THE INTERNATIONAL ALLIANCE OF THEATRICAL STAGE EMPLOYEES LOCAL 6 HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

March 2020

THE INTERNATIONAL ALLIANCE OF THEATRICAL STAGE EMPLOYEES LOCAL 6 HEALTH AND WELFARE FUND PLAN COVERAGE

Dear Participant and Beneficiary,

This booklet outlines the Plan and program for The International Alliance of Theatrical Stage Employees Local 6 Health and Welfare Fund (the "Fund") benefits applicable to you, including the nature and extent of benefits, eligibility requirements, rules and regulations, and the manner in which you may file claims for benefits. We urge you to read and review this carefully.

Your Fund was made possible through the process of collective bargaining by and between The International Alliance of Theatrical Stage Employees Local 6 (the "Union") and its signatory employers. That collective bargaining has resulted in the negotiation and execution of written labor agreements which require those employers to make contributions into your Fund to finance the benefits for you and your family.

The Fund is a joint labor-management employee benefit trust fund, financed by contributions fixed by collective bargaining or other written agreements, and administered by an equal number of Trustees designated by the contributing employers and by the Union pursuant to a Trust Agreement, which may be amended from time to time. The Trust Agreement gives the Board of Trustees authority and discretion to determine benefits, and the Trustees have accordingly adopted a Plan of benefits set forth and described by this Summary Plan Description (SPD). Under the Trust Agreement and SPD, the Trustees may, in their discretion, revise, discontinue, improve, reduce, modify or make changes in the Plan, the types and amounts of benefits provided, the coverage and eligibility provisions, conditions and rules, at any time. Any question of interpretation, construction, application or enforcement of the terms of the Plan and SPD are subject to the discretion of the Board of Trustees whose determinations are final and binding.

We sincerely hope that you rarely find it necessary to utilize the benefits provided for you. However, we think you will agree that a sense of personal security is derived from the knowledge that these fine benefits are available in the event they become necessary.

More information about the Plan may be obtained by contacting the Plan Administrator at:

International Alliance of Theatrical Stage Employees
Local 6 Health & Welfare Fund
6405 Metcalf Ave., Ste. 200
Overland Park, KS 66202
800-542-4482

Sincerely yours,

Management and Union Designated Board of Trustees

I. GENERAL INFORMATION / SCHEDULE OF PROVIDERS

Name of Plan:
The International Alliance of Theatrical Stage Employees Local 6 Health & Welfare Fund

Name And Address Of Plan Sponsor:
Board of Trustees
The International Alliance of Theatrical Stage Employees Local 6 Health & Welfare Fund
6405 Metcalf Ave., Ste. 200 Overland Park, KS 66202.

Employer Identification Number (EIN):
43-0791005

Type Of Plan:
This Plan is maintained for the purpose of providing medical, dental, long-term and short-term disability, vision and life and accidental death and dismemberment. These benefits are insured by the Companies shown in the "Important Contact Information for Benefits" section below.

Type Of Administration:
The Plan is administered by the Board of Trustees. The Trustees maintain a Fund Office to handle the day-to-day operations of the Plan and have entered into agreements with group insurance providers to handle various functions and arrangements of the Plan, including claims administration and processing of medical and pharmacy benefits, dental, vision, life and short- term disability benefits.

The companies providing services listed in the "Important Contact Information for Benefits" do insure the benefits provided under this Plan.

Name And Address Of Plan Administrator:
The International Alliance of Theatrical Stage Employees Local 6 Health & Welfare Fund
6405 Metcalf Ave., Ste. 200 Overland Park, KS 66202.

Agent For Service Of Legal Process:
The International Alliance of Theatrical Stage Employees Local 6 Health & Welfare Fund Plan Administrator
6405 Metcalf Ave., Ste. 200 Overland Park, KS 66202 (913) 236-5490.

Board of Trustees

Union Designated Trustees: Tim McDonald and Tim McCarthy

Employer Designated Trustees: Jeff Antrainer and Sean Smith

Legal Counsel:
Spector, Wolfe, McLaughlin & O'Mara, LLC
Daniel M. McLaughlin; Gary S. Wolfe
710 S. Kirkwood Road
Kirkwood, MO 63122
Phone: (314) 909-0303

Health and Ancillary Insurance Broker
Cornerstone Insurance Group
Scott Robson and Diane Myers
721 Emerson, Suite 500
St. Louis, Missouri 63141
Phone: 844-358-5444

Investment Consultant:
Visionary Wealth Advisors, LLC
Bill Lauber (advisor)
12300 Old Tesson Rd., #100C
Sappington, MO 63128-2228
Phone: (314) 843-9999

Source of Contributions and Funding:
The benefits described in this Plan Document are financed by employer contributions in accordance with their collective bargaining agreements with the Union. The Fund Participants and beneficiaries may examine these collective bargaining agreements and may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees at the address listed above. The Fund Office will provide, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Participants working under the collective bargaining agreements.

Plan Years:
The financial records of the Plan are kept on a Plan Year basis. The Plan Year ends on each May 31.

Benefit Plan Year:
The Benefit Plan Year ends on August 31 and begins September 1.

Plan Details:
The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, denial or loss of any benefits are described in this document. With respect to medical and pharmaceutical benefits, such circumstances are described in the group insurance Certificate issued by the Medical Insurance Provider. With respect to life and accidental death and dismemberment benefits, such circumstances are described in the group insurance Certificate issued by the Life Insurance Provider. With respect to long-term and short-term disability benefits, such circumstances are described in the group insurance Certificate issued by the Long and Short Term Disability Provider. With respect to the dental benefits, such circumstances are described in the group insurance Certificate issued by the Dental Provider. With respect to the vision benefits, such circumstances are described in the group insurance Certificate issued by the Vision Provider.

Authority to Interpret, Construe and Apply the Terms of the Plan:
The Board of Trustees has the authority and discretion to interpret, construe and apply all of the terms of this Summary Plan Description, the Trust Agreement and other documents governing the operation of this Plan, including any ambiguous terms in such documents. The Trustees will, pursuant to the terms of the Plan documents, make all final determinations regarding eligibility for benefits and the amount of benefits due Participants and beneficiaries. The decisions of the Trustees will be binding. All decisions made by the Trustees are intended to be subject to the most deferential standard of judicial review.

Amendment or Termination of the Plan or Trust

The Plan may be amended or terminated by a majority vote of the Trustees at any regular or special meeting of the Board of Trustees, subject to applicable collective bargaining agreement provisions. The benefits described in this booklet are those currently provided by the Plan. Those benefits, including benefits provided to retirees, can be altered, modified, reduced or terminated at any time the Trustees determine, in their discretion, such action is necessary. None of the benefits provided by this Plan, including retiree benefits are vested.

Should the Trustees determine to terminate the Trust, any assets remaining in the Trust shall be used consistently with the purposes of the Trust. No assets of the Trust shall revert to any employer.

Important Contact Information for Benefits:

Benefit Description	Provider	Group ID/Name	Customer Service
Medical & Pharmacy Insurance	United Healthcare	Local 6 HW Fund 914510	United Healthcare Customer Service ph: 866-527-9597 www.myuhc.com for medical or pharmacy See back of ID card for Cust Service and information for Providers and Claims
Dental Insurance	Delta Dental	Local 6 HW Fund 06181101	Customer Service ph: 1-800-335-8266 www.deltadentalmo.com P.O. Box 8690 St. Louis, MO 63126-0690
COBRA Administration	TIC International Corporation	Local 6 H&W Fund	(800) 542-4482
Life Insurance & AD&D Retiree Life Insurance	The Hartford	Local 6 HW Fund Number: OGL 681489	For Claims contact the Fund Office or online at: Thehartford.com/ mybenefits
Vision Insurance	Eye Med	Local 6 HW Fund 1001085	Customer Care 866-800-5457 www.eyemed.com Claims: First American Administrators, Attn: OON Claims P.O. Box 8504 Mason, Ohio 45040-7111
Short Term & Long Term Disability Insurance	The Hartford	Local 6 HW Fund Number for both Short/Long Term disability claims: GRH 885513	For Claims contact the Fund Office or call 1-800-549-6514 - voice 1-866-411-5613 – fax; or Thehartford.com/mybenefits

FOR ELIGIBILITY OR OTHER INQUIRIES, CONTACT PLAN ADMINISTRATOR INTERNATIONAL ALLIANCE OF THEATRICAL STAGE EMPLOYEES LOCAL 6 HEALTH & WELFARE FUND AT (800) 542-4482

II. ELIGIBILITY

GENERALLY

An employee will be eligible for medical, pharmacy, dental, long-term and short-term disability, vision and life and accidental death and dismemberment benefits for one or more signatory employers obligated to make contributions on their behalf to the Fund. Eligibility for coverage is based only upon contributions received by contributing employers based upon a formula established between the Union and the signatory employers (e.g. 13-15% of gross wages). The current contribution formula established and agreed to, and requirements for coverage, will be attached to the Trust documents. Eligibility requirements for coverage of Participants under the Trust can be reviewed by the parties and can be amended annually by the Board of Trustees in accordance with Article XI of the Trust Agreement.

