administrator under the mandatory appeal process described earlier. The Claims Administrator will send your claim to an independent review organization. The independent review organization will then refer your case for review by a neutral, independent, board-certified physician with appropriate expertise in the area in question.

The independent review organization will make its determination on your claim within 45 days after your request and all necessary information have been submitted. Expedited reviews are available if your physician certifies that a delay in service would jeopardize your health. Expedited reviews will be decided within 72 hours of your request. Once the review is complete, the independent review organization will send the final determination letter directly to you. The Claims Administrator will abide by the decision of the external review organization.

Limitation of Legal Actions for All Self-Insured Benefits and Eligibility Claims

Neither the covered individual nor any beneficiary may take action against the Plan, the Plan Administrator, Plan fiduciaries, Hilton, or the Claims Administrators to recover benefits under the Plan or to enforce or clarify his or her rights under sections 502 or 510 of ERISA, or any other provision of law, whether or not statutory, until the Plan's claim and appeal procedures have been exhausted in their entirety. A claimant must file a civil action pertaining to a benefit claim within one year after the date the Claims Administrator has made a final determination of the claim or appeal in accordance with the Plan's internal claims review procedures, or should have been made in accordance with the Plan's internal claims review procedures. With respect to eligibility claims, a claimant must file a civil action pertaining to a claim within one year after the date giving rise to the eligibility claim occurred, *e.g.*, termination of active employment with Hilton.

Claims and Appeals Procedure Table

	Initial Claims			*First Level Appeal*		*Second Level Appeal*	
Type of Claim	***You will be notified of determination as soon as possible but no later than..,***	***Extension period* allowed for circumstances beyond Claims Administrator's control.,***	***If additional information is needed, you must provide within..,***	***You must file an appeal within..,***	***You will be notified of determination as soon as possible but no later than..,***	***You must file an appeal within..,***	***You will be notified of determination as soon as possible but no later than..,***
Medical Benefits (including Health Care FSA)							
Urgent Care	72 hours (24 hours if additional information is needed from you before a determination can be made)	None	48 hours (Claims Administrator must notify you of determination within 48 hours of receipt of your information)	180 days of claim denial	72 hours from receipt of appeal	N/A. Some Aetna options allow a second level of appeal for urgent care claims. See your Aetna Coverage	N/A Some Aetna options allow a second level of appeal for urgent care claims. See your Aetna Coverage Booklet for details.
Pre-Service	15 days from receipt of claim	One extension of 15 days	45 days of date of extension notice	180 days of claim denial	15 days from receipt of appeal (30 days for Anthem Blue Cross HMO)	60 days of 1st level appeal denial*	15 days from receipt of appeal*
Concurrent: To end or reduce treatment prematurely	Notification to end or reduce treatment will allow time to finalize appeal before end of treatment	N/A	N/A	Denial letter will specify filing limit	15 days from receipt of appeal	Denial letter will specify filing limit*	15 days from receipt of appeal*
Post-Service with only 1st level appeal*	30 days from receipt of claim	One extension of 15 days	45 days of date of extension notice	180 days of claim denial	60 days from receipt of appeal	N/A	N/A
Post-Service with 2nd level appeal	30 days from receipt of claim	One extension of 15 days	45 days of date of extension notice	180 days of claim denial	30 days from receipt of appeal	60 days of 1st level appeal	30 days from receipt of appeal*
Other							
- Eligibility and Enrollment; - Life Insurance; - AD&D; - Business Travel Accident; - Dependent Care FSA	90 days from receipt of claim	One extension of 90 days	45 days of date of extension notice	60 days of claim denial	60 days from receipt of appeal (with one 60-day extension beyond the Plan's control). You must submit requested documentation within 45 days	N/A	N/A

Disability Benefits	45 days from receipt of claim for LTD benefits 10 days for STD benefits.	Two extensions of 30 days each	45 days of date of extension notice	180 days of claim denial	45 days from receipt of appeal (with one 45-day extension beyond the Plan's control). You must submit requested documentation within 45 days	180 days of claim denial	45 days from receipt of appeal (with one 45-day extension beyond the Plan's control). You must submit requested documentation

* For fully-insured options, check your coverage booklet to determine whether second level appeals are offered.

MEDICAL COVERAGE

Medical Coverage

OVERVIEW OF YOUR MEDICAL COVERAGE

Your medical coverage is a key component of the Plan. This coverage is a group health plan and pays benefits for the treatment of an illness or injury and offers many features, such as mental/behavioral health coverage, preventive health care coverage, well-baby care and prescription drug coverage.

You may choose from one or more of the following medical coverage options offering both in and out of network care*:.

- Bronze Plus(with a Health Savings Account (HSA)
- Silver (PPO)
- Gold (PPO)
- Gold II (HMO, CA only)
- Platinum (PPO)

*Some available insurance carriers in CA, CO, DC, GA, MD, OR, VA and WA, offer an HMO plan that covers in network care only.

As you read about your coverage, keep the following in mind:

You have a choice as to how you wish to access and manage your health care through a PPO or HMO option with varying levels of member cost share.and HMOs offered vary depending on your location. When you enroll, you may choose any medical plan option that is available in the ZIP code area of your work facility (or your home ZIP code area if you are a corporate employee).

All medical coverage options cover similar medical expenses.

Generally, the options differ in the amount you pay for out-of-pocket expenses (deductibles, copayments and coinsurance) and in the way you may access medical care (through a primary care physician, network providers or non-network providers).

If you are eligible and elect medical coverage under an HMO option, care generally must be authorized and provided by the HMO's network to be covered. You may elect one of the different HMO options to best fit what you are looking for in a medical plan.

If you elect an HMO option, you and your covered dependents must choose a primary care physician. Only in-network benefits are covered under an HMO.

If you elect a PPO option, you and your covered dependents can choose to receive medical treatment from any health care provider or from a health care provider who has "contracted" with that carrier's network. The Plan pays significantly higher benefits when you receive care from a contracted provider.

Prescription Drug Coverage. If you elect one of the self-insured carrier options (Aetna, Anthem, Cigna or United), your coverage is provided through Hilton's prescription drug program described later in this section.

You may choose medical coverage for yourself and your eligible dependents under the following coverage levels:

- You Only
- You + Spouse
- You + Child(ren)
- You + Family

Coverage Booklets, Benefit Summaries, and Certificates for Medical Plans

Some medical plan options are fully insured by an insurance carrier, while other options are self-insured by Hilton. Regardless if an option is self-insured or fully-insured, coverage booklets are made available by the Claims Administrators online, or upon request (the "Benefit Summaries" or "Coverage Booklets") provide more detail with regard to covered expenses, plan limitations and exclusions, and other coverage information. See the General information section for how to access these booklets.

Hospital Admissions for Maternity

The Newborns' and Mothers' Health Protection Act requires medical plans to provide a minimum hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a cesarean section unless the attending physician, in consultation with the mother, determines a shorter hospital length of stay is adequate.

Medical Coverage

Post-Mastectomy Care

If you or a covered dependent is receiving benefits in connection with a mastectomy and you or your covered dependent elect breast reconstruction, the medical program options also cover, in a manner determined in consultation with the attending physician and the patient:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Coverage for prosthetic devices and reconstructive surgery is subject to the same copayments and deductibles as those established for other benefits under the medical program options.

Voluntary Medical Benefits

You may enroll in voluntary medical benefits if you are enrolled in medical coverage under the Plan or another major medical plan. If you elect to enroll in voluntary medical benefits, the premiums for the coverage are 100% paid by you on an after-tax basis. You may choose voluntary medical benefit coverage for you and your eligible dependents. The insurance documents provide further detail on coverage benefits as well as important exclusions, limitations, and requirements applicable to receive benefits.

Choice of Primary Care Provider

If your medical plan option generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in the medical plan option you have selected and who is available to accept you or your family members. If the Plan or insurance coverage designates a primary care provider automatically, then until you make this designation, the Claims Administrator designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Claims Administrator or, if you are a current member, your contact number on the back of your ID card.

If your medical plan option allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your medical plan option provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from your Claim Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your selected network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Claims Administrator or, if you are a current member, your contact number on the back of your ID card.

Diagnostic Testing for COVID-19:

Beginning March 18, 2020 and extending until further notice, the plan will cover the following without cost share (meaning deductibles, copays or coinsurance). Further, such coverage will not adversely impact HSA eligibility for those participating in an HAS.

- FDA approved diagnostic testing products (and certain other COVID testing products as required by the recently enacted Cares Act and agency guidance) to determine if you have COVID-19 or the virus that causes it (“Diagnostic Testing”) and the administration of that Diagnostic Testing. NOTE: This covers both kits and the associated lab-developed tests (LDTs); and
- Services or items furnished to covered individuals in an office setting, telehealth (i.e. other than in-person), urgent care, or emergency room that lead to an order for Diagnostic Testing and then only to extent such items or services relate to the implementation or administration of the

Diagnostic Testing or to evaluate the need for Diagnostic Testing.

Contact the Hilton Benefits Center or your carrier for further information. Treatment for a COVID-19 diagnosis will be subject to all other plan terms and conditions.

PRESCRIPTION DRUGS

THE PRESCRIPTION DRUG BENEFIT PROGRAM

Your prescription drug coverage is a key component of the Plan. Prescription drug coverage is included when you enroll in medical coverage under the Plan.

Even if you are familiar with this type of coverage, you should learn the details of some special provisions in this program to make the best use of your benefit.

How Much to Pay — Your Deductible and Co-payment

The table below provides an overview of the Plan's prescription drug coverage.

The prescription drug coverage does not have a deductible, except when provided under the Bronze High Deductible Health Plan (HDHP). However, you will continue to pay the cost-sharing amounts below until you reach the out-of-pocket. The applicable cost sharing will depend on which medical plan you enrolled in. The out-of-pocket maximum is combined with the medical plan.

Your choice, and your doctor's choice, will affect the amount you pay for your prescription:

Prescription Drug (Retail)

	Bronze Plus Plan (HDHP)	Silver Plan	Gold Plan	Platinum Plan
Generic	TM pays Annual Deductible ($2,450 individual/$4,900 family) plus 25% of the remaining cost per prescription after the applicable deductible is met. (Deductible and OOP Max are combined with medical)	$12 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $5,300 individual/$10,600 family is met.	$10 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $3,600 individual/$7,200 family is met.	$8 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $2,300 individual/$4,600 family is met.
Brand/Formulary	TM pays Annual Deductible ($2,450 individual/$4,900 family) plus 25% of the remaining cost per prescription after the applicable deductible is met. (Deductible and OOP Max are combined with medical)	$50 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $5,300 individual/$10,600 family is met.	$40 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $3,600 individual/$7,200 family is met.	$30 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $2,300 individual/$4,600 family is met.
Brand/Non-Formulary	TM pays Annual Deductible ($2,450 individual/$4,900 family) plus 25% of the remaining cost per prescription after the applicable deductible is met. (Deductible and OOP Max are combined with medical)	$70 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $5,300 individual/$10,600 family is met.	$60 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $3,600 individual/$7,200 family is met.	$50 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $2,300 individual/$4,600 family is met.
Specialty Medicines	TM pays Annual Deductible ($2,450 individual/$4,900	$12 for generic/ $50 for preferred brand/ $70 for non-preferred	$10 for generic/ $40 for preferred brand/ $60 for non-preferred	$8 for generic/ $30 for preferred brand/ $50 for non-preferred

	family) plus 25% of the remaining cost per 30-day supply of specialty medications through CVS Specialty. Visit CVSSpecialty.com to get started.	brand for a 30-day supply of specialty medicines. Visit CVSSpecialty.com to get started.	brand for a 30-day supply of specialty medicines. Visit CVSSpecialty.com to get started.	brand for a 30-day supply of specialty medicines. Visit CVSSpecialty.com to get started.
Plan pays 100% for eligible prescriptions once the annual prescription drug out of pocket (OOP) maximum is met. (Prescription drug OOP Max is combined with medical)				

Prescription Drug (Mail Order)

	Bronze Plus Plan	Silver Plan	Gold Plan	Platinum Plan
Generic	TM pays Annual Deductible ($2,450 individual/$4,900 family) plus 25% of the remaining cost per prescription after the applicable deductible is met. (Deductible and OOP Max are combined with medical)	$30 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $5,300 individual/$10,600 family is met.	$25 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $3,600 individual/$7,200 family is met.	$20 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $2,300 individual/$4,600 family is met.
Brand/Formulary	TM pays Annual Deductible ($2,450 individual/$4,900 family) plus 25% of the remaining cost per prescription after the applicable deductible is met. (Deductible and OOP Max are combined with medical)	$125 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $5,300 individual/$10,600 family is met.	$100 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $3,600 individual/$7,200 family is met.	$75 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $2,300 individual/$4,600 family is met.
Brand/Non-Formulary	TM pays Annual Deductible ($2,450 individual/$4,900 family) plus 25% of the remaining cost per prescription after the applicable deductible is met. (Deductible and OOP Max are combined with medical)	$175 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $5,300 individual/$10,600 family is met.	$150 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $3,600 individual/$7,200 family is met.	$125 co-pay per fill. Plan pays 100% for eligible prescriptions once the out of pocket maximum of $2,300 individual/$4,600 family is met.
Plan pays 100% for eligible prescriptions once the annual prescription drug out of pocket (OOP) maximum is met. (Prescription drug OOP Max is combined with medical)				

If the cost of your prescription is less than the co-pay, you will only pay the cost of the prescription.

NOTE: It is up to **YOU** to discuss the availability of a generic drug **before** the doctor writes you a prescription.

