Welfare Fund

of Local No. One IATSE

SUMMARY PLAN DESCRIPTION

May 2016

Welfare Fund
of Local No. One, IATSE

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Dear Participant:

We are pleased to present you with this Summary Plan Description (SPD) for the Welfare Fund of Local No. One, IATSE (Fund). This document describes the benefits to which you and your family may be entitled under the Fund's plan of health benefits (Plan) as of May 2016. Should there be any changes in the Plan, you will receive written notice in the form of a Summary of Material Modification (SMM).

Also included as part of this SPD is a Medical Benefits Booklet prepared by our Medical Benefit Manager (MBM) , which provides additional information about Fund-provided medical benefits. Contact information for the Fund's MBM and Pharmacy Benefit Manager (PBM) are included as a separate insert, and you will receive a replacement insert if there are any future changes.

We urge you to carefully study this SPD and all subsequent SMMs and share them with your family so that you fully understand your rights and obligations as a Fund Participant and can take advantage of all of the benefits provided to you through the Fund. When you receive an SMM, please keep it with this SPD for future reference. You should refer to these documents whenever you need information about your benefits. If you lose any of these documents, please contact the Fund Office for a replacement or download a copy at the Fund's website: www.FundOneIATSE.com. If you have questions about any of your benefits, please contact the Fund Office at (212) 247-5225.

We believe that the Fund provides an excellent program of benefits and we urge you to use these benefits intelligently by becoming a wise and careful consumer of health services. Your prudent use of these benefits will assist the Fund in continuing to provide welfare benefits to current and future participants and their families.

Sincerely,

BOARD OF TRUSTEES

TABLE OF CONTENTS

SECTION I

IMPORTANT INFORMATION ABOUT THE FUND

The Fund is maintained and operated in accordance with collective bargaining agreements between contributing employers and Theatrical Protective Union, Local No. One, IATSE (Local One).

Individuals covered by the Fund include: (i) all eligible employees of employers that are required to contribute to the Fund (Contributing Employers) pursuant to a collective bargaining agreement or written agreement with Local One (Active Participants), (ii) eligible retirees (Retired Participants), and (iii) eligible Fund employees and Local One employees. These three groups are collectively referred to throughout this document as "Participants." Also covered by the Fund are a Participant's eligible family members. The Fund is administered by a Board of Trustees comprised of representatives from Local One and Contributing Employers in accordance with the Fund's Trust Agreement.

This document, together with the Medical Benefits Booklet, describe the key features of the Fund's plan of health benefits (Plan). Complete details of the Plan are set forth in other official Plan documents, including the Fund's contracts with insurance companies, the Trust Agreement and the collective bargaining agreements, all of which legally govern the operation of the Plan. These documents are available for your inspection at the Fund Office during normal business hours. All statements made in this document are subject to the provisions and terms of those documents.

Nothing in this document is intended to interpret, extend or change in any way the provisions contained in the other official Plan documents. In the event of a conflict or inconsistency between this document and the other official Plan documents, the other official Plan documents will govern in all cases.

A. Amendment, Modification or Termination of Plan Benefits

The Trustees hope to continue providing Plan benefits indefinitely. However, the Trustees reserve the right, in their sole and absolute discretion, to amend, modify or terminate Plan benefits (including any related documents or policies), in whole or in part, at any time and for any reason, with respect to Participants and their covered family members. Among other things, the Trustees are empowered to change eligibility rules, establish or increase deductibles and co-insurance, eliminate or reduce benefits, substitute an existing benefit for another, impose or decrease maximum benefits payable under the Plan and, if deemed necessary by the Trustees, increase self-pay premiums. If the Plan is modified or terminated, the ability of Participants and their family members to participate in and receive Plan benefits may be modified or terminated.

In summary, Plan benefits and eligibility rules are not guaranteed; may be changed or discontinued by the Trustees at any time, in their sole and absolute discretion; are subject to rules and regulations adopted by the Trustees; and are subject to the Trust Agreement, the collective bargaining agreements and the other official Plan documents that establish and govern the Fund's operations.

In the event the Fund is terminated, the Trustees will use Fund assets to provide benefits or otherwise to carry out the purposes of the Fund in an equitable manner until all Fund assets have been disbursed. Under no circumstances will any Fund benefit become vested or nonforfeitable with respect to any Participant or covered family member.