The initial eligibility requirement is waived for full-time Employees of the Union. Business Representatives and Employees of the Union, however, must be employed and regularly working more than thirty (30) hours per week to remain eligible for benefits from the Fund. The initial eligibility requirement may be waived or reduced for existing Employees of a new contributing employer when, as a result of union organizing, the employer first signs a collective bargaining agreement requiring the employer to contribute to the Fund.

All employees working under the jurisdiction of the Union will remain eligible if they are eligible for contributions from contributing employers to be made on their behalf.

A. MEMBERS

1. Member Participation

   a. Member Eligibility Date. The eligibility date for coverage of each Member shall be the September 1st following the immediately preceding Qualifying Period during which the Member was an Active Qualifying Participant.

   b. Effective Date of Member Coverage. Subject to the Member Effective Coverage Date set forth in sub-paragraph (c) below, the coverage of each Member shall become effective on the applicable date given below:

      1. For Active Qualifying Participants, coverage shall become effective on the Member's Eligibility Date.

      2. If coverage for a Member or Dependent has been terminated at their request or due to failure to make any required member contribution for such coverage, coverage shall again become effective at the next Member Eligibility Date, provided that the Member or Dependent qualifies for the eligibility period (through open enrollment), absent an otherwise qualifying event.

c. Member Effective Coverage Date. The effective date of Member coverage shall be subject to the Member being Actively at Work. See Section XIII, Definitions, subparagraph 19 for an explanation of this term. Termination of Member Coverage. Coverage for each Active Qualifying Member shall, subject to COBRA, terminate at midnight on the earliest of the following dates:

1. August 31st of the first year following the year in which the most recent Insured Period began;

2. The date of Plan termination; or

3. As to any particular coverage or benefit, the date such coverage or benefit is terminated, the date the Member ceases eligibility for such coverage or benefit including COBRA for a qualifying event or the date of the Member's death.

B. BUSINESS REPRESENTATIVE PARTICIPATION AND OFFICE EMPLOYEES

1. Business Representative Participation

a. Business Representative Eligibility Date. The eligibility date for each Business Representative shall be the date of employment as a Business Representative.

b. Effective Date of Business Representative Coverage. The coverage of each Business Representative shall be effective as set forth above in sub-paragraph (c) immediately below.

c. Business Representative Effective Coverage Date. The date of the Business Representative coverage shall be subject to the definition of Effective Date of Coverage in Section XIII, paragraph 19 which defines Coverage for Participants Actively at Work.

d. Termination of Business Representative Coverage. A Business Representative will remain covered until the end of the month of the date employment as a Business Representative comes to an end, unless employment as a Business Representative comes to an end in accordance with the provisions of sub-paragraph (1) below. In all other cases, COBRA continuation coverage will then be offered if the Participant is otherwise eligible.

Coverage for each Business Representative shall terminate at midnight on the earliest of the following dates:

1. A Business Representative will remain covered until the end of the month of the date employment as a Business Representative comes to an end if the employment ends in termination due to cause;

2. If the Business Representative voluntarily resigns his/her position or retires, the coverage continues through August 31 of the next subsequent coverage year to allow the Member time to work sufficient hours to re-establish another coverage period.

3. If the Business Representative runs for re-election and is not re-elected the Representative shall have continuous coverage through August 31 of the next subsequent coverage year to allow the Member time to work sufficient hours to re-establish another coverage period;

4. The date of Plan termination;

5. As to any particular coverage or benefit, the date such coverage or benefit is terminated, the date the Business Representative ceases eligibility for such coverage or benefit including COBRA for a qualifying event or the date of the Business Representative's death; or

6. The date the Business Representative becomes eligible as a Member for coverage under the Benefits provided for under this Plan as a result of contributions made from contributing employers during the most recently ended Qualifying Period.

2. Office Employee Participation

a. Office Employee Eligibility Date. The eligibility date for each Office Employee shall be the date of hire.

b. Effective Date of Office Employee Coverage. The coverage of each Office Employee shall be effective as set forth in subparagraph (c) immediately below.

c. Office Employee Effective Coverage Date. The effective date of the Office Employee coverage shall be subject to the definition of Effective Date of Coverage in Section XIII, subparagraph 19 which defines Coverage for Participants Actively at Work.

d. Termination of Office Employee Coverage. Coverage for each Office Employee shall terminate at midnight on the earliest of the following dates:

1. The last day of the month in which the Office Employee terminates employment; or

2. The date of Plan termination; or

3. As to any particular coverage or benefit, the date such coverage or benefit is terminated, the date the Office Employee ceases eligibility for such coverage or benefit or the date of the Office Employee's death.

C. DEPENDENTS

1. Generally. A Dependent of an Employee who is eligible for family coverage is eligible for coverage of medical, dental and vision benefits if the Dependent is:

a. An Employee's spouse (if not legally separated or divorced from the Employee).

b. An Employee's child, with respect to Medical, Dental, and Vision Benefits only, from the moment of birth or placement for legal adoption (but not after the child is removed from placement prior to legal adoption), until the child attains Age 26.

c. With respect to Medical, Dental, and Vision Benefits only, an Employee's disabled or handicapped child who has attained Age 26 provided such child is:

1. Mentally or physically incapable of earning his own living. Proof of incapacity must be furnished to the Plan within 31 days of his attainment of the limiting Age; and
2. Dependent on the Employee for support and maintenance; and
3. A Covered Person on the day immediately prior to attaining the limiting Age.

d. With respect to Medical, Dental and Vision Benefits only, a covered Employee's child who is recognized under a Qualified Medical Child Support who is recognized under a Qualified Medical Child Support Order (QMCSO), as determined by federal law, as having a right to receive benefits under the Plan.

The term Child includes not only a biological child, but also:

1. A stepchild;
2. An adopted child;
3. A child who has been placed in the Employee=s home for adoption;
4. A foster child placed with the Employee by an authorized placement agency, or by judgment, decree or other order of any court of competent jurisdiction.
5. A child for whom the Employee has been appointed permanent legal guardian, provided the child resides with the Employee and is dependent upon the Employee for support.

2. Effective Date for Dependent Coverage. Each Participant's eligibility date of dependent coverage shall be the first date on which the Participant is eligible for and elects personal coverage under this Section and has one or more eligible Dependents, as defined in sub-paragraph 1 herein, provided that a Participant whose Dependents shall all cease to be eligible shall have a new eligibility date for dependent coverage if, and when, the Participant again has an eligible dependent while the Participant is eligible for personal coverage under the Plan

3. Enrollment Requirements for Dependents of Business Representative or Office Employees. The Dependents of a Business Representative or Office Employees are eligible for coverage for medical, dental and vision benefitsonly:

    a. Based on the Business Representative's or Office Employee's eligibility date for dependent coverage provided they authorize and submit contributions to the Fund for dependent coverage on or before such date;

    b. Based on the date the Business Representative or Office Employees submits contributions to the Fund for dependent coverage, provided they do so within thirty-one (31) days after their eligibility for coverage;

    c. Based on the date specified by the Trustees with respect to each and every dependent the Business Representative or Office Employee has on the date they authorize and submit contributions to the Fund, if they do so more than thirty-one (31) days after their date of eligibility for coverage.

4. Business Representative or Office Employee and Member Active Work on a Full-Time Basis Proviso for Dependent Coverage. The dependent coverage of a Business Representative, Office Employee or Member who is unable to perform due to injury or illness on the day preceding the date his coverage would otherwise become effective, and who was not covered under this preceding day for the benefits provided under the Plan of benefits shall become effective on such date provided that the effective date of such coverage of any individual Dependent shall be subject to the Dependent Effective Date of Coverage as defined in Section XIII, subparagraph 19.

5. Addition of Eligible Dependents

   A Dependent will become a Covered Person on the date the Employee qualifies for Dependent coverage. For any member who already qualifies for dependent coverage and has children under the age of 26 who were previously not eligible for dependent coverage, the Plan will send an Enrollment Form to the member to determine if the child is eligible for coverage.

Furthermore, and subject to the Dependent Effective Date of Coverage dependent coverage shall be extended to cover each additional Dependent of a Participant. Dependents are eligible for coverage only if the Fund is notified by the Participant of the Dependent's eligibility and only if contributions are received for coverage of the Dependent.

With respect to a newborn child, the Participant is responsible for notifying the Fund Office of the addition of a newborn, adopted child or child to which the Participant is legally responsible for providing coverage of benefits. This notification must take place within thirty-one (31) days of the qualifying event (i.e. date of birth, date of adoption, date of placement or date of legal proceeding)

6. Termination of Dependent Coverage. The dependent coverage of each Participant's dependent(s) shall automatically terminate on the earliest of the following dates:

   a. The date the Participant's personal coverage under the Plan terminates;

   b. The date of expiration of the period for which the last required Member contribution toward the cost of dependent coverage is made by the Member if Member contributions are required;

   c. As to any particular coverage or benefit, the date such coverage or benefit is terminated, the date the Participant ceases eligibility for such coverage or benefit; or

   d. The date of Plan termination.

If dependent coverage has been terminated at the request of the Participant, or because of failure to make the required contribution for such coverage, their coverage shall become effective at the next qualifying period, provided the Participant or Dependent qualifies for the eligibility period (through open enrollment), absent an otherwise qualifying event.