Recommended preventive services will also be covered without cost to you in accordance with the Patient Protection and Affordable Care Act (PPACA) and the regulations issued thereunder. For a list of recommended preventive services, required to be provided by PPACA, please visit the United States Preventive Services Task Force ("USPSTF") website, www.healthcare.gov/center/regulations/prevention/recommendations.html.

These services will change from time to time and any new services will not be effective sooner than the first day of the plan year that is 1 year from the date the new recommendation is added. Covered Services only include those recommended services provided in accordance with the guidelines

established for each recommended service by the USPSTF.

Women's preventive services are covered without cost to you as set forth in the Health Resources and Services Administrations Guidelines at http://www.hrsa.cov/womensguidelines/, including but not limited to counseling and coverage for contraceptives.

CVS Customer Care

Visit CVS/Caremark website, www.caremark.com, to view your plan design and co-payment information, search for details on your prescription medications, locate a participating pharmacy near you, and manage your home delivery prescriptions or to obtain a list of preferred and non-preferred medications. For additional Plan inquiries, you may call Customer Care directly at 1-855-311-3158.

Benefit ID Cards

CVS/Caremark will provide an initial benefit card upon enrollment in the plan. Present your ID card when filling a prescription at a Network Pharmacy. Should you need additional or replacement ID cards, please contact Customer Care at 1-855-311-3158 or visit www.caremark.com to either request a new card or print a temporary card.

Your Local CVS/Caremark Pharmacy

The CVS/Caremark system is a nationwide electronic network linked by computers to CVS/Caremark headquarters. Using this sophisticated system, the pharmacist submits your prescription drug claim in a few seconds, sending full information and usually with no written claim form.

When you give your business to an CVS/Caremark-affiliated pharmacy, you simply pay your co-payment when the prescription is filled, and there is no need to submit a written claim form. You must obtain prescriptions at a CVS/Caremark pharmacy, a pharmacy participating in the CVS/Caremark Network, or through CVS Specialty Pharmacy in order to receive prescription benefits through the health plan. If you elect to use a pharmacy that is not affiliated with CVS/Caremark, you will be required to pay the full cost of the prescription to the pharmacy.

Choosing a Generic or Brand-Name Drug

When the patent protection expires for a brand-name drug, other manufacturers may legally produce a generic equivalent. These generics, like their brand-name counterparts, are approved for safety and effectiveness by the Food and Drug Administration (FDA).

Increasing the usage rate of quality generic drugs is a safe and effective way for both you and the Plan to save money when prescription drugs are required.

CVS/Caremark's generic drug incentive program only addresses United States FDA rated class "A" generic drugs, which are widely accepted as bioequivalent to their brand-name counterparts by the medical and pharmacy communities. Though generic drugs are suggested whenever possible, it is your doctor who has complete control over the medication that should be dispensed.

CVS Specialty Pharmacy

All specialty prescriptions must be filled through CVS Specialty Pharmacy. Infused drugs cannot be purchased at a pharmacy. If a particular infused drug is available through CVS Specialty Pharmacy that drug must be purchased through the CVS Specialty Pharmacy program. If a particular infused drug is not available through CVS Specialty Pharmacy and such an infused drug is purchased from another source, the Plan will only cover the costs that the Plan would have paid had the drug been purchased through the CVS Specialty Pharmacy program and only if approved in advance by CVS.

Participation in the Specialty Pharmacy Program can be initiated by a phone call from the member or the physician. There are no mailers necessary for the CVS Specialty Pharmacy program. Most orders through CVS Specialty Pharmacy can be processed and shipped by overnight delivery within two days of receipt of the prescription from the physician. Orders require a signature for delivery and can be shipped to your home. Alternatively, you are able to request to have specialty prescriptions delivered to any CVS Pharmacy retail location, as this may be a more

convenient option. All orders receive necessary supplies to administer the drug at no cost.

Member initiates enrollment:

1. You call CVS Specialty Pharmacy customer service line (1-800-237-2767) and request specialty medication through the program.

2. Customer Service Associate will ask you for your ID number, address, day-time phone number, specialty drug, date of next fill, and physician name and phone number.

3. The CVS Specialty Pharmacy team will contact physician for prescription and initiate order processing.

4. If prior authorization is required, the Pharmacy team will follow predetermined Prior Authorization process for client to obtain the Prior Authorization.

5. After claim is processed, CVS Specialty Pharmacy will contact you to confirm copayments and arrange delivery (within two days of receiving prescription). If a copayment exists, payment will be required prior to shipping.

Physician initiates enrollment:

1. Physician calls CVS Specialty Pharmacy physician line (1-866-814-5506) for direct access to a pharmacist; or physician faxes prescription directly to the CVS Specialty Pharmacy at 1-800-323- 2445.

2. CVS Specialty Pharmacy team initiates order processing

3. Prior authorization is obtained if required.

4. You are contacted to confirm copayments and arrange delivery (within two days of physician's initial call).

Quantity Limits

The Plan may have certain coverage limits. For example, a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period. For more information, please visit www.caremark.com or contact Customer Care at 1-855-311-3158.

The Prescription Drug Authorization Process

The Prescription Drug Authorization Process applies:

- If you have been required in the past to receive Prior Authorization to obtain a prescription, injectable or infused drug;

- For any prescription that your pharmacist or CVS/Caremark indicates a requirement for Prior Authorization.

These are normally not routine prescriptions. You may talk with your pharmacist, physician, or call CVS/Caremark for information only. Clinical information for Prior Authorization review is accepted only from physicians or pharmacists, not from you.

Refill Process:

1. CVS Specialty Pharmacy team calls you 5-7 days prior to their next order.

2. If you are continuing on drug therapy, delivery of next order is arranged.

NOTE: All prescription drugs must be medically necessary and used in an appropriate manner in order to be covered under the Plan.

What's Included and What's Not Included

For an all-inclusive list of covered or excluded prescription drug benefits, please visit www.caremark.com or contact CVS/Caremark Customer Care to verify specific coverage.

Also note: Any Prior Authorizations currently in place will remain in effect until that prescription's Prior Authorization has expired. Physicians and pharmacists are advised how long the Prior Authorization is valid when the Prior Authorization is issued. If continued authorization is required after the expiration date, the physician or pharmacy must contact CVS/Caremark to request a new Prior Authorization.

Here's how the process will work:

- Your doctor must call CVS/Caremark toll-free at 1-800-294-5979 to request prior authorization. Early notification will avoid delays.

- Once CVS/Caremark receives the prior authorization request, the turnaround time for review is two business days or sooner.

- If the drug in question will be covered, CVS/Caremark will set up the Prior Authorization and the physician or pharmacist will be notified by return fax. If the drug is not covered, CVS/Caremark will notify the requesting physician or pharmacist

by return fax indicating why the drug is being denied. You will be mailed a notice of denial that will also explain how you can appeal this decision.

When You Have Questions

You will always want to discuss your prescription needs with your doctor during your office visit. If you have other questions, or forget exactly how to take your medicine or how your medicine will interact with other medicines you are taking, your local pharmacist can help. Pharmacists are well informed about prescription drugs, how often and how long to take each drug, possible side effects and so forth. Ask your pharmacist if you have any concerns about your prescription.

For any assistance or information about specific features of this prescription drug plan, please contact:

Customer Care Support: 855-311-3158

Web Support: www.caremark.com

DENTAL COVERAGE

Dental Coverage

OVERVIEW OF YOUR DENTAL COVERAGE

The Plan promotes preventive dental care and also provides benefits for corrective services. You may choose from one of more of the following dental options, available in your area.:

- Bronze
- Silver
- Gold
- Platinum (*offered only in some locations)*

You may choose dental coverage for yourself and your eligible dependents under the following coverage levels:

- You Only
- You + Spouse
- You + Child(ren)
- You + Family

Certificates of Coverage

Your dental plan options are fully insured by an insurance carrier. The separate Certificates of Coverage provided by the insurance carrier will govern the terms of the insured dental plans.

VISION COVERAGE

Vision Coverage

OVERVIEW OF YOUR VISION COVERAGE

Under the Plan, you can elect vision coverage as part of your overall health and wellness program for you and your eligible dependents. You may choose from one of more of the following dental options, available in your area:

- Bronze
- Silver
- Gold

You may choose vision coverage for yourself and your eligible dependents under the following coverage levels:

- You Only
- You + Spouse
- You + Child(ren)
- You + Family

Certificates of Coverage

Your vision plan options are fully insured by an insurance carrier. The separate Certificates of Coverage provided by the insurance carrier will govern the terms of the insured dental plans.

FLEXIBLE SPENDING ACCOUNTS

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts

OVERVIEW OF YOUR FLEXIBLE SPENDING ACCOUNTS

Hilton offers eligible Team Members a way to pay certain health care and dependent day care expenses with pre-tax dollars through two types of Flexible Spending Accounts (the "FSAs") — a Health Care FSA and a Dependent Day Care FSA. As you read about the FSAs, keep the following in mind:

- Each year at annual enrollment, you decide whether or not to use one or both of the FSAs and how much to contribute during the upcoming year. Because your contributions are not considered taxable, you may want to consider whether an FSA can help you pay less in taxes in an upcoming year.
- You make contributions to your FSAs through authorized pre-tax salary deductions. These contributions remain in your FSAs until you file an appropriate claim form for reimbursement or pay for health care expenses using the YSA Card (or until they are forfeited after the end of the year). After filing a claim form, you are reimbursed for eligible expenses with tax-free dollars from the appropriate FSA.
- If you have any money left in either FSA at the end of the year, you can submit claims incurred through March 15 of the following year (the "grace period") to be reimbursed from the prior year's balance.
- If, at the end of the year and its grace period, there are funds remaining in either FSA for which you do not submit a timely claim form, you forfeit those amounts as required by Internal Revenue Service (IRS) regulations.

A SNAPSHOT OF YOUR FLEXIBLE SPENDING ACCOUNTS

By using pre-tax dollars to pay certain eligible health care and dependent day care expenses, you may save some taxes each year. Here is a snapshot of the Health Care and Dependent Day Care FSAs.

	Health Care FSA	Dependent Day Care FSA
Eligible Expenses	Generally, medical, prescription drug, dental, vision and hearing expenses not eligible for reimbursement from any other source, but are otherwise tax deductible[1]	Eligible dependent day care expenses you incur while you and your spouse, if any, are at work
Qualified Dependents	Your eligible dependents under the Plan, whether or not they are covered under the other health care programs (excludes domestic partners) of Hilton	A child under age 13 Any dependent that is incapable of self-care that resides with you and that you claim as a dependent on your tax return
Minimum Annual Contribution	$260	$260
Maximum Annual Contribution	$2,700[2]	$5,000 ($2,500 if married, but file federal income tax return as a single individual)[3]

[1]If you elect a Limited Purpose FSA, only dental and vision expenses will be Eligible Expenses.

[2] Certain Team Members may be eligible for a company-provided contribution to their Health Care FSA if they elect certain medical coverage. If you are eligible, this benefit will be reflected on your Confirmation of Enrollment.

[3]To satisfy the requirements of federal law, Dependent Day Care FSA contributions made by highly compensated employees (those who earned over $125,000 in 2019) may be subject to a lower contribution limit.

Flexible Spending Accounts

HOW YOUR FLEXIBLE SPENDING ACCOUNTS WORK

If you decide to participate in one or both of the FSAs, the Plan Administrator will establish one or two accounts, as applicable, in your name. Your FSA is a bookkeeping account only; so no actual funds are segregated for this benefit. The Health Care and Dependent Day Care FSAs generally work in the same manner, but they are two separate accounts that are subject to some different rules and restrictions. In addition, amounts credited to your Health Care FSA may not be used to reimburse you for your dependent day care expenses, and amounts credited to your Dependent Day Care FSA may not be used to reimburse you for your health care expenses.

What You Need to Do

To make the FSAs work for you, follow these steps:

- Estimate your expenses

  Consider your estimate carefully because you forfeit any unused amounts left in your FSAs under the IRS's "use-it-or-lose-it" rule.

- Determine how much to contribute

  After you decide on the annual dollar amount (subject to each FSA's maximum) for your estimated expenses, you will make a separate election for each FSA.

- Incur expenses

  The FSAs reimburse enrolled participants for eligible expenses they or their dependents incur during the Plan year (January 1 through December 31) and until the following March 15 (the "grace period").

- Receive reimbursement

  You can use your Health Care FSA to pay for eligible health care expenses by using your YSA Card or by seeking reimbursement for expenses you paid directly. For eligible dependent day care expenses, you must pay the service provider and then seek reimbursement from your Dependent Day Care FSA. See "Using Your YSA Card" at the end of this FSA Section for more information about the YSA Card.

If You Terminate Employment

For the Health Care FSA, only the expenses incurred while you are an active Employee and contributing to the FSA are eligible for reimbursement, unless, with respect to the Health Care FSA only, you continue your participation through COBRA. (See "Medical Coverage Continuation Rights" in the "Participation" section of this handbook for more details.)

If you terminate employment and are rehired within the same year, special rules apply to your new Health Care FSA contributions. If when you terminated you had received reimbursements totaling more than you contributed for the year, any new contributions made when you are rehired will first be used to reimburse the Plan for the excess payments made to you earlier in the year.

If you terminate employment with Hilton and are immediately hired by either of the other employers participating in this Plan, you will not be treated as having terminated employment for purposes of the Plan.

If You Return from a Leave of Absence or Furlough

If you go on a paid leave of absence, your contributions to the Health Care FSA will continue. If you go on an unpaid leave of absence, you may continue contributions on an after-tax basis by submitting payments to the COBRA Administrator. By continuing contributions, expenses incurred during the leave will be reimbursable, if they are eligible expenses (Dependent Care FSA expenses are likely not reimbursable expenses if incurred during a leave but you may continue to access any remaining funds for any eligible expenses. See the Dependent Care FSA section below for more information.)