B. Interpretation of Plan Documents

No one, other than the full Board of Trustees or its duly authorized designee(s) (which may be the insurance companies or professional administrators with which the Fund has contracted) has any authority to interpret Plan documents or to make any promises to you about Plan benefits, or to alter or modify any provision of the Plan. Only the full Board of Trustees, or its authorized designee(s), has the exclusive right and power, in its sole and absolute discretion, to interpret the Plan and to decide all matters arising thereunder.

SECTION II

COVERAGE FOR ACTIVELY EMPLOYED PARTICIPANTS

A. Your Eligibility for Coverage

Your "covered earnings" in a calendar year determine whether you are eligible for benefits in the following Plan Year, which runs from July 1 through June 30. Covered earnings are earnings on which employer contributions are payable to the Fund. The Plan provides three levels of benefits to Active Participants (Tiers I, II and III) and three types of coverage (Participant Only, Participant Plus One, and Family). The level and type of insurance for which you qualify depend on your covered earnings and the self-pay premium you remit to the Fund Office.

Important Note: If you believe you are entitled to credit for covered earnings not reflected in the Fund's records, it is your responsibility to provide adequate documentation supporting that claim. Failure to produce such documentation could result in your not receiving credit for those covered earnings.

1. COVERED EARNINGS REQUIREMENT

Your covered earnings in a calendar year determine what tier of benefits you qualify for in the subsequent Plan Year beginning July 1. If you and your spouse both have covered earnings, your earnings may be combined for this purpose. Following is the covered earnings requirement for each tier of benefits in calendar year 2016, for coverage beginning July 1, 2017:

Minimum Calendar Year Covered Earnings

BENEFIT LEVEL	**2016** (for coverage 7/01/17-6/30/18)
Tier I	$37,500
Tier II	$55,001
Tier III	$90,001

The covered earnings requirement for calendar year 2016 will continue to apply until the Trustees implement a change, and notice of any change will be provided to you. If you have a question concerning the covered earnings requirement in a particular calendar year, contact the Fund Office at (212) 247-5225 or visit **www.FundOneIATSE.com**.

With respect to Fund employees, your eligibility for benefits will be determined according to the rules specified in the Fund Office Employee Handbook. With respect to Local One employees, your eligibility for benefits will be determined according to the policies of Local One.

Please note that different eligibility rules apply to "New Shop" Employees and Local One Apprentices as described on pages 7-8.

2. BASIC COVERAGE FOR NEW PARTICIPANTS

If you are a new Welfare Fund participant qualifying for coverage for the first time based on your 2015 or later covered earnings, you will be eligible to receive "Basic Coverage". Basic Coverage consists of Tier I hospital/medical coverage and coverage of generic drugs only for the pharmacy benefit. Participants qualifying for Basic Coverage are not eligible for the Buy-up options discussed in Section II.A.4 below.

The self-pay premium for Basic Coverage is the same as Tier I for Participant Only coverage, and if you would like to add any eligible family members to your coverage, your monthly self-pay premium will be the self-pay premium for Tier I Participant Only coverage plus the incremental expense for Participant + One or Family coverage based on the applicable COBRA rates. (Premium rates are subject to change at the discretion of the Board of Trustees.)

After you have qualified for Basic Coverage for 3 consecutive Plan years, you will then be eligible for Tier I, II or III coverage based on the normal eligibility rules then in effect. For participants who elect the Early Enrollment Option described in Section II.D.3, that coverage will be considered part of the first Plan year of Basic Coverage .

Note: If you qualify for coverage as a New Shop employee or Local One Apprentice, your coverage is determined under Sections II.B.2 and 3, respectively. If you qualify for coverage as a result of a union merger, your coverage is determined by the terms of the applicable merger agreement.

3. SELF-PAY PREMIUM

In addition to satisfying the covered earnings requirements described above, you must enroll in the Plan (see details in Section II.D below) and pay the applicable self-pay premium before you begin receiving Plan benefits. The self-pay premium is billed to you every quarter and payment is **due on or before July 1, October 1, January 1, and April 1** of each Plan Year. If your payment is not received in the Fund Office by the due date (or the next business day following the due date if it falls on a Sunday or bank holiday), you will be charged a **$25 late fee** in addition to the required self-pay premium. If your self-pay premium and late fee are not received in the Fund Office by the end of the month in which the self-pay premium is due (July 31, October 31, January 31, or April 30), or the next business day following the due date if it falls on a Sunday or bank holiday, **your coverage will be terminated** retroactively to the end of the prior quarter, and you will not have another opportunity to enroll for coverage until the next Annual Open Enrollment Period (usually in June).