D. SURVIVING DEPENDENT PARTICIPATION

Notwithstanding any terms or conditions to the contrary in Article II, Section C (Dependent Coverage), the Following provisions will apply to the Surviving Dependents of deceased Business Representatives and Members

1. Surviving Dependent(s) Eligibility Date. The eligibility date for coverage for each Surviving Dependent of a deceased Business Representative, Office Employee or Member shall be:

a. In the case of a Member who was an Active Qualifying Participant during the most recently ended Qualifying Period, the eligibility date for coverage of each Surviving Dependent shall be the day after the date of the Member's death;

b. In the case of a Business Representative or Office Employee, the eligibility date for coverage of each Surviving Dependent shall be the day after the date of the Business Representative's death.

2. Effective Date of Surviving Dependent(s) Coverage. The coverage for each Surviving Dependent of a Business Representative or Member shall be effective on the Surviving Dependent(s) eligibility date.

3. Termination of Surviving Dependent(s) Coverage. Coverage for each Surviving Dependent(s) of a Member or Business Representative shall terminate at midnight on the earliest of the following dates:

a. In the case of a Surviving Dependent of an Active Qualifying Participant, the date the current Insured Period ends;

b. As to any particular coverage or benefit, the date such coverage or benefit is terminated, the date the Participant ceases eligibility for such coverage or benefit; or

c. The date of Plan termination.

E. SPECIAL ENROLLMENT RIGHTS PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty (30) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information contact the Plan Administrator.

Board of Trustees
The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6405 Metcalf Ave., Ste. 200
Overland Park, KS 66202
(800) 542-4482

F. RETIREES

Retirement Criteria: A covered Plan Participant is eligible for Retiree status if the Participant transitions from being a covered Plan Participant to Retiree status and has no break in continuous coverage. This continuous coverage can be for a member who: (1) is actively at work and covered as a Participant; or (2) was an active member and has continuing coverage through the Fund for the subsequent coverage period as described in the example below; or (3) is a Plan Participant through COBRA Continuing Coverage and remains in the Plan as a covered Participant. If there is any break in continuing coverage a member will not be eligible for Retiree status.

Once an active member retires, he/she must complete a retirement form. Once the active member retires, he/she is terminated from all lines of coverage (medical, dental and vision) as an active member on August 31 of that Plan year and may continue coverage for the subsequent Plan year if they meet the eligibility requirements set forth below. Retirees will be provided Life Insurance and A&D (accidental death) Benefits in the amount of $10,000 if under sixty- five (65) years of age and $5,000 if over sixty-five (65) years of age at no cost to the Retiree. If a Retiree is eligible for and receiving Medicare benefits the Fund will provide assistance with Medicare Supplements by reimbursing fifty percent (50%) of the cost of that Medicare Supplement coverage.

In the event an active member retires during the Plan year and their employer made the required amount of contributions on their behalf during the qualifying period said member shall be eligible for retiree coverage for the subsequent Plan year under the same terms and conditions as an active member. Example: If Participant A decides to retire in March 1, 2020 and their employer contributed $15,000 on his/her behalf, he/she will be eligible for coverage for the coverage period of September 1, 2020 through August 31, 2021.

Coverage under this Plan shall become secondary to Medicare the first day of the Plan month in which the Retired Members becomes eligible for Medicare.

After retirement and once Active or Retired Member coverage ends the retired Member will be offered COBRA Continuation Coverage. This COBRA coverage is not free and must be paid at the appropriate COBRA rate by the retired Member. That COBRA coverage will last for eighteen (18) months.

If the Fund is not notified in writing of a member's retirement and the member does not qualify for benefits, he/she will be terminated from coverage and offered a life insurance conversion as well as COBRA continuation coverage.

*Retiree benefits are not a guarantee of benefits. The Trustees may, at their discretion, terminate Retiree coverage at any time.

G. ENROLLMENT AND BENEFICIARY DESIGNATION

You must complete an individual enrollment form in order to activate your eligibility for benefits within thirty (30) days of your effective date of eligibility. You may obtain the enrollment form from the Fund Office. Return the completed form to the Welfare Fund Office.

In order to enroll your dependents, you may be required to furnish proof of their status as eligible dependents. If you have any questions about your dependents' eligibility, please contact the Welfare Fund Office.

You will also be required to complete an annual information form updating information about yourself and your eligible dependents. The Fund Office will send you this form. Benefits will not be paid until the Fund Office has received the completed annual information form.

Your failure to complete the original enrollment form for yourself or any dependent or your failure to complete an updated form can make you ineligible for benefits. Further, if you fail to provide the enrollment form or annual information form within the time limit for filing a particular claim, that claim will not be covered.

Children will also be enrolled as required by any Qualified Medical Child Support Order (QMCSO), on the date the Welfare Fund Office receives such an order or, later based on the date specified in the QMCSO. If you would like information about the Plan's procedures for processing a QMCSO, call the Welfare Fund Office.

When you enroll, you will also designate your beneficiary for your death benefits. You may change your beneficiary at any time. See Section VI of this Booklet regarding Death Benefits for more information.

H. LEAVE OF ABSENCE PROTECTED BY THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

If your participating employer is subject to the Family and Medical Leave Act of 1993, Plan coverage for you and your dependents may be continued during a FMLA leave for the maximum period as allowed by law. If your Employer approves your leave, the Fund will extend your Plan coverage and that of your covered dependents at no cost to you during your leave.

Your Employer must properly grant the leave under FMLA and notify the Fund Office in writing.

Any hours you miss from scheduled work because of FMLA leave will count as hours worked in determining your eligibility for benefits.

Your Employer is required to continue your health coverage during your leave under the same terms and conditions as if you had continued to work. In addition, when you return to work, the law generally requires your employer to restore you to the same or an equivalent position and health care benefits you enjoyed when your FMLA leave started.

I. LEAVE OF ABSENCE PROTECTED BY THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Your coverage will continue if you serve in the Uniformed Services of the United States (active duty or inactive duty training) for up to thirty-one (31) days.

If you serve more than thirty-one (31) days, you may continue coverage at your own expense for up to twenty-four (24) months under COBRA and USERRA. Your right to continue coverage under this provision will end twenty-four (24) months after you begin your protected military leave or when you fail to return to work within the time period prescribed by USERRA, whichever is earlier. If your coverage is canceled while you are on a protected military leave, it will be reinstated on the date you return from the leave, provided that date is within the period prescribed by USERRA. You will not be required to satisfy any eligibility or benefit waiting period or any pre-existing condition limitation to the extent that they had been satisfied before the start of your protected military leave. This exception does not apply to coverage of any illness or injury incurred in, or aggravated during, performance of service in the uniformed services.

III. COBRA CONTINUATION COVERAGE

A. GENERALLY

Under certain circumstances, called "Qualifying Events," you, your covered dependents, or both may continue the benefits provided under this Plan except Short-Term Disability Benefits, Long-Term Disability, Accidental Death and Dismemberment and Death Benefits. You or your dependents do not have to show you are insurable, but you must pay for these continuation benefits.

1. Qualifying Events

You, your covered dependent(s), or in some cases both, may choose COBRA Continuation Coverage when your coverage would otherwise end due to one of the following events:

a. You and your covered dependent(s) if your employment is terminated, voluntarily or involuntarily, for any reason other than your gross misconduct;

b. You and your covered dependent(s) if the hours of your employment are reduced so that your employer is no longer required to contribute on your behalf (includes strike, layoff, and disability);

c. Your covered spouse and covered children in the event of your death;

d. Your covered spouse and covered children in the event of your divorce or legal separation, provided the Fund is notified within sixty (60) days;

e. Your covered dependent child who no longer meets the Plan's definition of an eligible child, provided the Fund Office is notified within sixty (60) days;

f. If you are a retired employee whose employer is bound to continue making contributions to the Welfare Trust on your behalf and you lose coverage because that employer files a Chapter 11 bankruptcy, you and your dependent spouse may choose continuation coverage.

If you or your dependent(s) choose COBRA continuation coverage, the Plan is required to provide you coverage which, at the time the coverage is being provided, is identical to the medical and/or dental and/or vision coverage provided under the Plan to similarly situated eligible employees or dependents. Weekly Indemnity Benefits, Long-Term Disability and Death Benefits cannot be continued.

2. Qualified Beneficiaries

Each person who was covered on the day before a qualifying event and who loses coverage due to that qualifying event is a qualified beneficiary who has the right to choose COBRA continuation coverage. Further, if you have a new baby

or adopt or have a child placed with you for adoption while you are on COBRA continuation coverage, that child becomes a qualified beneficiary who could make an independent election to continue COBRA coverage for the balance of the applicable period if your COBRA coverage ends for some reason before the end of the maximum period. For example, if you chose to drop your own COBRA coverage before the eighteen (18) months was up, the child could elect COBRA for the remaining balance of the eighteen (18)-month period.

B. REQUIRED NOTICES, ELECTION, AND PAYMENTS

1. Your Notice to the Plan

Under the law, the eligible employee or dependent(s) has the responsibility to inform the Welfare Fund Office of a divorce, legal separation, or a child losing dependent status under the Plan within thirty (30) days after such event or, if later, within thirty (30) days after coverage would terminate because of that event. **If you or your dependent fails to give the Fund Office notice of one of these events within that 30-day period, all rights to continue coverage are lost.**

The employer making contributions on behalf of an employee has a responsibility to notify the Plan of the employee's death, termination of employment or reduction in hours of employment. Employees and their dependents are additionally responsible to provide the Fund Office with notification of these events as well.