For the Dependent Day Care FSA you may continue to access your FSA funds for eligible dependent care expenses incurred in the same plan year as long as you are employed and have a positive Dependent Day Care FSA balance.

If you choose not to continue coverage in your FSAs during your leave of absence, upon your return you can choose to:

- ✓ Reinstate your per pay period deduction amount, or
- ✓ Adjust your per-pay-period deduction to meet

your elected annual contribution.

In either case, you will not be able to receive reimbursement from your Health Care FSA for eligible expenses incurred during your leave of absence (unless you elect COBRA coverage). As discussed below, any YSA Card will be deactivated during an unpaid leave.

If you begin your leave of absence in one plan year and return in a later plan year, you must make new FSA elections within 31 days of your return to work.

"Use-It-or-Lose-It" Rules

Tax laws require that all amounts that you contribute to your FSA during the year be used to reimburse eligible expenses that you incur during the same year. If you overestimate your expenses, the tax laws require that any unused pre-tax contributions be forfeited.

As an exception to this requirement, the FSAs offer a grace period that automatically extends the coverage period of all participants who are covered on the last day of the Plan year (December 31). You have until March 15 of the new year to **incur** claims for reimbursement from your prior year's FSA. Any claims or provider payments that cover expenses incurred during the grace period will be automatically paid out of the prior Plan year's account first and then, when that account balance is exhausted, the new Plan year account.

You have until April 30 of the next year to **submit** claims for reimbursement from your FSAs for eligible expenses incurred between the previous January 1 and December 31 and during the grace period. Once this deadline passes, you will forfeit any balance remaining in your FSA after all proper claims have been submitted and paid.

Uniform Coverage Rule

For the Health Care FSA, you are entitled to reimbursement for eligible expenses for the full amount of your annual election as of your first day of coverage. This is called the "uniform coverage rule". You will continue to be reimbursed for eligible expenses until your total reimbursements equal the annual amount you elected to contribute to your Health Care FSA.

The uniform coverage rule does not apply to your Dependent Day Care FSA. As you submit claims for eligible expenses, you will be reimbursed for all proper claims up to the actual amount that is credited to your Dependent Day Care FSA when the claim is received. If the balance in your Dependent Day Care FSA is less than the amount of a claim, the claim will be held and reimbursed after additional contributions sufficient to cover the claim have been credited to your Dependent Day Care FSA.

A Word About Taxes

FSA contributions reduce your taxable income – meaning you pay less in taxes. Your FSA contributions, as well as the money reimbursed to you, are not subject to:

- Federal income taxes
- Social Security (FICA) taxes
- In most cases, state and local income taxes[1]

Rules vary, and state and local tax laws are subject to frequent change. Please see the discussion "Pre-Tax vs. After-Tax" under "Cost of Coverage" in the "Participation" section of this handbook for a general discussion about the impact of reducing your taxable income by pre-tax contributions.

Health Care FSA vs. the Income Tax Deduction

Under current tax law, the types of expenses that can be reimbursed through your Health Care FSA are normally deductible on your federal income tax return if they exceed 7.5% of your adjusted gross income. When you use your Health Care FSA to reimburse these expenses, you give up the opportunity to take a tax deduction for these same items. Consult a professional tax advisor familiar with your personal situation for advice if you think your health expenses will exceed 7.5% of your adjusted gross income.

Dependent Day Care Account vs. the Income Tax Credit

Based on your income level, you can take a tax credit anywhere from 20% to 30% of your annual

[1] Not applicable to employees in New Jersey.

dependent day care expenses on your federal income tax return. These expenses are limited to $3,000 for a single dependent and $6,000 for two or more dependents receiving care.

You cannot use the Dependent Day Care FSA and the tax credit for the same expenses. The IRS reduces your available tax credit by $1 for each $1 of reimbursement you receive from such an account. However, you may be able to receive a partial dependent tax credit for expenses that are eligible for the tax credit and exceed the maximum amount allowed for reimbursement under the Dependent Day Care FSA.

There are some exceptions to this rule. The approach that offers you the better financial advantage will depend on your income and expenses. IRS Publication 503 (available at www.IRS.gov can provide you with information that you need to make a decision). Finally, you may want to get advice from your professional tax advisor to help you determine which method is better for you.

THE HEALTH CARE FSA

The Health Care FSA offers you an opportunity to pay for eligible expenses with pre-tax salary contributions that you allocate to this account. You may elect to make pre-tax salary contributions up to $2,700 to this account each year, unless your annual enrollment materials provide otherwise.

Eligible Dependents

You can use the Health Care FSA to reimburse your eligible dependents' health-related charges. This includes your spouse, children up to age 26, and any of your dependents eligible under the Plan as a Qualifying Relative or Qualifying Child, even if your dependents are not covered under the medical program.

However, note that you may only submit expenses for your domestic partner if your domestic partner qualifies as your dependent and satisfies the requirements of a Qualifying Relative. See "Domestic Partners: Tax Implications and Other Information" in the "Participation" section of this handbook for more information.

Reimbursable and Non-Reimbursable Expenses

The Health Care FSA reimburses you for many, but not all, health care expenses that are tax deductible. In general, you can receive reimbursement for expenses incurred for medical care, which includes amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, provided that they are not reimbursable from any other source and, if they are eligible for a tax deduction under IRS guidelines, you do not take the tax deduction. But, expenses incurred to merely benefit your general health or for personal reasons (such as cosmetic surgery, other than to correct or cure a deformity or correct a congenital abnormality) are not considered expenses for medical care. According to IRS regulations, services are "incurred" when you are provided with the medical care that gives rise to the medical expenses, and not when you are formally billed or charged for, or pay for, the medical care.

Remember that, except in the event you elect to continue your participation in the Health Care FSA through COBRA upon a qualified event, you must be contributing to your Health Care FSA in order to be eligible to be reimbursed for covered expenses. For example, if you stop contributing to your Health Care FSA due to a change in status event but are still covered as a Team Member under other benefits offered under the Plan, you will not be eligible to receive reimbursements from your Health Care FSA for expenses incurred after the date you stop contributing to the Health Care FSA. To learn more, contact Your Spending Account at the number set forth in the General Information section.

The following chart identifies just some examples of eligible and ineligible expenses. Other expenses not listed below may or may not be eligible for reimbursement. For those participating in the general purpose Health Care FSA, expenses incurred on or after January 1, 2020 for over-the-counter drugs or medicines will no longer need a prescription to be reimbursed from your Health Care FSA. Also, menstrual products (i.e., tampons, liners, and similar products) will be considered a medical care expense eligible for reimbursement from your Health Care FSA (subject to all other requirements, such as substantiation).

Flexible Spending Accounts

Reimbursable Expenses	Non-Reimbursable Expenses
Insurance deductibles and copay for office visits and prescriptions ▪ Charges that exceed reasonable and customary limits ▪ Acupuncture if treating a medical condition ▪ All out-of-pocket non-cosmetic dental expenses not covered by a benefit plan ▪ Hearing care expenses, including those for examinations and hearing aids, if not covered under the medical program or other source ▪ Vision care expenses such as examinations, treatments, eyeglasses and contact lens expenses and laser eye surgery not covered by a benefit plan ▪ Weight loss treatment (with the exception of food costs) associated with a diagnosed disease or ailment such as obesity or hypertension, prescribed by your doctor ▪ Expenses for medical treatments and procedures that are not covered by insurance ▪ Drugs available through prescription only and not covered by the medical program and not used for cosmetic purpose ▪ Over-the-counter medicines and drugs obtained by prescription and purchased to alleviate or treat physical injury or illness (such as antacid medicine, allergy medicine, pain reliever and cold medicines), but not medicines merely beneficial for general health ▪ Insulin purchased without a prescription	Cosmetic treatment or drugs (unless prescribed to treat a congenital defect or accident reconstruction), including: ▪ Hair loss treatments or transplants ▪ Face lifts ▪ Piercings ▪ Teeth whitening ▪ Health club memberships or exercise classes to promote general health ▪ Household help (even if recommended by your doctor because you are unable to do housework) ▪ Individual or group health or dental insurance premiums ▪ Nutritional supplements, vitamins, herbal supplements or “natural medicines,” which are merely beneficial to general health ▪ Weight loss programs or medications to promote general health ▪

THE LIMITED USE HEALTH CARE FSA

The Limited Use Health Care FSA is designed for you if you participate in a high deductible health plan and want to contribute to a health savings account (HSA). The Limited Use Health Care FSA is subject to the same contribution and eligibility requirements that apply to the Health Care FSA. However, the Limited Use Health Care FSA will only reimburse you for dental and vision care expenses not covered by the Plan.

THE DEPENDENT DAY CARE FSA

You can use the Dependent Day Care FSA to pay for some or all of the expenses you incur for the care of a child or adult dependent who resides with you and is incapable of self-care while you work.

However, to qualify as an eligible expense, all of the following must be true:

- Care for your dependent(s) must be necessary for you and your spouse, if any, to work, look for work, go to school full-time, or if your spouse, who lives with you, is incapable of self-care as defined by the IRS. In other words, expenses are not eligible if they are for services provided while you are out for the evening socially or on vacation.

- If the care is provided by a day care facility that cares for six or more individuals at the same time, the facility must be licensed and comply with all federal, state and local regulations governing day care centers.

- Your care provider is anyone other than the child’s parent or a person whom you claim as a dependent on your federal income tax return

(a relative who provides care must be at least age 19). In addition, you must provide your caregiver's name, address and Social Security number or taxpayer identification number when you file for reimbursement. You also must provide this information on your federal income tax return, unless your caregiver is a church or other religious organization.

If You Are Married

Under federal law, if you participate in the Dependent Day Care FSA and your spouse participates in a similar account through his or her own employer, your combined contributions to both accounts in a calendar year may not exceed $5,000 (a lesser limit may apply to highly compensated employees). This limit applies regardless of the number of dependents receiving care. If you and your spouse file separate income tax returns, the most each of you may contribute is $2,500. In addition, your Dependent Day Care FSA contributions may not exceed the annual income of the lower-paid spouse, if that amount is smaller than the benefit limits indicated above.

In general, you may not participate in the Dependent Day Care FSA if your spouse does not work outside the home. There are two exceptions: if your spouse does not work outside the home and is physically or mentally unable to care for himself or herself, or if he or she is a full-time student. In either of these cases, for purposes of calculating the contribution limit, the IRS considers your spouse's earned income to be:

- $250 a month ($3,000 a year) if you have one dependent
- $500 a month ($6,000 a year) if you have two or more dependents

If you participate, it is your responsibility to comply with the federal limits.

Eligible Dependents

An eligible dependent is a child younger than age 13 whom you claim as a dependent on your income tax return. An eligible dependent can also be an older dependent who:

- Depends on you for at least half of his or her support;
- Has the same principal residence as you for more than one-half of the taxable year; and
- Is physically or mentally unable to care for himself or herself.

Your dependent may be a spouse, an elderly parent, or any other relative or dependent, as long as he or she is incapable of self-care and meets all of the above requirements.

Reimbursable and Non-Reimbursable Expenses

Similar to the Health Care FSA, the Dependent Day Care FSA reimburses you for dependent day care expenses that are tax deductible so that you and your spouse, if any, may work or attend school full time.

The following chart identifies just some examples of eligible and ineligible expenses. Other expenses not listed below may or may not be eligible for reimbursement. To learn more, contact Your Spending Account at the number set forth in the General Information section.

Flexible Spending Accounts

Reimbursable Expenses	Non-Reimbursable Expenses
▪ Dependent care provided in your home, including care provided by a babysitter or housekeeper. The provider may be a relative (provided he or she is not the child's parent or your child under age 19, your spouse or any other person whom you claim as a dependent on your federal tax return) ▪ Care provided in a neighbor's home or in a licensed day care center, provided your dependent regularly spends at least eight hours a day in your home ▪ Before- and after-school programs for children under age 13 ▪ Day camp services for children under age 13, but not overnight camp ▪ Preschool expenses for pre-kindergarten and below ▪ Transportation provided by the day care provider	▪ Care provided in 24-hour nursing care facilities ▪ Expenses you claim as an after-tax dependent day care tax credit on your federal income tax return, or expenses paid by any similar reimbursement plan ▪ Expenses to attend kindergarten or beyond ▪ Services provided by a child's parent, your spouse, your child under age 19, or someone you or your spouse claim as a dependent on your tax return ▪ Payments to a housekeeper while you are home from work because of illness ▪ Child or dependent day care provided while: ✓ You are at work and your spouse is doing volunteer work (or vice versa), even if a nominal fee is paid ✓ You and your spouse are doing volunteer work (even if a nominal fee is paid) ✓ You or your spouse is not working (such as weekend or evening babysitting fees) ▪ Transportation expenses to and from the care site (unless the transportation is furnished by the provider) ▪ Expenses for overnight camp ▪ Expenses for food, clothing and entertainment of a qualified dependent, unless charges are incidental and cannot be separated easily from the overall dependent day care cost

APPLYING FOR REIMBURSEMENT

Reimbursement from either FSA is available only after the service for which you are seeking reimbursement is performed and you receive reimbursement from all other sources. As described above, you can pay for eligible health care expenses by using your YSA Card or by seeking reimbursement for expenses you paid directly. For eligible dependent day care expenses, you must pay the service provider and then seek reimbursement from your Dependent Day Care FSA.