Following are the quarterly self-pay premium rates for each tier of benefits and each type of coverage for coverage beginning July 1, 2017:

Quarterly Self-Pay Premium*

COVERAGE TYPE	Tier I	Tier II	Tier III
Participant Only	$241.00	$315.00	$493.00
Participant + One	$338.00	$434.00	$605.00
Family (Participant + More Than One)	$375.00	$500.00	$719.00

***** *The Welfare Fund is currently offering a reduction of $100 per quarter to participants who meet specified wellness-related goals. Please contact the Fund Office if you have any questions regarding the Fund's Wellness Incentive Program.*

Self-pay premium rates are subject to change in the discretion of the Board of Trustees and notice of any change will be provided to you. If you have a question concerning the self-pay premium rates currently in effect, contact the Fund Office at (212) 247-5225 or visit www.FundOneIATSE.com.

Please note that different self-pay premium rates apply to Retired Participants as described on pages 13-14.

4. BUY-UP PREMIUM

If you have met the covered earnings requirement for either Tier I or Tier II, but not Tier III, you may elect Tier III coverage during the Annual Open Enrollment Period if you pay a buy-up premium to obtain those benefits*. The buy-up premium is billed to you every quarter and payment is due on or before **July 1, October 1, January 1, and April 1** of each Plan Year. Following are the quarterly buy-up premium rates for each tier of benefits and each type of coverage for coverage beginning July 1, 2017:

Quarterly Buy-Up Premium

COVERAGE TYPE	Buy-Up Tier I to Tier III	Buy-Up Tier II to Tier III
Participant Only	$1,607.00	$660.00
Participant + One	$2,790.00	$944.00
Family (Participant + More Than One)	$3,894.00	$1,203.00

* *As described in Section II.A.2, new participants are not eligible for the buy-up option.*

Buy-up premiums are subject to change in the discretion of the Board of Trustees and notice of any change will be provided to you. If you have a question concerning the buy-up premium rates currently in effect, contact the Fund Office at (212) 247-5225 or visit www.FundOneIATSE.com.

IMPORTANT NOTE: If you elect to buy-up for a Plan Year, you must continue to pay the applicable buy-up premium for the entire Plan Year. If you fail to pay a quarterly buy-up premium, you and any of your covered family members will lose all coverage under the Plan for the remainder of the Plan Year.

B. Special Eligibility Rules

1. Disability Crediting and Self-Pay Waivers

(a) *Disability Crediting*

If you are unable to work due to disability, you may be credited with deemed earnings for each week you are unable to work due to the disability for the purpose of satisfying the Fund's covered earnings requirement. For each week of proven disability, you will be credited with 1/52nd of the covered earnings attributed to you during the 52-week period immediately preceding the week in which your disability commenced. You are entitled to buy-up to Tier III only if you were in Tier III on the day your disability commenced.

Initial and ongoing proof of disability must be submitted to the Fund Office in the form and manner the Board of Trustees requires, and may include medical documentation, proof of disability insurance payments, and/or an examination by a doctor of the Board of Trustees own choosing, at the Plan's expense. If at any time it is determined that there is no longer sufficient proof that a disability is ongoing, your disability crediting will cease.

You will not receive disability credits for more than one-hundred four (104) weeks of disability in your lifetime, whether for one disability or multiple disabilities, unless you fall within the following exception: If you have received 104 weeks of disability credits, but have yet to receive a Social Security Disability Award for which you have applied, and you would have sufficient pension credits to qualify for retiree medical coverage were you to later receive a disability pension from the Pension Fund of Local No. One, IATSE, you will be granted up to an additional one-hundred fifty-six (156) weeks of disability credits, provided you remain totally and permanently disabled (and submit ongoing proof of such disability to the Fund Office in the form and manner required) and continue to timely pay for coverage on the same basis as retirees receiving Plan benefits. This exception does not apply to apprentices; extended coverage for a disabled apprentice is limited to a maximum of 104 weeks of coverage from the start of the disability.

(b) ***Disability Self-Pay Waivers***

You may request that your required self-pay premium be waived for any month in which you qualify for at least one week of disability credit under the provisions of subsection (a) above. Buy-up premiums will not be waived.