2. Plan's Notice to Employee and Dependents

Within thirty (30) days after the Fund Office receives notice that one of the qualifying events has occurred, it will in turn notify you, your dependents, or both of the procedures for electing COBRA continuation coverage.

3. Election

You or your dependents must elect COBRA continuation coverage in writing. Under the law, you and your dependents have sixty (60) days from the later of the date you would lose coverage because of one of the events described above or the date the Fund Office provides the written notice of your continuation rights to inform the Welfare Fund Office in writing that you want continuation coverage.

If you or your dependents do not inform the COBRA Administrator Provider in writing that you elect continuation coverage within the required time, all rights to continue coverage will end.

Each employee and covered dependent is entitled to make his or her own decision regarding COBRA continuation coverage. This is true even if the former employee chooses not to continue coverage. However, one family member can elect and pay for coverage on behalf of all qualified beneficiaries.

During the period between the termination of your regular coverage and your election and payment for COBRA continuation coverage, the Welfare Plan cannot pay for any expenses incurred after the termination of your active coverage. The Fund Office will notify providers of health care that you have not yet elected or paid for COBRA continuation coverage. If you do ultimately elect and pay for COBRA continuation coverage, the group Insurance Provider will then adjudicate claims you may have incurred in the interim.

4. Payment

COBRA continuation coverage is not free. You must pay for it. The initial payment is due within forty-five (45) days after the date you make your election. The first payment must include payment for all months between the termination of active coverage and the date of your election. Subsequent payments are due on the first day of each month, but will be accepted for up to thirty (30) days after the due date.

C. DURATION OF COBRA CONTINUATION COVERAGE

1. Termination or Reduction of Hours of Employment

a. Generally

If the qualifying event is the termination or reduction in hours of employment, the required period of COBRA continuation coverage ends eighteen (18) months after the date of the qualifying event.

b. Extensions

1. Disability

If prior to the end of that eighteen (18 -month period, any of the qualified beneficiaries who elected COBRA is determined by Social Security to have been disabled during the first sixty (60) days of COBRA continuation coverage, the maximum COBRA continuation period is extended for an additional eleven (11) months. The disabled person and all other qualified beneficiaries who have COBRA coverage by virtue of the same qualifying event may purchase coverage for up to a total of twenty-nine (29) months from the date of the original qualifying event. If the disabled person is covered during this eleven (11) month extension, the premium will be 50% higher.

Note: You must notify the Welfare Fund Office of the Social Security disability determination before the end of the original eighteen (18) month period and within sixty (60) days after Social Security makes the determination. You must also notify the Fund Office when the disability ends.

2. Medicare Entitlement

If the former employee was eligible for Medicare at the time of the qualifying event, the COBRA continuation coverage period of the employee's dependents will not end until thirty-six (36) months after the date the employee became eligible for Medicare. For example, if you became eligible for Medicare in May of 2018, and then terminated employment in June of 2018, <u>your</u> COBRA period ends December of 2019, but your eligible dependents can continue their COBRA coverage through May of 2021, which is thirty-six (36) months after your Medicare entitlement.

3. Second Qualifying Event

If a second qualifying event occurs during the eighteen (18) month (or twenty-nine (29) month) period, the maximum continuation period will be extended to thirty-six (36) months from the date of the original qualifying event for the qualified beneficiaries affected by that second qualifying event. For example, if your employment is terminated on December 21, 2018, you and your eligible dependents are entitled to COBRA continuation coverage until June 30, 2020. However, if in May of 2019, your son turns twenty-six (26), he has had a second qualifying event, and his COBRA continuation period can continue until December 31, 2021 (thirty-six (36) months from the date of the original qualifying event).

2 <u>Other Qualifying Events</u>

For all qualifying events other than the termination of employment or the reduction in hours of employment, the maximum COBRA continuation period is thirty-six (36) months from the date of the qualifying event.

D. <u>TERMINATION OF COBRA CONTINUATION COVERAGE</u>

All rights to COBRA continuation coverage permanently end on the <u>earliest</u> of the following occurrences:

1. The expiration of the applicable maximum COBRA continuation period;

2. The failure to make a payment before the end of the applicable grace period;

3. After the date that COBRA is elected, the covered individual becomes covered under Medicare or under another group plan, unless that other plan limits coverage of the individual due to the individual's pre-existing condition.

4. The Plan or the contributing employer for whom the employee worked or works stops providing group health benefits.

E. CONTINUATION FOR PERSONS ENTERING UNIFORMED SERVICES

If you leave covered employment and enter active duty in the uniformed services of the United States, you are entitled to continuation coverage without charge for thirty (30) days. If your period of active duty is longer than thirty (30) days, then COBRA coverage on a self-pay basis is available. **Please inform the Fund Office if you enter one of the uniformed services, otherwise you may lose your right to continue coverage.**

You may contact the Fund office with your questions regarding COBRA coverage. If further information is needed you can contact:

U.S. Department of Labor
Pension and Welfare Benefit Administration
200 Constitution Avenue NW, Room N-5658
Washington, D.C. 20210

IV. SHORT-TERM DISABILITY BENEFITS

A. GENERALLY

If you are eligible, weekly benefits are payable when you are unable to work because of a non-occupational injury, sickness, or disease. No benefits are payable for an injury, sickness or disease which arises from or in the course of employment or for which you are entitled to benefits under any workers' compensation law, occupational disease law, or any similar law.

The Plan does not cover any disability which begins during a period of unemployment.

Short-term Disability Benefits are not provided if you are covered under COBRA continuation coverage or if you are covered as a retiree.

B. AMOUNT AND PERIOD OF BENEFITS

See Schedule of Benefits Insert and the Short-Term Disability Provider's group insurance Certificate for more information and for any benefit exclusions. You will be paid 66 2/3% of your weekly earnings to a maximum amount of $350 per week.

C. WHEN BENEFITS ARE PAYABLE

Benefits begin on the day listed in the Schedule of Benefits and Short-Term Provider's Group Insurance Certificate for a continuous disability due to a non-occupational accident or illness. You shall continue to be eligible for Short-term Benefits as long as you remain disabled and under the care of a legally qualified physician up to the maximum period.

Benefit payments begin when the Elimination or Waiting Period is completed The Elimination Period is 14 days so your benefits begin on day 15 of your disability.

D. MAXIMUM PERIOD

See Schedule of Benefits Insert. The Maximum Period of benefits is 24 weeks.

Claim and Appeal procedures for short-term disability insurance benefits are described in the group insurance Certificate issued to you by the Company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this document.

V. LONG-TERM DISABILITY BENEFITS

A. GENERALLY

If you are eligible, benefits are payable when you are unable to work because of a non-occupational injury, sickness, or disease. No benefits are payable for an injury, sickness or disease which arises from or in the course of employment or for which you are entitled to benefits under any workers' compensation law, occupational disease law, or any similar law.

The Plan does not cover any disability which begins during a period of unemployment.

Long-term Disability Benefits are not provided if you are covered under COBRA continuation coverage or if you are covered as a retiree.

B. AMOUNT AND PERIOD OF BENEFITS

See Schedule of Benefits Insert and the Long-Term Disability Provider's group insurance Certificate. Currently, your benefit will be 60% of your pre-disability earnings up to a $4,000 maximum per month.

C. WHEN BENEFITS ARE PAYABLE

Benefits begin on the day listed in the Schedule of Benefits and Long-Term Provider's Group Insurance Certificate for a continuous disability due to a non-occupational accident or illness. You shall continue to be eligible for Long-term Benefits as long as you remain disabled and under the care of a legally qualified physician up to the maximum period.

Benefit payments begin when the Elimination Period is completed. The Elimination or Waiting Period is 180 days after you become disabled.

D. MAXIMUM PERIOD

See Schedule of Benefits Insert. If you become disabled before age 63 benefits may continue for as long as you remain disabled or until the greater of your Social Security normal retirement age or 4 years. If your disability occurs at age 63 or above, the number of payments may reduce.

Claim and Appeal procedures for long-term disability insurance benefits are described in the group insurance Certificate issued to you by the Company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this document.

VI. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT

A. GENERALLY

If you are eligible, the Plan provides a death benefit that is payable to your beneficiary in the event of your death. In order to qualify for these benefits, you must be covered under the Plan and must be actively working in covered employment.

No death benefits are provided under COBRA continuation coverage.

B. BENEFIT AMOUNT

See Schedule of Benefits for AD&D and the Life Insurance Provider's group insurance Certificate for more information and for any benefit exclusions. For Life Insurance: (1) the benefit is $50,000 for active members; (2) $10,000 for Retirees under age 65 and (3) $5,000 for Retirees 65 years or older.

C. BENEFICIARY

Your beneficiary shall be the beneficiary you designate in writing to the Welfare Fund Office. The Fund Office will provide you a copy of your beneficiary designation upon your request at any time.

If you designate more than one beneficiary but fail to specify their respective interests, the beneficiaries shall share equally.