Health Care FSA Reimbursements

You may use your prepaid Your Spending Account card (YSA Card) to pay for eligible health care expenses, which means you do not have to submit a claim for reimbursement for certain approved merchants (see the section below titled "Automatic Validation with Approved Merchants" for more details). If you participate in the Limited Use Health Care FSA, this will be the same YSA card used to pay eligible expenses from the HSA.

Supporting Documentation

Along with the claim form, submit the appropriate supporting documentation, such as:

- The explanation of benefits (EOB) from the insurance company
- An itemized bill for services not covered by insurance, including the name of the service provider, cost of the service, patient name, description of the services rendered and date of service
- Receipts for any medications and copays
- Copies of any prescriptions if the receipt for the medication does not include an Rx

number. This applies to over-the-counter drugs and medicine as well. No reimbursement will be provided for an over-the-counter drug without a prescription or Rx number.

Dependent Day Care Reimbursements

For Dependent Day Care FSA claims, only your current account balance is available to reimburse claims. If the dependent day care services exceed your account balance, you receive a partial reimbursement. You receive the unreimbursed portion of the claim as you make additional contributions to your Dependent Day Care FSA.

Supporting Documentation

When you seek reimbursement, please submit:

- Your provider's bill or itemized receipt; and
- Your dependent day care provider's name, address, and Social Security or federal tax identification number
- Signed provider certification on the YSA claim form along with dependent day care provider's name, address, and Social Security or federal tax identification number.

Using Your YSA Card

You may use your prepaid Your Spending Account card (YSA Card) to pay for eligible health care expenses if you've chosen to contribute to your Health Care FSA. Dependent care expenses aren't eligible for reimbursement through the YSA Card program.

If you elect to contribute to a Health Care FSA, you will receive a package containing one YSA Card issued in your name, activation instructions, a cardholder agreement, additional disclosures, and information explaining approved use of the card.

The YSA Card remains active for up to three years as long as your Health Care FSA is in good status, you consecutively re-enroll in the Health Care FSA, and you remain actively employed. Your card will be cancelled upon termination of employment—inactive participants may not use the YSA Card. By signing and using the card, you certify that:

- You will only use the card for your own eligible health care expenses and those of your eligible dependents under the Health Care FSA.
- Incurred expenses were for health care services or supplies purchased on or after the date your Health Care FSA took effect.
- Your expenses don't include any amounts that are otherwise payable by plans for which you or your dependents are eligible.
- Any expense paid with the card has not been, or will not be, reimbursed by another source.

You can present your YSA Card for eligible health care expenses anywhere Debit VISA cards are accepted.

Important: Save your itemized receipts

Because all YSA Card transactions must be verified as eligible health care expenses, you may be required to provide the Plan with supporting documentation to validate your expenses. Make sure that you save all of your itemized receipts (indicating the date of service, the name of the service provider, the name of the person receiving service, the name of the product or service, and any amount paid by other coverage).

After the end of any given year, expenses incurred in the prior Plan year (plus the grace period) can be submitted via the manual claim process through April 30. If you re-enrolled, your balance on the YSA Card will be updated to your new election amount on January 1. YSA Card transactions that are not automatically validated will apply toward the new Plan year balance until additional documentation is provided and the claim is approved.

Automatic Validation with Approved Merchants

When you purchase eligible health care items by using your YSA Card with approved merchants, your transaction may be validated automatically without having to provide an itemized receipt or supporting documentation. For a complete listing of eligible expenses and approved merchants, visit the Your Spending Account Web site. Please note that the listing is subject to change at any time.

Flexible Spending Accounts

Automatic Validation for Other Medical Providers

Your YSA Card can also be used for other types of health care transactions without the need for submission of itemized receipts or further review. These transactions include recurring expenses, copayments and specific merchant category code. Below is a brief explanation of each type of transaction.

Recurring Transactions

If you purchase an eligible health care item or service using your YSA Card, that same item or service will be validated automatically the next time you purchase it with your YSA Card (at the same provider and for the same dollar amount). Your YSA Card will be programmed to recognize your plan's copayment amounts without any additional validation being required (for example, a $25 copayment at a physician's office).

Supporting Documentation

Manual claim submission and supporting documentation are sometimes required for the purchase of any prescription drug or health care service or item that isn't validated automatically. These types of purchases are conditionally reimbursed, pending validation of the expenses. You will be sent a letter or email informing you that itemized receipts or other documentation are required to validate the YSA Card transaction. Expenses for which you don't provide adequate documentation are considered ineligible and treated as overpayments. See the Overpayment Process section for more information.

Limited Use Health Care FSA Expenses

When you use your YSA card to pay for eligible expenses, your Limited Use Health Care FSA account will reimburse you first, if the expense is for dental or vision care. If the eligible expense is for medical care, the reimbursement will come from your HSA. This will happen automatically.

Overpayment Process

If you purchase products or services with your YSA Card that are ineligible for reimbursement through your Health Care FSA, you will receive notification from Your Spending Account that your transaction has been deemed an overpayment. This notification will be sent by email, so be sure that the Hilton Benefits Center has your valid email address.

Once an overpayment has been identified, the following actions will be taken immediately:

- Your YSA Card will be suspended and will remain suspended when your overpayment exceeds $100.
- If you provide the required validation documentation, the overpayment(s) will be cancelled and any claim(s) applied to offset the overpayment will be applied to the appropriate Plan year.
- Future paper claims will be processed, and eligible amounts will be applied to the outstanding overpayment. Payment will not be made on any paper claim until the overpayment has been fully repaid.
- You will be notified that you must refund the overpayment by mailing a check to Your Spending Account.
- Your Spending Account will allow you to resolve an overpayment on your account in one of the following ways. You will be given the option to:
    - Resubmit your claim with additional information;
    - Submit a new claim; or
    - Repay your overpayment by repaying online, the Reimbursement mobile application, or mailing a check to Your Spending Account.

The overpayment will remain active on the account until all amounts are recovered. If the overpayment amount isn't recovered through the options above, Hilton will determine whether further action should be taken.

When Not to Use Your YSA Card — Coinsurance

If you enrolled in a plan that has coinsurance and you visit your doctor, wait until after your doctor submits a claim to your health plan to pay for any coinsurance using your YSA Card. Doctors often

have negotiated reduced rates, so using your YSA Card at the time of service may result in an overpayment. Once your health plan pays its portion of the claim, your doctor will bill you for your portion. At that time, you may use your YSA Card to pay your portion of the bill. Remember to save your receipt in case it is requested.

Also, do not use the YSA Card to pay bills or claims incurred in the prior plan year during the current Plan year or grace period balance. Any YSA Card charges can only be incurred within the current plan year, however once approved the amount can be applied against any remaining prior year's balance during the extension period.

Finally, your YSA Card will be deactivated if you are on a leave of absence. You can still file claims manually by sending in any paper claim forms.

HEALTH SAVINGS ACCOUNT

HEALTH SAVINGS ACCOUNT

HEALTH SAVINGS ACCOUNT (HSA Account)

HOW THE HSA WORKS

If you elect coverage under a high-deductible medical plan (HDHP), you may be able to establish a Health Savings Account (HSA Account) to complement the HDHP provided you have no other disqualifying health coverage (e.g., through a spouse or otherwise). An HSA Account is an account funded by you. The HSA Account can help you to cover, on a tax-free basis, medical plan expenses that the HDHP requires you to pay out of pocket, such as deductibles or coinsurance. It may be used to pay for certain medical expenses not covered under the HDHP. Amounts may be distributed from the HSA Account to pay non-medical expenses, but these amounts are subject to income tax and may be subject to a 20% penalty tax.

You must be covered under a high deductible health plan in order to participate in the HSA Account. In addition, you:

- Must not be covered by any high deductible medical plan considered non-qualified by the IRS. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS.);
- Must not participate in a full health care Flexible Spending Account (FSA) or other group health plan that is not a high deductible health plan;
- Must not be entitled to benefits under Medicare (i.e., enrolled in Medicare);
- Must not have received medical benefits from the Department of Veterans Affairs within the preceding three (3) months; and
- Must not be claimed as a dependent on another person's tax return.

If you are eligible to participate in the HSA Account, you will fund your HSA Account by making contributions to it. All funds placed into your HSA Account are owned and controlled by you, subject to reasonable administrative restrictions imposed by the trustee. In general, you may begin making contributions to your HSA Account beginning on the first day of the month you are enrolled in the HDHP until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the contributions reach the contribution maximum. If your coverage terminates under the HDHP, you may not make any further contributions to your HSA Account.

For 2020, the maximum HSA Account contribution is $3,550 for an individual and $7,100 for a family. If you do not use all of the funds in your HSA Account during the calendar year, the balance remaining in your HSA Account at the end of the year will roll over.

If you are age 55 or older, you can contribute up to an additional $1,000 in catch-up contributions. If your spouse is age 55 or older and is covered by the high deductible health plan, he or she can also open an account and contribute $1,000 in catch-up contributions to his or her account.

If you enroll in your HSA Account during the year (not on January 1), you will still be allowed to contribute the maximum amount. However, you must be eligible as of December 1st and remain enrolled in a high deductible health plan and HSA Account until the end of the next tax year or you will be subject to tax implications and an additional penalty tax of 10%.

The funds in your HSA Account will be available to help you pay your or your eligible dependents' out-of-pocket costs under the medical plan, including annual Deductibles and coinsurance. You may also use your HSA Account funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time ("Internal Revenue Code"). Such expenses are "qualified health expenses". HSA Account funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include expenses for medical care (as defined in Section 213(d) of the Internal Revenue Code) for you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code.

HSA Account funds may also be used to pay for non-qualified health expenses but will generally be subject to income tax and a 20% additional tax

unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional medical services and you have funds in your HSA Account, you may use the funds in your HSA Account to pay for the medical expenses. If you choose not to use your HSA Account funds to pay for any Section 213(d) expenses that are not covered health services, you will still be required to pay the provider for services. The monies paid for these additional medical expenses will not count toward your deductible or out-of-pocket maximum.

You have the option of using funds in your HSA Account to pay for non-qualified health expenses. A non-qualified health expense is generally one which is not a deductible medical expense under Section 213(d) of the Internal Revenue Code. Any funds used from your HSA to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA Account to pay for other health insurance without incurring a tax. You may use your HSA Account to pay for COBRA premiums and Medicare premiums.

The HSA Account offers a debit card that may be used to pay your health care expenses. Rules regarding the use of the debit card will be provided shortly after you enroll in the HSA Account.

Rollover Feature

If you do not use all of the funds in your HSA Account during the calendar year, the balance remaining in your HSA Account will roll-over. If your employment terminates for any reason, the funds in your HSA Account will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the accompanying high deductible health plan. If you choose to transfer the HSA Account funds from one account to another eligible account, you must do so within 60 days from the date that HSA Account funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA Account funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

Important

Be sure to keep your receipts and medical records. If these records verify that you paid qualified health expenses using your HSA Account, you can deduct these expenses from your taxable income when filing your tax return by filing IRS Form 8898 with your Form 1040. However, if you cannot demonstrate that you used your HSA Account to pay qualified health expenses, you may need to report the distribution as taxable income on your tax return. Consult your tax advisor to determine how your HSA Account affects your unique tax situation.

Additional Information about the HSA

It is important for you to know the amount in your HSA Account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, the health care professional may be provided with information regarding the balance in your HSA Account. If you do not want this information disclosed, you must notify the Claims Administrator and the financial institution in writing.

Although described in this SPD, the HSA Account is not part of the Plan and is not subject to ERISA.

EMPLOYEE ASSISTANCE PROGRAM

EMPLOYEE ASSISTANCE PROGRAM

Employee Assistance Program

OVERVIEW OF THE EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP), offered through ComPsych® GuidanceResources® Worldwide, provides a wide range of resources and information to help you balance your work and personal life. A simple toll-free call can connect you with a Guidance Consultant who can provide assistance with a wide range of issues. The EAP is available to you at no cost.

ACCESSING SERVICES

You and the members of your immediate family (spouse and dependents) may utilize the EAP services immediately upon employment if you are an eligible Team Member of Hilton.

You and your family members can access ComPsych by phone or the internet 24 hours a day, 7 days a week. For phone access, simply call toll-free 1.888.295.4327. Internet access is at www.guidanceresources.com. The company ID is HC311.

CONFIDENTIAL COUNSELING

ComPsych's Guidance Consultants are available 24 hours a day, 7 days a week to listen to your concerns and refer you to a professional in your community to help you with a variety of concerns, including:

- Marital and family conflicts
- Grief and loss
- Drug and alcohol abuse
- Anxiety and stress
- Eating disorders
- Physical or emotional abuse

During your scheduled appointment, an experienced EAP counselor will discuss your situation and help you develop a solution-focused plan of action.

You and your family members are eligible for up to six (6) free face-to-face counseling sessions per problem per Plan year. If you live in California, however, your face-to-face counseling sessions will be limited to three (3) such sessions in any 6-month period, except that additional sessions may be approved for acute emergencies, consultations after referral or re-referral, or consultations due to a management or union request for information or assessment regarding work performance issues.

The face-to-face counseling sessions are available separately and apart from any mental health or other related benefits that may be available under the Plan.

FINANCIAL INFORMATION, RESOURCES AND TOOLS

GuidanceResources financial program offers you unlimited telephone access to certified public accountants, certified financial planners, and other financial professionals who are trained and experienced in handling personal financial issues and can offer guidance on issues such as family budgeting, credit and debt problems, tax questions, investment options, money management and retirement programs.

LEGAL, INFORMATION AND RESOURCES

GuidanceResources legal program provides you with unlimited telephone consultation with attorneys who are trained and dedicated to providing legal information and guidance to clients with such issues as divorce, bankruptcy, family law, real estate purchases and wills. However, the LegalConnect program cannot assist you with any employment related issues.