2. "NEW SHOP" EMPLOYEES

If you are a regular employee of an employer when that employer is designated by the Board of Trustees as a "New Shop," you are not required to satisfy the covered earnings requirement (described in Section II.A.1) prior to enrolling in the Plan. Instead, as soon as administratively feasible following your employer's designation as a New Shop, you will be eligible for Participant-Only Tier I benefits. Contact the Fund Office to determine if your employer constitutes a New Shop.

If your employer made health insurance available to your spouse (as defined in Section II.C.1 below), you may pay a self-pay premium (as determined by the Trustees) to obtain Tier I benefits for your spouse.

If you wish to obtain Tier III benefits, you can do so by paying the relevant buy-up premium (described in Section II.A.4) for yourself and, if available as provided in the previous paragraph, your spouse. If you elect to buy-up, you must continue to pay the applicable buy-up premium for the remainder of the Plan Year. If you fail to pay a quarterly buy-up premium, you and, if applicable, your spouse will lose all coverage under the Plan for the remainder of the Plan Year.

As a New Shop employee, your self-pay premium (including any buy-up premium) must be paid on a quarterly basis on or before July 1, October 1, January 1 or April 1.

Your status as a New Shop employee will end on the earliest of the following dates:

- The last day of the second month following the date your employment with the New Shop terminates. If your New Shop employer closes temporarily, your eligibility will not be discontinued if you return to work for the same employer when it reopens; or

- the June 30th following the twelve-month period beginning on the date your employer is designated as a New Shop.

When your status as a New Shop employee ends, you and, if applicable, your spouse will become subject to the Plan's regular eligibility rules (as set forth in this Section II). Your and, if applicable, your spouse's coverage will end on the date your status as a New Shop employee ends unless you qualify for coverage under the Plan's regular eligibility rules.

Your status as a New Shop employee for one employer will not prevent you from becoming a New Shop employee for a different employer, and the Plan will not take into account your prior period of service as a New Shop employee.

New Shop employees must adhere to all other Plan rules and procedures.

3. LOCAL ONE APPRENTICES

As a Local One Apprentice, you are eligible to elect Tier I coverage effective on the first day of the month following the date Local One designates you as an Apprentice, even if you did not qualify for that coverage by meeting the covered earnings requirement (described in Section II.A.1) in the prior calendar year. During the Annual Open Enrollment Period only, you may elect Participant-Only Tier III benefits by paying the applicable buy-up premium.

Your coverage may continue without regard to your covered earnings for up to 3 years, or if earlier, until you lose Apprentice status. At that time, your eligibility for coverage will be based on your covered earnings in the prior calendar year.

Apprentices must adhere to all other Plan rules and procedures.

C. Coverage for Your Family Members

1. ELIGIBLE FAMILY MEMBERS

You may elect coverage for the following eligible family members:

(a) Your spouse, defined as the person to whom you are legally married under federal law; and

(b) Your child, including any stepchild, adopted child (including a child placed with you for adoption during a waiting period prior to the finalization of the child's adoption), foster child or a child for whom you are the legal guardian. Such child will be eligible for coverage under the Plan until the end of the calendar year in which he/she attains age twenty six (26), whether or not the child is living with you, financially dependent on you, in school, or married.

If the child qualifies for coverage under this Plan based on his/her own work, or that of his/her spouse, in Local One's jurisdiction, the Participant-parent may elect to include the child (but not the child's spouse) as a covered family member or the child will be eligible to enroll for his/her own separate coverage.

No person may be eligible for benefits both as a Participant and as a covered family member or as a covered family member of more than one Participant. A family member cannot be covered unless the Participant is covered.

2. CHILDREN AGE 26 TO 29

Coverage for children beyond the end of the calendar year in which they attain age twenty-six (26) may be purchased at a cost equal to 100% of the full premium rate for individual coverage if they are: (1) unmarried, (2) ineligible for other medical insurance through the child's employer or Medicare, and (3) under twenty-nine (29) years of age. If elected, this coverage will end at the end of the month in which the child turns age 29, is married, or becomes eligible for medical insurance through his/her employer or Medicare, whichever occurs first. Such coverage may only be elected within 60 days of the end of the calendar year in which the child turns age 26, or during subsequent Annual Open Enrollment Periods.

D. Enrollment in the Plan

1. INITIAL ENROLLMENT

When Fund Office records indicate that you have attained eligibility for the first time, an application to enroll in the Plan will automatically be sent to you to be completed, signed and returned. On this form, you must submit the names, dates of birth, social security numbers, and marriage and/or birth certificates for all of your eligible family members (see Section II.C above for the definition of who constitutes an eligible family member).