If any designated beneficiary predeceases you, the interest of such beneficiary shall terminate and his/her share shall be payable to such other designated beneficiaries as survive you, unless you had made written request to the contrary. In the event no designated beneficiary survives you or you failed to name a beneficiary, the amount due shall be payable as follows:

> To your spouse, if living; if not living, to your surviving child or children equally; if none survive, to your surviving parents equally; if none survive, to surviving brothers and/or sisters; if none survive, to the executors or administrators of your estate.

You are at liberty to change your beneficiary at any time. To do so, simply ask for a change of beneficiary request form, complete and return it to the Fund Office so that the change can be properly endorsed by the Welfare Fund Office, and coordinated with the Life Insurance Provider. When received, the change shall relate back and take effect as of the date you signed the written request for change, whether or not you are living at the time of the receipt of such request, but without prejudice to the Welfare Fund on account of any payment made before receipt of such written notice.

VII. MEDICAL BENEFITS

A. SCHEDULE OF MEDICAL BENEFITS

See Schedule of Benefits Insert and the Medical Insurance Provider's group insurance Certificate.

(All deductibles, co-pays, and benefit limits are listed in the Schedule of Benefits)

B. THE DEDUCTIBLES

1. Medical

The deductible is the amount of covered medical expenses each covered individual must pay each calendar year before that person receives certain benefits from the Plan. Further, the deductibles for In-Network providers and Out-of-Network providers do NOT cross-apply. If you use both In-Network and Out-of-Network providers, the maximum amount an individual will pay in deductibles in a calendar year is listed in the Schedule of Benefits and Medical Provider's group insurance Certificate.

Co-payments do not count toward the deductible **(unless specifically identified in the Schedule of Benefits and Medical Provider's group insurance Certificate)**

2. Prescription Drugs

As indicated in the Schedule of Benefits, you will have a copayment, and/or coinsurance payment, before the Plan will provide any benefits for prescription drugs. This copayment, and/or coinsurance, is in addition to the medical deductible. Every covered member of your family must meet this prescription drug copayment, and/or coinsurance payment, before the Plan will pay any benefits for prescription drugs that person obtains.

C. OUT-OF-POCKET LIMITS

This Plan feature limits the amount you or a dependent could pay for covered medical or pharmacy expenses for you or your dependent(s) during a calendar year.

Generally, for most covered expenses, the Plan pays as outlined in the Schedule of Benefits after the deductible is satisfied, and the covered individual must pay the remainder of the covered charges by co-payments or co-insurance. Once the covered individual's deductible and co- payments have reached the limits outlined in the Schedule of Benefits in a calendar year, the Plan will pay 100% of the covered charges incurred by the same person within the balance of that calendar year.

Currently, the annual out-of-pocket limit for In-Network benefits is $6,350 per individual and $12,700 per family. These limits may increase each calendar year.

Once the deductibles and co-payments paid by all of your covered family members have reached the limits outlined in the Schedule of Benefits during a calendar year, the Plan will pay 100% of any additional charges incurred by any of your covered family members during the balance of that same calendar year.

Some co-payments do not count toward the out-of-pocket maximum. For example, chiropractor co-payments do not count toward the out-of-pocket maximum.

If you use Out-of-Network providers, the Out-of-Pocket Limits are higher. This is another reason you should always make every effort to use In-Network Providers.

D. LIFETIME MAXIMUM BENEFITS

This Plan of benefits provided for by the Fund does not establish or recognize Lifetime Maximum benefit levels. Subject to the specific limitations as outlined in the Schedule of Benefits, all expenses for covered services shall be paid in accordance with the terms and conditions of this Plan so long as the Participant remains eligible for coverage.

E. NETWORK PROVIDERS

The Medical Insurance Provider has made arrangements with a network of doctors, hospitals and other providers of medical services. These In-Network providers have agreed to accept as payment for their services, amounts which are often less than amounts charged by other providers. When you and your dependent(s) use the In-Network providers, the Plan will pay a greater percentage of the covered charges you incur than when you or your family use Out-of-Network providers. You will pay a significantly greater portion of the charges for Out-of-Network. In addition, because the Out-of-Network providers often charge more, you will be paying a greater portion of higher charges. Thus, it is always in your best interest to use In-Network Providers.

In order to make sure you have the most up to date information about which providers are in the Network, call the Medical and Pharmacy Plan Provider at the number shown on your medical I.D. card or visit the Medical and Pharmacy Provider’s website. It is your responsibility to verify that your provider is in the Network.

F. COVERED MEDICAL EXPENSES

See Schedule of Benefits Insert. For a complete list of covered medical expenses please refer to the group insurance certificate.

Claim and Appeal procedures for denial of covered medical expenses are described in the group insurance Certificate issued to you by the Company providing such benefits identified in the “Important Contact Information for Benefits” section at the beginning of this document.

G. CONDITIONS AND LIMITS ON SPECIFIC BENEFITS

See Schedule of Benefits Insert.

Claim and Appeal procedures for conditions and limitations on specific medical benefits are described in the group insurance Certificate issued to you by the Company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this document.

H. MEDICAL BENEFITS EXCLUSIONS AND LIMITATIONS

See Schedule of Benefits Insert. For a complete list of benefit exclusions and limitations please refer to the group insurance certificate.

VIII. DENTAL BENEFITS

A. GENERALLY

If you are eligible, dental care benefits are payable when a covered individual incurs expenses for basic dental care, denture replacement and orthodontia by a licensed dentist or orthodontist. An expense is considered to be incurred on the date the service is rendered.

B. SCHEDULE OF BENEFITS

See Schedule of Benefits Insert and the Dental Provider's group insurance Certificate.

C. MAXIMUM BENEFITS

You and each of your covered dependents have a calendar year maximum which applies to Basic Dental Care and Denture Replacement benefits. Currently, this calendar year maximum is $1,500 per person. There is also a lifetime maximum benefit of $1,000 for Orthodontic treatments per person. See the Schedule of Benefits Insert for the lifetime and calendar year maximum amounts as the amounts may change between dental providers.

D. DENTAL BENEFITS EXCLUSIONS AND LIMITATIONS

See Schedule of Benefits Insert. For a complete list of benefit exclusions and limitations please refer to the group insurance certificate.

E. COORDINATION OF BENEFITS

Please contact or refer to the Dental Provider's group insurance Certificate. Coordination of Benefits (COB) means the benefits provided by the Plan for a particular benefit will be coordinated with the benefits provided by any other plan(s) covering the individual for whom the claim is made for the same type of benefit. This is so that a covered individual's total payment from all plans will not exceed 100% of his or her total Eligible Expenses under this Plan.

IX. VISION CARE BENEFITS

A. GENERALLY

If you are eligible, vision care benefits are payable when a covered individual incurs expenses for eye examinations, eyeglasses and contact lenses performed or prescribed by a licensed optometrist or licensed doctor of medicine. An expense is considered to be incurred on the date the service is rendered.

B. MAXIMUM BENEFITS

See Schedule of Benefits Insert and Vision Provider's group insurance Certificate.

C. WHEN BENEFITS ARE PAYABLE

Benefits are payable in the amount of the covered vision care expenses incurred by a covered individual, up to the maximum benefits specified above. For a complete listing of covered vision expenses see the Schedule of Benefits and Vision Provider's group insurance Certificate. Certain benefits selected may result in costs to you the covered individual or your dependent(s) over and above the maximum benefits allowable under the Plan.

D. VISION BENEFITS EXCLUSIONS AND LIMITATIONS

See Schedule of Benefits Insert. For a complete list of benefit exclusions and limitations please refer to the group insurance certificate.

X. COORDINATION OF BENEFITS UNDER THIS PLAN WITH OTHER COVERAGE

A. MEDICARE BENEFITS

As between Medicare and this Plan, this Plan will pay as the Primary Plan (as defined below) for all active employees of contributing employers and the covered dependents of such active employees regardless of the age of such active employees and their dependents.

There are special coordination rules for individuals who have end stage renal disease. Generally, if an individual first becomes eligible for Medicare by virtue of having end state renal disease, this Plan will be primary for the first thirty (30) months of the individual's Medicare eligibility. Thereafter, Medicare becomes primary.

B. COORDINATION OF BENEFITS

1. Benefits Subject To This Provision

All medical benefits and dental benefits provided under this Plan are subject to this provision, except prescription drug benefits. If another plan is primary with respect to an individual this plan will not pay any part of the cost of prescription drugs for that individual.

2. Effect On Benefits

Coordinate of Benefits (COB) means that the benefits provided by this Plan will be coordinated with the benefits provided by any other plans covering the individual for whom the claim is made. If this Plan is a Secondary Plan, the benefits payable under this Plan may be reduced, so that a covered individual's total payment from all plans will not exceed 100% of his or her total Eligible Expenses under this Plan. Thus, if another plan is primary and pays first, this Plan will subtract the amount paid by the other plan from the amount this Plan would have paid and will pay the remainder, if any. If the other plan paid more then this Plan would have paid in the absence of the other plan, no benefits willbe due from this Plan.

3. Primary and Secondary Plan

"Primary Plan" means the Plan which pays benefits or provides services first under the Order of Benefit Determination Rules below. The Primary Plan does not reduce its benefits because of duplicate coverage.