If you need legal representation or extended assistance that cannot be provided by phone, LegalConnect professionals can provide referrals to local attorneys. You or your family member will receive a free 30-minute face-to-face consultation. If you choose one of ComPsych's network attorneys, you will receive a 25% reduction in fees for representation.

INFORMATION, REFERRALS FAMILYSOURCE® WORK-LIFE PROGRAMS

ComPsych's Work-life specialists offer practical guidance through telephone consultation, accurate and timely referral information, and educational literature. Specialists research local resources and

Employee Assistance Program

provide a personalized reference package with helpful resources to help you with:

- Finding child and elder care
- Relocating to a new city
- Understanding programs such as Medicare and Medicaid
- Home repair
- Planning for college

ComPsych will follow up to make sure callers have received all the information necessary to meet their specific needs.

International SOS Program

International SOS Program

OVERVIEW OF THE INTERNATIONAL SOS PROGRAM

The International SOS Program provides assistance to you when you are traveling outside your home country if you have a medical question or concern, medical emergency, safety concern, security emergency, or if you require travel assistance. The International SOS Program provides services 24 hours a day, 365 days a year, worldwide. The International SOS Program offers services at no cost to you.

ACCESSING SERVICES

You may utilize the International SOS Program services immediately upon employment if you are an eligible Team Member of Hilton. Expats and employees traveling with their immediate family (spouse and dependents) on company paid and approved travel may access services for their immediate family members.

Before you travel, you can access real-time information by following these steps:

- Go to www.internationalsos.com
- Click on: members login
- Enter member ID: **11BCMA000227**
- Select resources:
    - Country guides
    - Online reports
    - E-mail alerts
- Call an alarm center for pre-travel information.

While you are out of the country, if you need medical or security advice or assistance, you may access services 24 hours a day, 7 days a week, by any of the following methods:

- Visit www.internationalsos.com
- Call the service center closest to you:
    - Philadelphia: +1 215 942 8226
    - London: +44 20 8762 8008
    - Singapore: +65 6338 7800
- Collect calls to International SOS may be placed, if necessary.

MEDICAL SERVICES

International SOS offers a wide range of medical services from Western-trained doctors and provides support in over 70 languages. Contact International SOS while you are traveling for any of the following services:

- If you need health or safety advice at any time;
- If you are ill or injured and need advice on whether you should visit a doctor;
- If you need a referral or help with doctor or hospital appointments;
- If you require supplies of medication or equipment;
- If you need to arrange an ambulance;
- To pay medical fees when approved;
- To monitor your condition and advise on your condition;
- To evacuate you to a center of medical excellence;
- To evacuate you to a safe area;
- To help with your family; or
- To deal with a fatality.

SAFETY AND SECURITY ADVICE

International SOS also offers safety and security advice. International SOS will answer questions regarding safety in particular regions (for example, “Is it safe to leave my hotel for a coffee?”). International SOS will provide services in a security emergency (for example, “There are rioters outside my hotel!”). International SOS will also provide travel assistance (for example, “I’ve been pick-pocketed”).

Medical Benefits Abroad Program

Medical Benefits Abroad Program

OVERVIEW OF THE MEDICAL BENEFITS ABROAD PROGRAM

The Medical Benefits Abroad Program provides emergency medical benefits to you and your Eligible Dependents when you are traveling outside your country of residence on business if you have a medical emergency. The Medical Benefits Abroad Program offers these emergency care services at no cost to you.

ACCESSING SERVICES

You may utilize the Medical Benefits Abroad Program emergency services in accordance with the timing listed in the "Participation" section if you are:

- an eligible Team Member of Hilton who is classified by Hilton as full-time;
- you normally work thirty (30) or more hours per week and are actively at work; and
- you are traveling outside the country of your residence or permanent assignment for no more than 180 consecutive days per trip on business of or at the expense of Hilton.

While you are out of the country, if you need emergency medical services or security advice or assistance, you may access services 24 hours a day, 7 days a week, by contacting the number on your benefits identification card.

MEDICAL SERVICES

Medical Benefits Aboard offers emergency medical services such as hospitalization, physician services, outpatient facilities, etc. as set forth in the Certificate of Coverage. The Medical Benefits Abroad Program benefits are fully insured by an insurance carrier. The separate Certificate of Coverage provided by the insurance carrier will govern the terms of the insured Medical Benefits Abroad Program.

METLIFE LEGAL PLAN

METLIFE LEGAL PLAN

MetLife Legal Program

OVERVIEW OF THE METLIFE LEGAL PLAN

The Metife Legal Plan ("MLP") provides pre-paid legal services for you, your spouse or domestic partner and your dependents. The services include telephone and office consultations with an attorney of your choice for an unlimited number of personal legal matters. Legal representation covers the following practice areas:

Estate planning documents	Real Estate
Document review and preparation	Traffic offenses
Family law	Personal property protection
Immigration assistance	Financial matters
Elder law	Juvenile matters
Defense of civil lawsuits	Consumer protection

For complete details of the services provided, please refer to the Coverage Booklet issued by MLP, which will govern in the event of any conflict with this summary.

ACCESSING SERVICES

You may utilize the MetLife Legal Plan by first contacting MLP at www.legalplans.com (access GETLAW) (click on "Thinking About Enrolling" and enter password 6090590) or calling the MLP customer service center at 1-800-821-6400, Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern Time).

DISABILITY COVERAGE

Disability Coverage

OVERVIEW OF YOUR DISABILITY COVERAGE

If you become disabled from a non-work-related injury or illness and can't work, the Plan helps you meet the challenge by offering two disability coverages: short-term disability (STD) (salary continuation for Corporate Team Members) and long-term disability (LTD). As you read about these coverages, keep the following in mind:

- As long as you are actively at work for at least one full day on or after the date you meet the eligibility requirements, you receive STD coverage automatically and, if elected, Optional STD Buy-Up and LTD coverage. LTD coverage starts on the first day of the month following the month in which you meet the eligibility requirements. For example, if you are a Team Member who becomes disabled on your 60th day of employment, you will not be entitled to disability benefits. For STD, you must work for 31 more days (so you will have 91 days of employment) before you will be eligible for benefits. For LTD, you must work through the first month of the month following the month you meet the eligibility requirements.

- If you are on a leave of absence and elect to increase the amount of your disability coverage, the new coverage amount will not take effect until you are actively at work. See the "Coverage During Unpaid Absences" section in the Participation chapter for more details on when election changes take effect.

Evidence of Insurability (EOI)

If you elect coverage under the optional STD Buy-Up or optional LTD when you are first eligible, you will not have to satisfy any EOI requirements. However, if you elect optional coverage at any later date, you will have to satisfy the insurance company's EOI requirements. EOI requires you to provide a statement of your medical history that the insurance company will use to determine if you are approved for coverage.

Consult your insurance booklet for the EOI rules that apply to the coverages you've chosen.

In addition, if you are assigned to an international position as an expatriate, your disability coverage will not begin until approved by Prudential.

Basic Weekly and Monthly Earnings

Although the STD benefit is based on "basic weekly earnings" and the LTD benefit is based on "basic monthly earnings", both benefits actually base these calculations on the same annual earnings figure.

Your annual earnings figure will be updated once annually and communicated to you at annual enrollment. The amount will be effective for benefits purposes starting the next January 1st. This figure will remain constant throughout the year even if your earnings change during the year. For example, if your annual enrollment materials indicate that your annual earnings are $26,000 per year (which would be $500 per week or $2,000 per month) in 2019, your disability benefits for 2020 will be based on annual earnings of $26,000, even if your actual annual earnings at the time of your disability in 2019 are higher or lower than $26,000.

Disability Coverage

A SNAPSHOT OF YOUR DISABILITY COVERAGE

Here's a snapshot of your disability benefits.*

	Feature	Duration	Amount of Benefit
Basic STD* **	Provides a portion of your income if you become temporarily disabled due to a non-work related illness or injury	Length of disability up to 26 weeks	60% of basic weekly earnings, less any deductible sources of income up to $250 per week**
Optional STD Buy-Up	Provides a higher portion of your income during the STD period. Note: In some cases where state mandated temporary disability benefits are higher, there may be little/no additional coverage available from the STD Buy-Up.	Length of disability up to 26 weeks	60% of basic weekly earnings, less any deductible sources of income up to $2,308 per week (Basic and Buy-Up combined)***
LTD	Provides a portion of your income if your disabling illness or injury lasts longer than the STD period	Begins after 180 days and continues for length of disability up to age 65 or the Social Security retirement age generally	Option 1 – 50% of basic monthly earnings, less any deductible sources of income, up to $3000 per month Option 2 - 60% of basic monthly earnings, less any deductible sources of income, up to $20,000 per month

*Additionally, you may be eligible for Social Security benefits for your disability. Contact your local Social Security office for more detailed information. Also, if you are disabled under the LTD program, the Claims Administrator can offer assistance with your application for Social Security disability benefits or appeal. Please contact the Claims Administrator (at the address and phone number in the General Information section) for more information if you would like this assistance.

**The amount of the STD benefit for Corporate Team Members and Team Members in certain states with statutory short-term disability benefits may vary. For information on the amount of your STD coverage, see the Corporate Team Members' Handbook.

Disability Coverage

***Corporate Team Members receive short-term disability benefits through their Employer's salary continuation program and may have other options in lieu of the Optional STD Buy-Up. If you have a question as to whether you are a corporate or non-corporate Team Member, please check with your HR team. If you are a Corporate Team Member, contact the Hilton Benefits Center to request a copy of the salary continuation program document for more details.

SHORT-TERM DISABILITY

Under the STD program, a disability is considered short-term if it lasts for 26 weeks or less. If it lasts for more than 26 weeks and you purchased LTD coverage, you may become eligible to receive long-term disability benefits, which are described later in this section.

Eligibility for STD Coverage

Depending on where you work, you may be eligible to participate in either the Basic STD or a state mandated short-term disability program. Regardless of which program covers you, coverage is provided automatically. In some states a mandatory employee contribution is required for state mandated STD coverage. In addition, you may be eligible to increase your STD coverage level by participating in the STD Buy-Up program.

Basic STD

You are eligible to participate in the Basic STD program if you meet the eligibility requirements described in the "Participation" section of this handbook and do not work in any one of the following states: California, New Jersey, New York or Rhode Island. This section describes the benefits under the Basic STD program. If you are a Corporate Team Member, your STD benefits may vary. If you have a question as to whether you are a corporate or non-corporate Team Member, please check with your HR team.

State Mandated Benefits

If you work in California, New Jersey, New York or Rhode Island, you are covered by your state-mandated short-term disability insurance and not the Basic STD program.

In New York, you are covered under the Disability Benefits Law (DBL) insurance plan. The DBL plan is insured with Prudential, the Claims Administrator for both the STD and LTD programs. The plan pays short-term disability benefits at the level provided under New York's program, and is administered by Prudential. Coverage under the DBL plan will begin on your 29th day of employment. Team Members working part-time in New York are eligible to participate in the DBL plan only after 25 days worked.

If you work in California, New Jersey or Rhode Island, please contact your local Human Resources Department for information on your eligibility and how to obtain short-term disability benefits under your state's program.

STD Buy-Up

You may purchase additional STD coverage under the optional STD Buy-Up program if:

- You participate in:
  - ✓ The Basic STD program; or
  - ✓ A state-mandated short-term disability insurance program and are otherwise an eligible Employee (see "Eligibility" in the "Participation" section of this handbook for more details); and
- Your annual earnings are at least $10,833. Note that some state mandated coverages may have different base salary limits that may impact whether or not you can elect STD Buy-Up and/or the value of such additional coverage. Please contact the appropriate state agency for more information.

  Corporate Team Members are eligible to participate in the Salary Continuation Plan, rather than STD Buy-Up. You should review Hilton's Salary Continuation Plan document if this benefit applies to you.

Eligibility for STD Benefits

Covered Disabilities and Elimination Period

Before you can qualify for Basic STD and STD Buy-Up benefits, you must be "disabled" (defined

below) for seven consecutive days because of a non-work related covered injury or sickness. This seven-day period is referred to as the "elimination period" and begins on the day you become disabled. Please refer to the booklet provided by the insurance carrier for more information on the insurance carrier's requirements for determining whether a covered person is "disabled", as well as for a list of excluded disabilities. If you work in California, New Jersey, New York or Rhode Island, you will be considered "disabled" in accordance with your state's disability benefit program.

Physical Examination

The Claims Administrator, at its expense, may require you to undergo a physical examination if you submit a claim for STD benefits or while you are receiving STD benefits. If you refuse to be examined, the Claims Administrator may deny your claim or terminate your benefits.

Amount of STD Benefits

If you are eligible for STD benefits, the STD program pays the following:

- ***Basic STD Coverage.*** You receive 60% of your basic weekly earnings minus amounts from other deductible sources of income. The maximum benefit is $250 per week for up to 26 weeks. If you work in California, New Jersey, New York or Rhode Island, your STD benefits are paid at the level provided under the state-mandated short-term disability insurance plan that covers you. Corporate Team Members' disability benefits may vary. See the Corporate Team Member handbook for more information.

- ***STD Buy-Up Coverage.*** You receive 60% of your basic weekly earnings minus amounts from other deductible sources of income. The maximum benefit is $2,308 per week for up to 26 weeks (Basic and Buy-Up combined; or, if applicable, state-mandated benefits and Buy-Up combined). Corporate Team Member may have other options in lieu of the STD Buy-Up coverage.

If you are covered under the state-mandated benefits provided in New York, California, New Jersey or Rhode Island, it is your responsibility to file with the state for any state-mandated benefits due to you. If you do not file for such state-mandated benefits and you receive benefits under STD Buy-Up, your STD Buy-Up coverage benefits will be reduced by the amount you would have received under the state-mandated disability program.