"Secondary Plan" means any Plan which provides coverage for the individual for whom claim is made and which is not a Primary Plan.

4. Eligible Expense

"Eligible Expense" means any necessary, reasonable and customary item of expense which is covered, in whole or in part, under this Plan.

5. Claim Determination Period

"Claim Determination Period" is the period of time during which Eligible Expenses are compared with total benefits payable to determine how much each Plan will pay. The Claim Determination Period is a calendar year.

6. Plans Considered for COB

A "plan" is any arrangement which provides medical coverage for the individual for whom claim is made.

COB applies to the following plans:

a. Group insurance or individually purchased health insurance or other medical benefits plans;

b. Other arrangements, whether insured or uninsured, covering medical expenses of individuals in a group;

c. Plans designed to pay a fixed-dollar benefit per day while the individual is hospital confined, but which, at the time of claim, allow the individual to elect an alternate benefit. COB will be applied only to the portion of the daily benefit;

d. Plans of other hospital or medical service organizations;

e. Group practice plans;

f. Pre-payment plans;

g. Coverage under Federal Government plans or programs, including Medicare;

h. Coverage required or provided by law. COB will not apply to state programs which provide benefits for individuals unable to pay for their care;

i. Individual no-fault auto insurance, by whatever name called;

j. Medical payments coverage under any auto or property insurance policy.

Note: This Plan is always a Secondary Plan to benefits provided under any mandatory No-Fault Auto Insurance Act in the state in which the Covered Individual resides.

7. Order of Benefit Determination

Any plan which does not have a COB or similar provision and any plan that provides it is always Secondary will pay its benefits first (Primary Plan).

When all plans involved contain COB or similar provisions, the first of the following rules that describes the situation determines the order in which the plans pay their benefits.

a. Non-Dependent or Dependent

The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary, and the plan that covers the person as a dependent is secondary.

However, when a person is covered as the dependent of his or her spouse who is actively employed and is also covered as a retiree or former employee, the Medicare statute and regulations provide that Medicare is Primary to the plan that covers the person as other than a dependent and Secondary to the plan that covers the person as a dependent. In such circumstances, the plan that covers the person as a dependent of an active employee pays first, Medicare pays second, and the plan that covers the person as a former or retired employee pays last

b. Child Covered Under More Than One Plan

(1) The Primary Plan is the plan of the parent whose birthday is earlier in the calendar year if:

(a) The parents are married;

(b) The parents are not separated (whether or not they ever have been married); or

(c) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

(2) If both parents have the same birthday, the plan that has covered either of the parents longer is Primary.

(3) If the specific terms of a court decree state that one of the parents is responsible for the 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. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is Primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.

(4) If the parents are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

(a) The plan of the custodial parent;

(b) The plan of the spouse of the custodial parent;

(c) The plan of the non-custodial parent; and then

(d) The plan of the spouse of the non-custodial parent.

c. Active or Inactive Employee

The plan that covers a person as an employee who is neither laid off nor retired (or that employee's dependent) is Primary. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Subsection 7(a) of this Section.

d. Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is Primary and the continuation coverage is Secondary.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

e. Longer or Shorter Length of Coverage

If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is Primary.

(1) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within twenty-four (24) hours after the first ended.

(2) The start of a new plan does not include:

(a) a change in the amount or scope of a plan's benefits;

(b) a change in the entity that pays, provides or administers the plan's benefits; or

(c) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(3) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plans has been in force.

f. If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

8. <u>Operation of COB</u>

In order to make this COB provision work properly:

a. Upon request, the covered individual is required to furnish to the Plan complete information concerning all plans which cover the individual for whom claim is made.

b. As permitted by law, this Plan may, without the covered individual's consent:

(1) obtain information from all plans which may cover the individual; and

(2) release to such other plans any information it has with respect to any individual.

c. If payments which should have been made by this Plan have been made under any other plans, this Plan may reimburse such other plans to the extent necessary to make this provision work. Any such payment will be a benefit paid under this Plan.

d. If this Plan has paid benefits which result in payment in excess of the amount necessary under this Plan to make this provision work, this Plan has the right to recover such excess payment from:

(1) any person;

(2) any insurance company; or

(3) any other organization

to or for or with respect to whom such payments were made. This Plan may also withhold future benefits payable on behalf of the covered person and family members as an offset to benefits it paid erroneously. (See Section XI, B2 of this booklet regarding the Plan's rights to recover overpayments).

9. Prescription Drug COB

These Coordination of Benefits Rules do not apply to prescription drugs.

If with respect to a covered individual, another health plan pays first under these COB rules, and that other plan requires the person to make a co-payment for prescription drugs, this Plan will not treat that co-payment as a covered expense. This Plan will not reimburse you for any part of that co-payment.

10. Coordination of Medical Benefits with Dental Benefits

To the extent that a treatment, service, or supply is covered under both the medical provisions of this Plan and the dental provisions of this Plan, a claim for such treatment, service or supply, will be considered first under the medical provisions of the Plan and then under the dental provisions.

XI. FILING OF CLAIMS AND SUPPORTING DOCUMENTS

A. GENERALLY

You may obtain any necessary claims forms from the Fund Office or the appropriate group insurance provider. Additionally, more specific claim filing procedures for insurance benefits are described in the respective group insurance Certificate issued to you by each specific provider. However, generally, if submitting a claim for benefits you must submit a claim form for any benefits within the time frame prescribed within the appropriate provider's group insurance Certificate. Generally, the claim should be accompanied by all supporting documentation. Generally, no claim for any benefits will be considered if it is received by the Fund Office or the appropriate provider after the allotted time in which to file a claim after the loss of which benefits are claimed.

To the extent you are required to file a claim form, read it and complete it carefully and provide all documents it indicates are required. If you need copies of bills, receipts and medical records, make copies of those before you submit the documents to the Plan or provider. The Fund Office nor provider can return the documents you submit.

1. Claims for Death Benefits

If you or your beneficiary has a claim for death benefits, contact the Fund Office to get a copy of any necessary claim form. You or your beneficiary must submit a certified copy of the death certificate of the deceased individual, but additional information or documentation may also be needed. The Fund Office personnel will also tell the claimant what documentation is necessary.

2. Claims for Short-Term Disability Benefits

You may obtain the claim form for short-term disability benefits from the Fund Office. **The form must be completed by you, your employer, and your physician and must be returned to the Fund Office. The completed claim form must be submitted within the time frame prescribed for in the provider's group insurance Certificate in connection with the disability. The completed claim form should be accompanied by all supporting documentation.**

3. Claims for Vision Benefits

If you or a covered dependent has incurred an expense for an eye exam, eyeglasses or contact lenses, your in-network provider must submit an itemized billing to the Vision Benefit Provider. If you use an out-of-network provider, you must submit the itemized doctor bill and itemized paid receipt for the eyeglasses or lenses to the Vision Benefit Provider.

4. Claims for Comprehensive Medical and Dental Benefits

a. Medical and Dental Benefits

(1) Generally

If you use a network provider, you will not be required to submit a claim for medical or dental benefits. Your in-network doctor, hospital or other provider will forward the bills to the Medical and Dental Provider or to the appropriate provider. Receipt of such bills will be regarded as receipt of a claim. In some circumstances, the Medical and Dental Provider will contact you for additional information. You should provide any such information as soon as possible after requested.

(2) When Another Plan is Primary

When another plan pays its benefits first under the Coordination of Benefits rules set out at Section X of this Booklet, you must submit a copy of the explanation of benefits provided by the other plan along with a copy of the itemized bills from the medical provider to the appropriate provider.

The most common circumstances in which you must submit a claim to another plan first are:

(a) Your spouse works and has health benefits through his or her own employer and the claim is for services rendered to the spouse. In such circumstances, you must submit the claim to the spouse's plan first, then to this Plan.

(b) The claim is for your child and your spouse's birthday is earlier in the year than yours. The claim must go to your spouse's insurer or health benefit plan first.

For greater detail about coordination of benefits and which plan pays first, see Section X of this Booklet.

b. Prescription Drug Benefits

In most cases, you will not file a claim in order to receive prescription drug benefits. You will simply present your pharmacy card to a network pharmacy, pay the required co-pay, and get your prescription. However, in order to file a claim for reimbursement for amounts you have paid for prescription drugs to Out-of-Network Pharmacies, send the itemized pharmacy prescription receipt or the itemized pharmacy billing statement to the appropriate provider. You should use this procedure when for any reason you have not used your pharmacy card or mail order service <u>or</u> when you believe the amount you were required to pay when using the pharmacy card or mail order service was in excess of the amounts set out

in this booklet, or if you are denied a drug by a network pharmacy or the mail-order service.

In order to take advantage of the mail-in drug program for maintenance drugs, you must obtain an order form from the Fund Office and send the completed order form, along with your doctor's prescription and the appropriate co-payment, to the address indicated on the order form.

5. Time Limits for Filing Claims

All claims for medical, dental and prescription benefits must be submitted within one (1) year from the date you received the service or supply for which claim is being made, or as required by the appropriate provider. The claim should be accompanied by all completed documentation. If the appropriate provider does not receive the claim and all documentation necessary for the Plan to decide the claim within this one-year period, the claim will be denied as untimely. The required documentation includes: itemized bills; paid receipts if you are seeking reimbursement; the original enrollment forms and annual updates reflecting the individual in question is covered; Explanation of Benefits (EOB's) from primary plan, if any; and any other documents and information requested by the appropriate provider.

B. PAYMENT OF CLAIMS

1. Generally

The benefits payable on account of your death will be paid to your beneficiary. Short-term disability benefits will be paid directly to you. Medical and dental benefits will be paid directly to the doctor, hospital, or other provider who provided the services unless you prove you paid the provider, in which case reimbursement will be made to you or to the person indicated in a QMCSO or applicable law governing the payment of benefits.

Similarly, reimbursements for vision benefits will be made to you or as required by a QMCSO or applicable law.

2. Plan's Right to Recover Overpayments or Mistaken Payments

If a payment for a claim filed by or for your or one of your dependents is found to be more than the amounts payable under the terms of the Plan or is found to have been made in error, then a refund of the excess or erroneous payment may be requested.

XII. CLAIMS REVIEW AND APPEAL PROCEDURES

A. SHORT-TERM DISABILITY BENEFITS

Claim and Appeal procedures for short-term disability insurance benefits are described in the group insurance Certificate issued to you by the Company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this document.

B. LONG-TERM DISABILITY BENEFITS

Claim and Appeal procedures for long-term disability insurance benefits are described in the group insurance Certificate issued to you by the Company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this document.

C. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Claim and Appeal procedures for life and accidental death and dismemberment insurance benefits are described in the group insurance Certificate issued to you by the Company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this document.

D. MEDICAL BENEFITS GENERALLY

Claim and Appeal procedures for medical and pharmacy insurance benefits are described in the group insurance Certificate issued to you by the Company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this document.

E. DENTAL BENEFITS

Claim and Appeal procedures for dental insurance benefits are described in the group insurance Certificate issued to you by the Company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this document.

F. VISION BENEFITS

Claim and Appeal procedures for vision insurance benefits are described in the group insurance Certificate issued to you by the Company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this document.

G. MISCELLANEOUS PROVISIONS PERTAINING TO CLAIMS AND APPEALS

You may designate another person to act as your authorized representative for purposes of the Plan's claims and appeals procedures. Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), to designate an authorized representative you will need to fill out a form which may be obtained from the Fund Office.

Under federal law you have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act ("ERISA") if you are dissatisfied with the decision of the trustees on appeal. Before bringing such an action you must exhaust the Plan's claims and appeals procedure. Any such action under ERISA must be filed within two years of the date on which your appeal was denied.

With respect to any claim or appeal involving medical or disability benefits which has been denied, you have a right to receive free of charge upon written request:

1. a copy of any rule, guideline, protocol or other similar criterion which was relied upon;

2. if a medical judgment was involved in the denial of your claim on appeal, an explanation of the scientific or clinical judgment upon which the decision on your claim or appeal was based; and

3. the identity of any medical or vocational experts who were consulted with respect to your claim.

You further have the right to receive free of charge upon written request all documents, records and other information relevant to your claim. Any written request encompassed by this paragraph should be sent to the Plan Administrator at the Fund Office.

Decisions on claims and appeals are uniformly made in accordance with the terms and conditions of the Plan Benefits and cannot be paid unless authorized by the Plan.

XIII. DEFINITIONS

GENERALLY

Because the Fund provides benefits on a fully insured basis each individual insurance provider may have special meanings for various terms. If a word or phrase in this Summary Plan Description has a special meaning it will be capitalized. If a Participant needs clarification for any capitalized word in this Summary Plan Description not defined within this Article, the Participant should consult the group insurance Certificate for the particular benefit provider in question. If you do not have, or have lost, any of the applicable group insurance Certificates copies may be obtained by contacting the Fund Office:

International Alliance of Theatrical Stage Employees
Local 6 Health & Welfare Fund
6405 Metcalf Ave., Ste. 200
Overland Park, KS 66202
(800) 542-4482

This section will contain definitions that are generally applied to all insurance providers providing benefits to Fund Participants. The terms listed in this Article shall have the meaning set forth below whenever the capitalized term is used in this document.

1. **Active Work on a Full-time Basis**
The Performance of work by the Member, Business Representative or Office Employee for their employer, either at their customary place of employment or such other place or places as required by their employer in the course of such work for the full number of hours and full rate of pay in accordance with the established employment practices of their employer and with respect to Members whose employment is covered by a Collective Bargaining Agreement, in accordance with the applicable provisions of that Agreement.

2. **Active Qualifying Participant**
A Member on whose behalf Contributing Employers have made the minimum amount of Contributions to the Trust during the most recently ended Qualifying Period. The Contribution amount is subject to change per Qualifying Period as determined by the Trustees.

3. **Benefits**
The health and welfare benefits provided pursuant to this Plan

4. **Business Representative**
The elected representative of the Union who is employed by the Union to transact business relating to wages, hours and conditions of employment of the Members and who, immediately prior to assuming his/her duties as Business Representative was a Member.

5. **Class R Member**
A Class R Member is a member who meets the qualifications outlined for early retirement, or is at least sixty-five (65) years of age and has qualified for benefits under the provisions of Medicare (either for disability or age).

6. Child
A child is any one of the following persons dependent upon a Participant, Member Office Employee or Business Representative for principal support and maintenance; a child naturally born to, adopted by, or a stepchild or foster child of, the Participant, Member, Office Employee or Business Representative's lawful spouse.

7. Collective Bargaining Agreement
Any written agreement governing the wages, hours and conditions of employment of Members which has been entered into by and between the Union and one or more Employers.

8. COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1986.

9. Coinsurance
The specific percentage of the Maximum Allowable Amount for Covered Services You must pay above the specified benefit payable as a condition of the receipt of certain services as provided in this Plan or the appropriate providers group insurance Certificate.

10. Contributions
Monies paid to the Fund on behalf of Members, Business Representatives or Office Employees by Contributing Employers in accordance with any agreement.

11. Contributing Basis
The conditions under which attaining or maintaining coverage under the Plan requires Member Contributions.

12. Contributing Employer
Any Employer who has entered into a Collective Bargaining Agreement or agreement to make Contributions on behalf of a Member, Business Representative or Office Employee.

13. Copayment
A specified dollar amount of the Maximum Allowable Amount for Covered Services You must pay as a condition of the receipt of certain services as provided in this Plan or the appropriate providers group insurance Certificate. There may be more than one Copayment charged by the same Provider on the same day.

14. Covered Services
The services and supplies provided to You for which the Plan will make payment, as described in the Summary Plan Description and group insurance Certificates.

15. Creditable Coverage
Coverage of an individual through one or more of the following:

- group health plan;
- health maintenance organization (HMO);
- an individual health insurance policy
- Medicare;
- Medicaid;
- Military Health;

- medical program of the Indian Health Service or of a Tribal Organization;
- State health pool;
- FEHP health plan;
- Public health plan; or
- Peace Corps Plan.

16. Deductible

The dollar amount of Covered Services, listed in the applicable Schedule of Benefits for this Summary Plan Description or group insurance Certificate, which You must pay for before the applicable insurance provider will pay for those Covered Services in each Insured Period.

17. Dependent

Any of the following persons not otherwise eligible for coverage under the Plan as a Participant, Office Employee, Member or Business Representative: the lawful spouse of a Participant, Office Employee, Member or Business Representative; each child of a Participant, Office Employee, Member or Business Representative, under the age of 26, as defined or qualified by the terms of any applicable in-force insurance contracts at the time of claimed eligibility.

No person may be covered as a dependent of more than one Business Representative, Office Employee or Member. For purposes of this Plan, each person shall derive eligibility through a Business Representative, Office Employee or Member.

18. ERISA

The Employee Retirement Income Security Act of 1974, as amended by law.

19. Effective Date of Coverage

The Plan provision as it applies to Members, Business Representatives and Office Employees:

a. If at any time during the day immediately preceding the date any coverage of a Members, Business Representatives and Office Employees would otherwise first become effective they were, by reason of injury or sickness, unable to perform Active Work on a Full-time Basis, whether or not they were scheduled to work on such preceding day, such coverage shall not become effective until such time on or after the date that such coverage would otherwise first become effect that they perform Active Work on a Full-time Basis. However, this provision will not apply to a Member, Office Employee or Business Representative if, on such preceding day, the Member or Business Representative was covered for the Benefits provided under the respective Article to which this provision applies.

20. Eligible Expenses

Charges for Covered Services incurred while you are eligible for coverage under the Plan of Benefits in effect.

21. Extended Benefits

An extended period of benefits for which the Fund will qualify a Participant for coverage until the end of the qualifying period (August 31) for a Participant qualified in the year of such coverage.

22. Fund
The International Alliance of Theatrical Stage Employees Local 6 Health and Welfare Fund.

23. Insured Period
The period during which the total amount of yearly benefits under Your coverage is calculated. The Insured Period is the period of twelve (12) consecutive months commencing on September 1 and ending August 31 of each respective year.

24. Maximum Allowable Amount
The maximum amount that the applicable insurance provider will pay for Covered Services You receive.

25. Medically Necessary
Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of service must not be greater than is necessary and appropriate to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Participant's physician or other insurance provider.