Your STD benefit amount will be reduced by any disability income benefits you may receive under any state compulsory benefit act or law. This minimum benefit may be applied to any overpayment that results, for example, from an error in processing your benefit amount. Your STD benefit amount will not be reduced by income from profit sharing, thrift, 401(k), Keogh, employee stock option, and tax-sheltered annuity plans.

Working While Disabled

If you are eligible to receive STD benefits, but return to work after satisfying the elimination period, you may still receive some benefits. See the benefit booklet issued by the insurance company for more details.

If you have any questions regarding the amount of your STD benefits, please contact:

- If you work in California, New Jersey or Rhode Island, the appropriate state agency.

- If you work anywhere else, Claims Administrator

Duration of STD Benefits

STD benefits will begin when the Claims Administrator approves your claim, generally the eighth day you are disabled. As noted above, before your claim can be approved, you must be disabled for the elimination period. Until STD benefits begin, you may use your Paid Time Off (if available).

You will need to file a claim for benefits to be paid, and you may be required to submit proof of your continued disability during your STD period. See "Applying for Benefits" at the end of this section for details. If your claim is approved, you generally receive your STD benefit check from the insurance company. The amount you receive may be subject to income tax withholding. See the benefit booklet issued by the insurance company for details such as payment frequency and when benefits end.

Disability Coverage

If You Return to Work

If you return to work full-time, and, again become disabled from the same or a related cause, your second disability may be treated as part of your prior claim. See the benefit booklet issued by the insurance company for more details.

Concurrent Disability

If a new, non-work related disability occurs while you are receiving benefits for another covered disability, your benefits will continue while you remain disabled. These benefits will be subject to the maximum length of benefits described above and any limitations and exclusions applied to the initial cause of disability.

LONG-TERM DISABILITY

If you are receiving STD benefits and your disabling illness or injury lasts longer than 26 weeks, and you are enrolled in LTD, you may be eligible for LTD benefits, which helps provide continued income replacement.

Eligibility for LTD Benefits

If you are enrolled in LTD coverage and are determined to be disabled under the LTD program, you will be eligible for LTD benefits in accordance with the terms of the LTD program.

Covered Disabilities and Elimination Period

Similar to the eligibility requirements for STD benefits, you must be continuously disabled for an elimination period. For LTD, the elimination period is 180 consecutive days, and must be satisfied before you are eligible to receive benefits.

You will be eligible for LTD benefits if, after you satisfy the elimination period and for the first 24 months for which LTD benefits are payable, the Claims Administrator determines that you are disabled.

Please refer to the booklet provided by the insurance carrier for more information on the insurance carrier's requirements for determining whether a covered person is "disabled", as well as for a list of excluded disabilities.

Physical Examination

The Claims Administrator, at its expense, may require you to undergo a physical examination if you submit a claim for LTD benefits or while you are receiving LTD benefits. If you refuse to be examined, the Claims Administrator may deny your claim or terminate your benefits.

Disabilities Excluded From Coverage

You will not be eligible for LTD benefits if you incur a disability that is caused by, contributed to by, or results from:

- An intentionally self-inflicted injury (sane or insane);
- Your committing, or attempt to commit, an assault, battery or felony;
- War or any act of war (declared or not declared);
- Insurrection, rebellion, or taking part in a riot or civil commotion; or
- A disability that starts during the first 12 months of your current LTD coverage, if it is caused or contributed to by a "preexisting condition." This means a condition for which, during the last three months before you last became covered, you:
  - ✓ Were diagnosed;
  - ✓ Received treatment or services; or
  - ✓ Took drugs or medicines prescribed or recommended by a physician.

Amount of LTD Benefits

Determining the Benefit Amount

The LTD program provides you with a monthly benefit based on a percentage of your basic monthly earnings. If you qualify for LTD benefits, you will receive a benefit equal to the following amounts, depending on which option you elected:

- Option 1 - 50% of your basic monthly earnings minus amounts from other deductible sources

of income. The maximum benefit is $3,000 per month

- Option 2 - 60% of your basic monthly earnings minus amounts from other deductible sources of income. The maximum benefit is $20,000 per month

The minimum benefit under either option is $100 per month.

Please refer to the booklet provided by the insurance carrier for more information on how your LTD benefit amount will be reduced by other benefits.

Working While Disabled

Even if you are disabled, you may feel well enough to return to work. Depending on how much you earn while working (your "disability earnings"), your LTD benefit amount may remain unchanged, may be adjusted or may terminate. If you are working while disabled, the Claims Administrator may require you to send proof of your disability earnings on a monthly basis.

Please contact the Claims Administrator or refer to the booklet provided by the insurance carrier for more information on working while disabled.

Rehabilitation Services

The LTD program offers you services to help you get back to work. Please refer to the booklet provided by the insurance carrier for more information on the criteria for this program.

Duration of LTD Benefits

Benefits will begin after the Claims Administrator approves your claim, provided you have satisfied the elimination period. Please refer to the booklet provided by the insurance carrier for more information on the frequency of payment and when benefits end.

Maximum Period for Payment

Subject to the limited pay period described in the booklet provided by the insurance carrier, the maximum period is the longest period for which you can receive LTD benefits. This period will depend on your age when your disability begins.

Please see the booklet provided by the insurance carrier for more information.

Limited Pay Period

A period of disability may be limited if it is determined that the disability is primarily caused by a Mental Health or Psychiatric condition, including physical manifestations of these conditions, but excluding those conditions with demonstrable, structural brain damage. Please refer to the booklet provided by the insurance carrier for more information on limitations and exclusions applicable in this situation.

Recurring Disabilities

If you return to work full-time after receiving LTD benefits and you have a recurrent disability, your recurrent disability may be treated as part of your prior claim and you will not have to complete another elimination period under certain circumstances. Please refer to the booklet provided by the insurance carrier for more information on the timing rules and other requirements applicable to recurring disabilities.

Survivor's Benefit

Your survivor will be entitled to receive a survivor benefit if he or she meets the insurance carrier's requirements. Please refer to the booklet provided by the carrier.

Recovery of Overpayments

Please note that you will be required to return to the insurance company any overpayment of STD or LTD benefits paid to you as a result of:

- Fraud;
- Any error the Claims Administrator may make in processing your claim; or
- Your receipt of any deductible sources of income.

If your survivors become entitled to the survivor benefit, the insurance company may first apply the survivor benefit to any overpayment that may exist on your claim.

Disability Coverage

Note: This information is designed to explain, in simple language, all important features of the plans. Every effort has been made to provide clear, complete and understandable information. However, the legal plan documents and insurance contracts, where applicable, have the final word about the rights of a participant and his or her representative, beneficiary or estate.

LIFE AND ACCIDENT PROTECTION

Life and Accident Protection

OVERVIEW OF YOUR LIFE AND ACCIDENT PROTECTION

The life and accident insurance program provides financial protection for you and your family in the event of a death or accidental loss of limb. The life and accident insurance program consists of: Basic Life Insurance, optional Supplemental Life Insurance, optional Dependent Life Insurance, optional Accidental Death and Dismemberment (AD&D) Insurance and Business Travel Accident Insurance.

Note: This information is designed to explain, in simple language, all important features of the plans. Every effort has been made to provide clear, complete and understandable information. However, the legal plan documents and insurance contracts, where applicable, have the final word about the rights of a participant and his or her representative, beneficiary or estate.

A SNAPSHOT OF THE LIFE AND ACCIDENT INSURANCE COVERAGE

Here's a snapshot of your life and accident benefits.

Type of Insurance	Coverage Amount
Basic Life Insurance ▪ Provides a benefit to your survivors in the event of your death	1 times regular annual earnings up to $2,500,000
Optional Supplemental Life Insurance ▪ Life Insurance available in addition to Basic Life Insurance	1 times regular annual earnings* 2 times regular annual earnings* 3 times regular annual earnings* 4 times regular annual earnings* 5 times regular annual earnings* 6 times regular annual earnings* 7 times regular annual earnings* 8 times regular annual earnings* Maximum benefit: $2,500,000 (in addition to basic life insurance)
Optional Dependent Life Insurance ▪ Life insurance for your dependents	Spouse/Domestic Partner: $5,000, $10,000, $25,000, $50,000 or $100,000** Each covered dependent child from live birth to age 26: $5,000 or $10,000

Life And Accident Protection

Optional AD&D Insurance ▪ Protection for you and your dependents if you or a covered dependent should die or become dismembered as a result of a covered accident	You: 1 times regular annual earnings 2 times regular annual earnings 3 times regular annual earnings 4 times regular annual earnings 5 times regular annual earnings 6 times regular annual earnings 7 times regular annual earnings 8 times regular annual earnings Maximum benefit: $2,500,000 Spouse/Domestic Partner: 40% (50% if you do not have eligible dependent children at the time of the accident) of your coverage amount. Spouse/Domestic Partner coverage cannot exceed $500,000. Each covered dependent child up to age 26: 10% (15% if you do not have an eligible spouse/domestic partner at the time of the accident) of your coverage amount. The coverage for a covered dependent child cannot exceed $50,000
Business Travel Accident Insurance Protection in the event of a covered accident while you are traveling on Hilton business For eligible dependents, insurance protection in the event of a covered accident while traveling with a Team Member on Hilton business	You: Either $100,000, $500,000 or $1,500,000 *** Spouse/Domestic Partner: Either $50,000 or $100,000*** Each covered dependent child to age 19, or age 25 if a full-time student: $50,000

*Evidence of Insurability required if coverage exceeds 3 times annual earnings or, if lower, $1,000,000, or for certain enrollments made after your initial eligibility period. This requirement does not apply to AD&D coverage.

**Your spouse's or domestic partner's coverage cannot exceed 100% of your combined Basic Life and Supplemental Life Insurance. EOI is required for spouse life coverage of $25,000 or more or for certain enrollments made after initial eligibility. This requirement does not apply to AD&D coverage.

***Refer to the insurance certificate to determine which amount is applicable to you.

Life and Accident Protection

WHEN YOU ENROLL

Naming a Beneficiary

When you first enroll for coverage, you designate one or more beneficiaries to receive the proceeds of your Basic Life, Supplemental Life (if you elect), Accidental Death and Dismemberment (AD&D) (if you elect) and Business Travel Accident insurances by providing your beneficiary information online using the Your Benefits Resource website at http://digital.alight.com/hilton . You may also change your designation at any time by using this same website. Your beneficiary designation is effective on the date you complete the online designation, but will apply to any insurance amounts paid after the insurance company receives your change. Please contact the Hilton Benefits Center with any questions.

If you elect the optional Dependent Life Insurance coverage, or AD&D Insurance coverage for your dependents, you are the named beneficiary. You are the beneficiary for your eligible dependents under Business Travel Accident Insurance. If you are not living and a benefit becomes payable (for example, your dependent dies during the 31-day conversion period for dependent life insurance following termination of coverage after your death), the benefit will be paid to your estate.

No Beneficiary Designation

If you do not designate a beneficiary to receive any of your life, AD&D and Business Travel Accident death benefits, your beneficiary or beneficiaries for any applicable life and accident insurance coverages is the first surviving person(s) listed below:

1. Your lawful spouse (or domestic partner, for Business Travel Accident Insurance)
2. Your natural or legally adopted children (benefit divided equally)
3. Your parents (benefit divided equally)
4. Your natural or legally adopted brothers and sisters (benefit divided equally)
5. Your estate, payable to your executor or administrator

Regular Annual Earnings

Basic Life, Supplemental Life, and AD&D benefits are based on your regular annual earnings. Your regular annual earnings for purposes of these benefits are based on your current year's pay, plus:

a) overtime, bonus and tips received July 1 through December 31 of the calendar year immediately preceding the prior calendar year; and

b) overtime, bonus and tips received January 1 through June 30 of the prior calendar year.

Earnings does not include the amount of any pre-tax contributions the Team Member makes to the Hilton 401(k) savings plan or the cost of health care coverage the Team Member pays on a pre-tax basis.

Evidence of Insurability

In some instances, you may be required to provide Evidence of Insurability (EOI) for your elected life insurance coverages. This may require that you, your spouse or domestic partner pass a thorough physical examination. Coverage in excess of the amount subject to EOI will only become effective when the insurance company approves the EOI. This means that if you enroll for any life insurance that requires EOI at annual enrollment, coverage will become effective at the later of January 1 or the insurance company's approval of EOI. If you are on a leave of absence during annual enrollment, you will not be able to add or increase your life insurance coverage for yourself or any dependent during annual enrollment. Instead, you may make a new election to add or increase coverage during the 31-day period that begins on the day you return to work. You must contact the Hilton Benefits Center to make this change to your coverage. The election you make during this 31-day period will become effective on the later of the date you return to work or the date the insurer approves any required EOI.

When is EOI Required

There are three possible times at which EOI may be required for Supplemental Life Insurance — upon initial eligibility, during annual enrollment and making changes to coverage amounts. There are three possible times at which EOI may be required for Dependent Life Insurance for your spouse or domestic partner — during initial enrollment and annual enrollment and making changes to

coverage amounts. Coverage for dependent child(ren) will not require EOI. The chart below sets forth the circumstances under which EOI may be required. No EOI is needed if you reduce your coverage from a higher amount to a lower coverage amount or to add coverage for your dependent child(ren).