26. Medicare
The programs of health care for the aged and disabled established under Title XVIII of the Social Security Act of 1965.

27. Member
A person who is or has been an Employee of any Contributing Employer whose employment is or has been subject to the terms of a Collective Bargaining Agreement.

28. Member Contributions
Monies submitted to the Fund by Members or their Dependents whose coverage under the Plan is on a Contributory Basis.

29. Office Employee
An active full-time Employee of the Union or an active full-time employee of the Fund, regularly working at least thirty (30) hours per week and excluding temporary Employees, Employees who work less than thirty (30) hours per week and Business Representatives.

30. Participant
Any covered Office Employee, Member or Business Representative. It is an individual who performs work falling under the jurisdiction of the Union or for whom one or more Contributing Employers, including the Union or the Fund, that are required to make contributions to the Plan.

31. Plan
The plan or program of health and welfare benefits established by the Trustees pursuant to this document and any amendments made to this document.

32. Qualifying Period
The twelve (12) consecutive month period beginning June 1 and ending May 31 of each respective year.

33. Surviving Dependent
A Dependent of a deceased Member or Business Representative who, on the date of the Member or Business Representative's death, was covered for one or more Benefits provided by the Plan.

34. Trust
The entity created by the Trust Agreement for the purpose of establishing and administering the Fund and the Plan, and for other purposes as described in the Trust Agreement.

35. Trust Agreement
The written agreement establishing the International Alliance of Theatrical Stage Employees Local No. 6 Health and Welfare Trust Fund.

36. Trustees
Are those individuals elected to serve as fiduciaries of the Trust on behalf of the Union and Contributing Employers.

37. Union
International Alliance of Theatrical Stage Employees Local No. 6.

XIV. ERISA INFORMATION

As a participant in The International Alliance of Theatrical Stage Employees Local 6 Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

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

3. Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

4. Review this Summary Plan Description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Welfare Plan. The people who operate your Plan, called "fiduciaries" of the Plan have a duty to do so prudently and in your interest and in the interest of other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the insurance company or the Trustees review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or 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 person you have sued to pay these costs and fees. If you lose, the court may order you to pay the costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you should have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

XV. NOTICE OF PRIVACY PRACTICES FOR THE INTERNATIONAL ALLIANCE OF THEATRICAL STAGE EMPLOYEES LOCAL 6 HEALTH & WELFARE FUND

Effective April 1, 2004, The International Alliance of Theatrical Stage Employees Local 6 Health and Welfare Fund must comply with the Privacy Rule set out by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act (HIPAA). While the Plan has always protected your confidential health information, the Plan became required as of April 14, 2003, to formalize its procedures in this regard. The notice set out below summarizes those procedures and rules that became effective as to this Plan on April 14, 2004.

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access To This Information. Review It Carefully.

This notice is intended to explain to you the practices of The International Alliance of Theatrical Stage Employees Local 6 Health and Welfare Fund related to the use and disclosure of your health information, and to inform you of your rights related to your health information.

We are required by law to:

1. Maintain the privacy of your health information;
2. Give you this notice of our legal duties and privacy practices with respect to health information about you; and
3. Follow the terms of the notice that is currently in effect.

This notice is effective as of April 13, 2004.

A. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We may use your health information, as described in each category below, for treatment purposes, for payment purposes, and for our health care operations. We have set out for each of these categories an example of how your health information might be used.

1. Treatment

   We may use or disclose your health information to facilitate your health care treatment. For example, we might disclose information to your health care provider to assist the provider in making a determination on a course of treatment for you or we may disclose your health information to a case manager retained by the Plan.

2. Payment

   We may use and disclose health information about you for purposes related to payment. For example, we may use your health information to obtain premiums or to determine our responsibility under the Plan. As another example, we may use your health information to coordinate benefits with another health plan.

3. Health Care Operations

We may use and disclose health information about you in order to carry-out the day-to-day health care operations of our health plan. For example, we may use health information in connection with:

a. legal services;

b. audit services;

c. business planning and development; and

d. business management of the Plan.

4. Other Potential Uses and Disclosures

In addition to the general uses and disclosure of your information discussed above, there may be other special situations where it is necessary, and permissible, for us to use or disclose your health information. These situations are discussed below:

a. Public Health Activities

For example, we may disclose information to a public health authority for the purposes of preventing or controlling disease.

b. Reporting Abuse, Neglect or Domestic Violence

For example, circumstances may arise where we need to disclose to appropriate authorities suspected abuse or domestic violence.

c. Health Oversight Activities

We may disclose health information to a government agency conducting an audit. For example, it may be necessary for us to disclose information pursuant to a Medicare audit.

d. Judicial or Administrative Proceedings

For example, we may disclose information pursuant to a court or agency order in a legal proceeding.

e. Law Enforcement Purposes

For example, it may be necessary for us to disclose information to law enforcement officials regarding the identification or location of suspects, fugitives, or missing persons.

f. Medical Directors, Coroners, and Funeral Directors

In the event of your death, we may disclose your health information to medical directors, coroners, or funeral directors. For example, disclosure may be necessary for determining a cause of death.

g. Organ and Tissue Donation

We may disclose your information to organizations handling organ and tissue donation.

h. Disclosures to Avert a Serious Threat to Health or Safety

For example, we may disclose information to appropriate authorities in order to protect the safety of an individual.

i. For Specialized Government Functions

We may disclose health information pursuant to certain governmental functions, for example, for military, veteran, or national security activities.

j. Workers' Compensation

We may release information in accordance with applicable Workers' Compensation laws.

k. Disclosures to the Plan Sponsor

The Plan may disclose health information to the Trustees of the Plan in order to carry out plan administration functions.

5. All Other Uses or Disclosures

We may not use or disclose your health information for any purpose other than as described above without your specific written authorization. You may revoke any such authorization in writing at any time. However, any revocation is limited to the extent that the Plan has already taken action in reliance upon your authorization.

B. YOUR RIGHTS REGARDING HEALTH INFORMATION

Federal law provides you with several rights regarding your health information:

1. Right to Inspect and Copy Your Health Information

You have the right to inspect and copy the health information that we maintain about you. You must submit any request to inspect or copy your health information in writing. All such written requests should be forwarded to:

The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6405 Metcalf Ave., Ste. 200
Overland Park, KS 66202
(800) 542-4482
ATTENTION PRIVACY OFFICER

If you request a copy of your information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

2. Right to Amend Your Health Information

You have the right to request an amendment to your health information maintained by our Plan, for as long as the information is kept by our Plan. You may wish to request an amendment to your information if you feel that the information is inaccurate or incomplete.

You must make any request for amendment in writing. Your request should be submitted to:

The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6405 Metcalf Ave., Ste. 200
Overland Park, KS 66202
(800) 542-4482
ATTENTION PRIVACY OFFICER

A request must state the reason you feel the amendment is necessary.

3. Right to an Accounting of Disclosures

You have the right to receive an accounting of certain disclosures of your health information made by the Plan. This accounting does not include disclosures made pursuant to treatment, payment, healthcare operations, or pursuant to your individual authorization.

You must make any request for amendment in writing. Your request should be submitted to:

The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6405 Metcalf Ave., Ste. 200
Overland Park, KS 66202
(800) 542-4482
ATTENTION PRIVACY OFFICER

Your request should state the time period for which you would like an accounting, which cannot to beyond the six (6) years prior to the date of your

request. You are not entitled to an accounting of disclosures made prior to April 14, 2004.

You are entitled to one free accounting within any twelve (12) month period. We may charge you a reasonable fee for any other accounting made within this same twelve (12) month period. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

4. Right to Request Restrictions

You have the right to request specific restrictions on our uses and disclosures of your health information. For example, you have the right to request that we not disclose any of your health information for treatment purposes. We do not have to agree to a requested restriction. Agreeing to a restriction is within our sole discretion.

5. Right to Request Confidential Communications

You have the right to request that we communicate specific information to you in a certain manner or at a certain location, if you feel that the communication might otherwise place you in danger. For example, you may request that an explanation of benefits be sent to your work rather than to your home if you feel that this information may put you in danger if sent to your home.

Any request for a confidential communication must be made in writing and be accompanied by a statement that the confidential communication is necessary to avoid your personal endangerment. All requests should be submitted to:

The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6405 Metcalf Ave., Ste. 200
Overland Park, KS 66202
(800) 542-4482
ATTENTION PRIVACY OFFICER

6. Right to a Paper Copy of This Notice

You have the right to receive a paper copy of this notice at any time. To request a paper copy of this notice, please contact:

The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6405 Metcalf Ave., Ste. 200
Overland Park, KS 66202
(800) 542-4482
ATTENTION PRIVACY OFFICER

C. REVISIONS TO THIS NOTICE

We reserve the right to change the terms of this notice. Any changes to this notice will be effective for health information that we maintain about you. Should we revise this notice, we will promptly provide you with a new Notice by mailing you a written copy of the new notice or including it in any mailing that is sent to you periodically from the Welfare Plan.

D. COMPLAINTS

If you believe your privacy rights have been violated, you have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact:

The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6405 Metcalf Ave., Ste. 200
Overland Park, KS 66202
(800) 542-4482
ATTENTION PRIVACY OFFICER