You elect a coverage amount for…	**Evidence of Insurability may be needed if you make your election during…**		
	Initial Eligibility*	**Annual Enrollment****	**Change in Coverage Amount****
*Supplemental Life Insurance**			
1x regular annual earnings	EOI may be required if the amount is over $1,000,000	No EOI required	No EOI required
2x regular annual earnings	EOI may be required if the amount is over $1,000,000	EOI required unless increasing coverage from 1x to 2x regular annual earnings	EOI required unless increasing coverage from 1x to 2x regular annual earnings
3x regular annual earnings	EOI may be required if the amount is over $1, 000,000	EOI required unless increasing coverage from 2x to 3x regular annual earnings	EOI required unless increasing coverage from 2x to 3x regular annual earnings
4x regular annual earnings	EOI required	EOI required unless increasing coverage from 3x to 4x regular annual earnings	EOI required unless increasing coverage from 3x to 4x regular annual earnings
5x regular annual earnings	EOI required	EOI required unless increasing coverage from 4x to 5x regular annual earnings	EOI required unless increasing coverage from 4x to 5x regular annual earnings
6 x regular annual earnings	EOI required	EOI required unless increasing coverage from 5x to 6x	EOI required unless increasing coverage from 5x to 6x
7 x regular annual earnings	EOI required	EOI required unless increasing coverage from 6x to 7x	EOI required unless increasing coverage from 6x to 7x
8 x regular annual earnings	EOI required	EOI required unless increasing from 7x to 8x	EOI required unless increasing coverage from 7x to 8x
$1,000,000 or greater	EOI required	EOI required	EOI required
Dependent Life Insurance(no EOI required for children)			
$5,000	No EOI required	EOI required for previously	EOI required for previously

Life and Accident Protection

		unenrolled spouse/domestic partner	unenrolled spouse/domestic partner
$10,000	No EOI required	EOI required for previously unenrolled spouse/domestic partner No EOI required if increasing coverage from $5,000 coverage level	EOI required for previously unenrolled spouse/domestic partner No EOI required if increasing coverage from $5,000 coverage level
$25,000	No EOI required	EOI required for previously unenrolled spouse/domestic partner No EOI required if increasing coverage from $10,000 level	EOI required for previously unenrolled spouse/domestic partner No EOI required if increasing coverage from $10,000 level
$50,000	EOI required	EOI required	EOI required
$100,000	EOI required	EOI required	EOI required

*EOI is required if coverage exceeds the lesser of 3 x annual earnings or $1,000,000.

**EOI is required if coverage exceeds $1,000,000. If you declined coverage upon initial eligibility and elect to enroll at a later time (e.g., annual enrollment), EOI may be required.

Life and Accident Protection

LIFE INSURANCE

Basic and Supplemental Life Insurance

As noted in the "Snapshot" chart, Basic Life Insurance coverage is equal to one times your regular annual earnings, rounded up to the next higher $1,000, up to a maximum benefit of $2,500,000 as of the date of enrollment. Your Basic Life Insurance coverage amount (as well as any Supplemental Life Insurance coverage you have elected for yourself) changes annually at annual enrollment, effective for the following plan year. Any mid-year adjustment will not be made effective until January 1 of the following plan year, provided you are still enrolled in the benefit at that time.

Supplemental Life Insurance coverage pays benefits in addition to your Basic Life Insurance coverage and is subject to a maximum benefit of $2,500,000. The cost of coverage for Supplemental Life Insurance is based on your age and tobacco use.

Your Basic and Supplemental Life Insurance coverage may be reduced beginning the year you reach age 65. Please refer to the booklet provided by the insurance carrier for details.

Tax Alert

Your Basic Life Insurance coverage may be automatically provided to you at Hilton's cost. If Hilton-provided Basic Life Insurance coverage does not exceed $50,000, the coverage is tax free to you. However, if Hilton-provided Basic Life Insurance coverage exceeds $50,000, you must include in your gross income the cost of the excess coverage that is paid by Hilton. For this purpose, the cost is computed using a uniform premium table published by the Internal Revenue Service and is reported to you on your Form W-2 ("C" in Box 12) and on your paycheck (under "Group Term Life").

Dependent Life Insurance

You may elect to purchase Dependent Life Insurance for your eligible spouse or domestic partner as well as any dependent children. If you elect dependent life insurance for any dependent who is confined for medical care or treatment at home or elsewhere, coverage for your dependent begins when the dependent is medically released from confinement.

Conversion and Portability Rights

If your Basic Life, Supplemental Life and Dependent Life Insurance end or are reduced for certain reasons, you have certain rights to continue the lost coverages at your expense. Please refer to the insurance carrier's documents for details.

Accelerated Life Insurance Benefit

An accelerated benefit feature is part of your Basic Life, Dependent Life and Supplemental Life Insurance coverage.

Tobacco Use

Supplemental Life

You must certify your tobacco status. If you elect coverage that requires evidence of insurability and the insurance carrier identifies that a tobacco status does not match what was originally submitted, the insurance carrier will notify Hilton of this change which may impact your life insurance premium rates. The certification will be similar to the following:

- Have you used tobacco in any form or electronic cigarettes during the past twelve months? You are considered a non-tobacco user if you have not used tobacco in any form or electronic cigarettes in the last 12 months.

Spouse/DP Life

You must certify your spouse/domestic partner's tobacco status. If you elect coverage that requires evidence of insurability and the insurance carrier identifies that a tobacco status does not match what was originally submitted, the insurance carrier will notify Hilton of this change which may impact your life insurance premium rates. The certification will be similar to the following:

- Has your spouse/domestic partner used tobacco in any form or electronic cigarettes during the past twelve months? Your spouse/domestic partner is considered a non-tobacco user if they have not used tobacco in any form or electronic cigarettes in the last 12 months.

Life and Accident Protection

ACCIDENT INSURANCE

Hilton offers two types of accident protection: Accidental Death and Dismemberment (AD&D) and Business Travel. If your loss happens to be payable under both types of protection, then benefits will be paid from both the AD&D and Business Travel Accident programs. Benefits will not be offset in this instance. (See the insurance carrier's booklet for information about exclusions from accident coverage.)

Accidental Death and Dismemberment Insurance

AD&D Insurance is available for purchase and pays benefits for a death or dismemberment occurring within 365 days of, and resulting from, a covered accident while your coverage is in effect. You must elect AD&D coverage. For AD&D Insurance, two coverage levels are available:

- You Only
- You + Family

For you, AD&D Insurance coverage is in salary increments of 1 – 8 x your earnings. The maximum coverage is the amount set forth in the documents provided by the insurance carrier.

If you elect Accidental Death and Dismemberment coverage for a dependent who is confined to a health care facility or disabled due to sickness or injury, coverage for your dependent begins when the confinement ends or your dependent is no longer disabled.

Your AD&D Insurance coverage may be reduced beginning the year you reach age 65. Please refer to the booklet provided by the insurance carrier for details.

Additional Accidental Death Benefits

The benefits listed below are also part of the AD&D benefit when you elect AD&D Insurance coverage. Please see the documents provided by the insurance carrier for details and eligibility requirements for these benefits.

- Child care benefit
- Education benefit (for your dependent child and for your spouse/domestic partner)
- Seat belt and air bag benefit
- Common accident benefit
- Coma benefit
- Disappearance benefit
- Exposure benefit

Business Travel Accident Insurance

Business Travel Accident Insurance, insured by Chubb, pays benefits in the event of accidental dismemberment or death while traveling on Hilton business if the loss occurs within 365 days of the accident. Generally, non-union Team Members working at least 30 hours per week are eligible for coverage under Business Travel Accident Insurance.

Business Travel Accident Insurance provides you with accident coverage while you are traveling on Hilton business away from your regular place of employment at Hilton's authorization, direction and expense and for periods of 365 days or less. Business travel includes travel or activities that are unrelated to business and which take place away from your residence or regular place of employment. Such travel or activities must coincide with your business travel and is limited to any consecutive seven-day period immediately prior to, during or immediately following your business travel.

Your spouse or domestic partner and covered dependent children are covered if they accompany you while you are traveling on Hilton business, at Hilton's authorization, direction and expense, for periods of 365 days or less. Coverage is also provided while your dependents are traveling with you on relocation travel that is more than 50 miles from your current work location. To qualify as a "covered dependent child" for purposes of Business Travel Accident Insurance, your dependent child must be:

- Unmarried
- Your natural child, grandchild, stepchild, or adopted child

- Primarily dependent upon you for maintenance and support
- Under age 19, or under age 25 if enrolled as a full-time student at an institution of higher learning, or classified as an incapacitated dependent child.

Business Travel Accident benefits are paid in addition to those under your AD&D Insurance in the event the loss is covered by both types of insurance.

Additional Business Travel Accident Benefits

The benefits listed below are also part of the Business Travel Accident Insurance coverage. Please see the documents provided by the insurance carrier for details and eligibility requirements for these benefits.

- Carjacking benefit
- Child care expense benefit
- COBRA premium expense benefit
- Coma benefit
- Education expense benefit
- Home alteration or vehicle modification benefit
- Medical evacuation and repatriation benefit
- Personal property benefit
- Psychological therapy expense benefit
- Rehabilitation expense benefit
- Seat belt and occupant protection device benefit
- Political evacuation benefit

Additional benefits may be available. Please review the policy for details.

When Benefits Are Paid Under the AD&D or Business Travel Accident Programs

For benefits to be paid under either accident insurance program, the accident must occur while your coverage is in effect and the loss must occur within 365 days of the accident. For benefits to be payable under Business Travel Accident, your accident must also occur while traveling on Hilton business. In the event of your death, 100% of the coverage amount is payable to your designated beneficiary. Depending on the severity of the loss and type of coverage, 100%, 50% or 25% of your coverage amount may be payable to you, as shown in the chart below:

Percentage of Coverage Amount Paid		Accidental Loss*
AD&D	**Business Travel Accident**	
100%	**100%**	Life
100%	**100%**	Entire sight of both eyes
100%	**100%**	Both hands at or above the wrist
100%	**100%**	Both feet at or above the ankle
100%	**100%**	Both hands, sight of both eyes or both feet
100%	**100%**	Paralysis of both arms and both legs (quadriplegia)
N/A	**100%**	Speech and one hand or one foot or sight of one eye
N/A	**100%**	Hearing and one hand or one foot or sight of one eye

Life and Accident Protection

Percentage of Coverage Amount Paid		Accidental Loss*
AD&D	**Business Travel Accident**	
100%	**100%**	A combination of any two of a hand, foot or sight of one eye
50%	**50%**	Paralysis of both legs (paraplegia)
50%	**50%**	Paralysis of arm and leg on one side of the body (hemiplegia)
25%	**25%**	Paralysis of one arm or one leg (uniplegia)
50%	**50%**	Entire sight of one eye
50%	**50%**	One hand at or above the wrist
50%	**50%**	One foot at or above the ankle
100%	**100%**	Speech and hearing in both ears
50%	**50%**	Speech
50%	**50%**	Hearing in both ears
25%	**N/A**	Hearing in one ear
25%	**25%**	Thumb and index finger of the same hand
100%	**N/A**	Third degree burns covering 75% or more of body
50%	**N/A**	Third degree burns covering 50% - 74% of body
50%	**N/A**	All four fingers on one hand

* *For definitions of key terms and phrases, please refer to the applicable insurance carrier's documents*

Maximum Benefit Amount

Under AD&D Insurance, the total payment for all losses due to any one accident will not be more than 100% of the applicable coverage amount, up to a maximum amount, as set forth in the documents provided by the insurance carrier.

If your loss due to an accident occurs while you are traveling on Hilton business, your Business Travel Accident Insurance benefit amount will be paid as well. The benefit amounts for you, your spouse or domestic partner and/or your dependent children) may vary. See the documents provided by the insurance carrier for more details. The total payment for all losses due to any one aircraft accident will not be more than $25 million for all covered persons with claims resulting from the accident.

When Benefits Are Not Paid

Both the AD&D Insurance coverage and Business Travel Accident Insurance coverage have a number of exclusions or circumstances under which benefits will not be paid. Please review the applicable insurance documents carefully to make sure you understand when benefits are not payable.

Retiree Life Insurance

You are eligible for retiree life insurance benefits if:

- You are an Employee who retired from Hilton Worldwide, Inc. (or Hilton Hotels Corporation) prior to September 1, 2000:

- With 10 years of service (if you were age 65 or older at retirement), or
- With 20 years of service (if you were older than age 55 at retirement); and
- your name is on a list of eligible individuals maintained by the Plan Administrator; OR

- You were an Executive Officer of Hilton Worldwide, Inc. when you retired and your name is on a list of eligible individuals maintained by the Plan Administrator.

The retiree life insurance benefits provided under the Plan are governed by the certificate provided to you by the applicable insurance carrier. Please see the policy and/or Coverage Booklet for terms of coverage, including any exclusions or limitations that may apply. Contact the Plan Administrator for more information about eligibility for these benefits.

GENERAL INFORMATION

General Information

PLAN ADMINISTRATION

The Plan Administrator has the sole and complete discretionary authority to determine eligibility for Plan benefits and to construe the terms of the Plan, including the making of factual determinations. The Plan Administrator shall have the discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. The decisions of the Plan Administrator shall be final and conclusive with respect to all questions relating to the Plan. If a Claims Administrator has the only review authority, the Claims Administrator's decision will be final and conclusive with respect to all questions.

The Plan Administrator may delegate certain of its Plan duties to other persons and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the Plan. The Plan Administrator shall be entitled to rely on the information and advice furnished by such delegates and experts, unless actually knowing such information and advice to be inaccurate or unlawful.

The Plan Administrator may adopt uniform rules for the administration of the Plan from time to time, as it deems necessary or appropriate.

Amendment and Termination

Hilton intends to offer the Plan indefinitely, but reserves the sole discretionary right to modify, amend or terminate the Plan, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by its Board of Directors or its designee. Hilton's decision to change or terminate the Plan could result from:

- Changes in federal or state laws governing employee benefits;
- Changes in an insurance contract or policy involving an insurance company;
- Changes in a collective bargaining agreement; or
- Any other reason.

If the Plan is modified, amended or terminated, you will be notified of the effect of such change to your Plan benefits or coverage. However, the modification, amendment or termination may be effective before you are notified, to the extent permitted by law. Subject to the terms of any collective bargaining agreement, no consent of any employee or any other person will be necessary for Hilton to modify, amend or terminate the Plan described in this handbook.

Representations Contrary to the Plan

No employee, director or officer of Hilton has the authority to alter, vary or modify the terms of the Plan except by means of a duly authorized written amendment to the Plan. No verbal or written representations contrary to the terms of the Plan are binding upon the Plan, the Plan Administrator or Hilton.

No Assignment

To the extent permitted by law, and except as specified below and under the terms of the Plan, no benefits or any amount payable under the Plan will be subject to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind, and any attempt to do so will be void. This anti-assignment rule prevents you from legally assigning your rights under the Plan (which are personal to you) to a third party, including any person, practitioner, facility or institution, by which these third parties would stand in your shoes and be permitted to make claims directly against the Plan. Any attempt to assign any payment or benefit under the Plan will be null and void and will not be recognized or given effect. Only eligible participants have benefit rights under the Plan. However, benefits under the Plan may be subject to a Qualified Medical Child Support Order (QMCSO).

You may assign your benefits under the Plan with the Plan's consent. When you assign your benefits under the Plan with the Plan's consent, and a provider submits a claim for payment, you and the provider represent and warrant that the covered health services were actually provided and were medically appropriate. When the Plan has not consented to an assignment, the Plan will send the reimbursement directly to you (the participant) for you to reimburse the provider upon receipt of their bill. However, the Plan reserves the right, in its discretion, to pay a provider directly for services rendered to you. When exercising its discretion with respect to payment, the Plan may consider whether you have requested that payment of your benefits be made directly to the provider. Under no circumstances will the Plan pay benefits to anyone

other than you or, in its discretion, your provider. Direct payment to a provider shall not be deemed to constitute consent by the Plan to an assignment or to waive the consent requirement. When the Plan in its discretion directs payment to a provider, you remain the sole beneficiary of the payment, and the provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your benefits will be directed to you, although the Plan or its Claim Administrator may in its discretion send information concerning the benefits to the provider as well. If payment to a provider is made, the Plan reserves the right to offset benefits to be paid to the provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan).

Recovery of Payments Made by Mistake and Failure to Cash Benefit Checks

You will be required to return to Hilton any benefits, or portion thereof, paid under the Plan by a mistake of fact or law. If you do not return benefits paid under the Plan by a mistake of fact or law, the Plan may offset your future benefits up to the amount you owe the Plan.

With respect to any self-funded benefits provided under this Plan, the payee's failure to cash a benefit check (whether due to an inability to locate the whereabouts of such person after reasonable efforts have been made or for other reasons) shall result in a forfeiture of such payment to the Plan upon the later of (i) the stale date indicated on the benefit check or (ii) one year anniversary of issuance of such payment.

Responsibility for Tax Implication of Benefits

You will be responsible for the tax implications of and determination of imputed income with respect to any benefits you elect for eligible dependents who are not entitled to tax-free benefits under current federal law.

No Contract of Employment or Service

Your participation in the Plan does not assure you of continued employment with Hilton or rights to benefits except as specified under the terms of the Plan. Nothing in the Plan or in this handbook confers any right of continued employment (or service, as applicable) to any employee or leased employee, as applicable.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan described in this book to be void, unlawful or unenforceable under any applicable statute or other controlling law, the remainder of the Plan shall continue in full force and effect.

Plan Funding

Benefits offered under the Plan are provided on either a self-insured basis by Hilton or are fully insured, as shown in the following chart.

	Self-Insured	Fully Insured
Benefits	▪ Medical Coverage ▪ Prescription Drug Coverage (included with medical election) ▪ Flexible Spending Accounts ▪ Wellness Programs	▪ Medical Coverage ▪ Dental Coverage ▪ Vision Coverage ▪ Life Insurance (Basic, Supplemental and Dependent) ▪ Accident Insurance (AD&D and Business Travel) ▪ STD (Basic and Buy-Up) ▪ Disability Benefits Law Plan (New York STD plan) ▪ LTD ▪ Employee Assistance Program ▪ Retiree Life ▪ Voluntary Medical Benefits

General Information

	Self-Insured	Fully Insured
Definition	As claims are made, covered benefits are paid from Hilton's general assets. However, Hilton has administrative services contracts with third-party administrators to decide on and process claims.	An insurance carrier insures the benefits and pays the covered benefits. Hilton pays premiums to the insurance carrier for benefit coverages from its own funds as well as employee payroll deductions. In addition, an insurance carrier provides administrative services and makes decisions regarding benefits.

Please see the "Plan Information" chart at the end of this section for more details on which third-party administrators and insurance companies Hilton has contracted with to provide services and benefits.

Applicable Law

The Plan described in this handbook shall be governed and construed in accordance with the laws of the Commonwealth of Virginia to the extent not preempted by the laws of the United States.

Governmental Benefits Exclusion

If services or benefits are reasonably available under any plan or program established by any government or under any plan or program in which any government participates (other than as an employer), benefits under the Plan are not payable for such services or benefits unless payment is legally required. In the case of any person who is not enrolled for all coverage for which he or she has become eligible under any such plan or program, services and benefits available shall nevertheless include all benefits to which he or she would be entitled if he or she were enrolled for such coverage. The term "any government" includes the federal, state, provincial or local government or any political subdivision thereof of the United States or any country. This provision is subject to any provision or regulation of such plan or program that requires that benefits be utilized before benefits are available thereunder.

Interpretive Authority

If the Plan document does not clearly dictate whether an expense is eligible under the Plan and/or what percentage of the eligible charge is covered, the Claims Administrator or insurer will make a determination and pay benefits accordingly. Except as provided above, if a question arises as to the interpretation of the terms of the Plan document, the Plan Administrator has discretionary authority to interpret, construe and apply the terms of the Plan document and to decide any such question, including but not limited to a question as to a Team Member's eligibility to participate in the Plan.

Statement of ERISA Rights

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

Receive Information About Your Plan and Benefits

- Examine without charge at 7930 Jones Branch Drive, McLean, VA 22102, and major Human Resources offices of Hilton, all Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as annual financial reports (Form 5500 Series).
- Obtain copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Plan Administrator (at the address above). The Plan Administrator may make a reasonable charge for the copies.
- Receive summaries of the Plan's annual financial reports. These summaries are prepared and distributed to Plan participants each year. The Plan Administrator is required by law to furnish each participant a copy of the summary annual report.

General Information

Continue Group Health Plan Coverage

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

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose group health care 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 under HIPAA) after your enrollment in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including Hilton or any other person, may discharge you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reasons for the denial. You have the 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 Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the 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 Plan Administrator to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator (at the address below). If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 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.

GENERAL INFORMATION

Plan Sponsor	Hilton Domestic Operating Company Inc. 7930 Jones Branch Drive McLean, VA 22102 1.703.883.1000 Employer Identification Number: 38-4009972
Participating Employers	Contact the Plan Administrator for a complete list of participating employers.
Plan Administrator	Global Benefits Administrative Committee 7930 Jones Branch Drive McLean, VA 22102 1.703.883.1000 You may obtain a copy of any of the official legal documents from the Plan Administrator at the above address.
Appeals Committee (Eligibility Claims)	Hilton Domestic Operating Company Inc. U.S. Appeals Committee 7930 Jones Branch Drive McLean, VA 22102 1.703.883.1000 You may obtain a copy of any of the official legal documents from the Plan Administrator at the above address.
Agent for Legal Service	Hilton Domestic Operating Company Inc. General Counsel 7930 Jones Branch Drive McLean, VA 22102 1.703.883.1000 Service of legal process may also be made on the Plan Administrator.
Plan Name **Plan Number** **Plan Year**	Hilton Domestic Operating Company Inc. Health and Welfare Plan 502 January 1 – December 31
Plan Type	Each Plan is an employee welfare benefit plan offering group health plan, disability, life and accident coverage.

Plan Information

PLAN INFORMATION

To access any available insurance certificates:

1. Access YBR via this website: http://digital.alight.com/hilton
2. Click on the "Choose a Language" drop-down box from the log on page, select "English" or "Spanish – Español".
3. Enter your User ID and password on the Logon page.
4. From the YBR Home page, hover over the tab titled "Knowledge Center".
5. From the Knowledge Center drop down menu items, click on the Plan Information link.
6. The SPD and available insurance certificates and Coverage Booklets will be displayed on the next screen.

Benefit Program	Funding	Claims Administration
Medical	Self-funded	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 05156 1.855.496.6289 http://www.aetna.com Anthem 1.883.993.1378 http://www.anthem.com Cigna 1.855.694.9638 http://my.cigna.com United Healthcare Services Insurance 9900 Bren Road East Minnetonka, MN 55343 1.888.297.0878 http://myuhc.com
Medical	Fully-insured	Various Contact the Hilton Benefits Center at 1.877.442.4772 for details.
Prescription Drug	Self-funded	CVS Caremark Customer Care Correspondence P.O. Box 6590 Lee's Summit, MO 64064-6590 1.855.311.3158 www.caremark.com
Dental and Vision	Fully-insured	Various Contact the Hilton Benefits Center at 1.877.442.4772 for details.

Plan Information

Benefit Program	Funding	Claims Administration
Health Savings Account	For inquiries regarding individual HSA Accounts (Note: Although available with CDHP coverage, the HSA is an individual account arrangement with UMB Bank, and is not a benefit plan sponsored by Hilton).	UMB Bank 1010 Grand Boulevard Kansas City, MO 64106 https://hsa.umb.com
Flexible Spending Accounts (Full and limited purpose)	Self-Insured	Your Spending Account (YSA) P.O. Box 64030 The Woodlands, TX 77387-4030 1.800.964.6307 As of March 26, 2019: http://digital.alight.com/hilton Claim fax number: 1.888.211.9900
COBRA Administrator	Not applicable	Alight Solutions 100 Bayview Circle Newport Beach, CA 92660 1.877.442.4772
Employee Assistance Program	Fully-insured insurance contract with: ComPsych	ComPsych NBC Tower, 13th Floor 455 N. Cityfront Plaza Drive Chicago, IL 60611-5322 1.888.295.4327 Company Code: HC311 www.guidanceresources.com
Short-Term Disability* **Long-Term Disability** Policy Control # G-51532 ***Salary continuation for Corporate Team Members is a self-funded payroll practice administered by Prudential.*	Fully-insured insurance contract with: Prudential	The Prudential Insurance Company of America 751 Broad Street Newark, New Jersey 07102 www.prudential.com/hilton 1.855.315.4778

Plan Information

Benefit Program	Funding	Claims Administration
Disability Benefits Law Plan (DBL) (New York residents only)	Fully-insured insurance contract with: Prudential	The Prudential Insurance Company of America 751 Broad Street Newark, New Jersey 07102 www.prudential.com/hilton 1.855.315.4778
Basic Life Insurance **Supplemental Life Insurance** **Dependent Life Insurance** Group Policy# SA3-890-LF0109-01 **Retiree Life Insurance**	Fully-insured insurance contract with: Lincoln Financial Group	Lincoln Financial Group Claims for life insurance benefits are administered by: **General Inquiries** Lincoln Life Assurance Company of Boston Main Administrative Office 175 Berkeley Street Boston, MA 20116 **Group Life Claims** Toll Free: 888.787.2129 Fax: 603.742.3873 grouplifeclaims@LFG.com To file a claim for life benefits, call the Hilton Benefits Center at 1.877.442.4772 Monday through Friday from 8:00 a.m. to 6:00 p.m. CT.
Group Life Insurance Conversion	Insurance contract with: Lincoln Financial Group	Lincoln Financial Group **General Inquiries** Lincoln Life Assurance Company of Boston Main Administrative Office 175 Berkeley Street Boston, MA 20116 **Group Life Claims** Toll Free: 800.423.2765, Option1 Fax: 603.742.3873 conversion@LFG.com

Plan Information

Benefit Program	Funding	Claims Administration
AD&D Insurance Group Policy# SA3-890-LF0109-01	Fully-insured insurance contract with: Lincoln Financial Group	Claims for life insurance benefits are administered by: **General Inquiries** Lincoln Life Assurance Company of Boston Main Administrative Office 175 Berkeley Street Boston, MA 20116 **Group Life Claims** Toll Free: 888.787.2129 Fax: 603.742.3873 grouplifeclaims@LFG.com To file a claim for AD&D benefits, call the Hilton Benefits Center at 1.877.442.4772 Monday through Friday from 8:00 a.m. to 6:00 p.m. CT.
Business Travel Accident Insurance Group Policy # N16743872	Fully-insured insurance contract with: Chubb	Chubb Group of Insurance Companies Claims Service Center 600 Independence Parkway P.O. Box 4700 Chesapeake, VA 23327-4700 1.800.252.4670
Medical Abroad Benefits Group Policy # 04307A	Fully-insured contract with: Cigna Health and Life Insurance Company	Cigna Health and Life Insurance Company Cignaenvoy.com Please use the number of the back of your identification card.
Legal Services	Fully-insured contract with: MetLife Legal Plan	MetLife Legal Plan 1111 Superior Ave. Suite 800 Cleveland OH 44114 1.800.821.6400 Customer care center is available from 8:00 a.m. to 8:00 p.m. EST