If you did not submit the required self-pay premium payment with your enrollment application, the Fund Office will send you an invoice for the amount due (see Section II.A.3 above regarding self-pay premiums). The Fund will deny all claims and pay no benefits on behalf of you or your eligible family members until it has received the applicable self-pay premium.

No medical examination is required as a condition of enrolling in the Plan, and all eligible Participants and family members will be insured regardless of age or physical condition.

2. ANNUAL OPEN ENROLLMENT PERIOD

Once each year, usually during the month of June, the Fund Office conducts an Annual Open Enrollment Period. At that time, you may:

- Enroll for the first time (yourself and any eligible family members);
- Add or drop eligible family members from coverage (and therefore possibly elect a different type of coverage (Participant Only, Participant Plus One, or Family); or
- Elect to buy up to Tier III coverage.

Elections made during the Annual Open Enrollment Period become effective July 1. The Fund Office will notify you each year of the Annual Open Enrollment Period and will send you the appropriate enrollment materials.

3. EARLY ENROLLMENT OPTION

If you met the Tier I covered earnings threshold in the prior calendar year but were not enrolled in the Plan effective July 1 of that prior calendar year, you will be offered the option to purchase Tier I coverage for yourself and any eligible family members effective March 1. (You will be offered enrollment effective February 1 if you actually began employment on January 1 of the prior calendar year.)

The self-pay premium for Participant-Only Early Coverage is $296.00 per month in 2016, and the monthly premiums for coverage through June are due at the time of enrollment. If you would like to add any eligible family members to the coverage, your monthly self-pay premium will be $296.00 per month plus the incremental expense for Participant + One or Family coverage based on the applicable COBRA rates. (Premium rates are subject to change at the discretion of the Board of Trustees.)

If you elect Early Enrollment coverage, you will have the ability to participate in the next Annual Open Enrollment Period for coverage beginning on July 1 based on the regular eligibility rules and self-pay rates specified in Section II.A. above.

4. SPECIAL ENROLLMENT OPTIONS

(a) *Loss of other Health Coverage*

If you are eligible to enroll as an Active Participant, but choose not to enroll (either yourself or any of your eligible family members) during the Annual Open Enrollment Period because you (or your eligible family members) are covered under another health plan, you may be able to enroll yourself (and any eligible family members) in this Plan if employer contributions toward the other coverage cease or you (or your eligible family members) suffer a "loss of eligibility" under that other plan. Loss of eligibility includes loss of coverage due to legal separation, divorce, death, termination of employment, or reduction in hours. It does not include loss of coverage due to a failure to pay premiums on a timely basis or termination of coverage for cause. You must request enrollment in this Plan within sixty (60) days after the other coverage for you (or your eligible family members) ends, submit valid documentation verifying the loss of other coverage, and pay any self-pay premium required by the Plan. If enrollment is permitted, you (and/or your eligible family members) will begin receiving Plan benefits on the first day of the first calendar month following the month in which a completed request for enrollment is received by the Fund Office.

(b) *Newly-Acquired Family Member*

If you are eligible to enroll as an Active Participant, but choose not to enroll (either yourself or any of your eligible family members) during the Annual Open Enrollment Period, and you subsequently acquire a new family member as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or that new eligible family member in the Plan. You must request enrollment in the Plan within sixty (60) days after the marriage, birth, adoption, or placement for adoption, submit valid documentation verifying the new family member(s), and pay any self-pay premium required by the Plan. If enrollment is permitted, in the case of marriage, Plan benefits will begin on the first day of the first calendar month following the date a completed request for enrollment is received by the Fund Office, and in the case of birth, adoption, or placement for adoption, Plan benefits will begin on the date of such birth, adoption, or placement for adoption.

(c) *Additional Special Enrollment Rights*

If you are eligible to enroll as an Active Participant, but choose not to enroll (either yourself or any of your eligible family members) during the Annual Open Enrollment Period, and subsequently either: (i) you or your eligible family member's coverage under Medicaid or the Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility for such coverage, or (ii) you or your eligible family member becomes eligible for a state subsidy for enrollment in the Plan under Medicaid or CHIP, you may be able to enroll yourself and/or your eligible family members in the Plan if you request enrollment in the Plan within sixty (60) days after such termination or eligibility, submit valid documentation verifying

the termination or eligibility, and pay any self-pay premium required by the Plan. If enrollment is permitted, Plan benefits will begin on the first day of the first calendar month following the month in which a completed request for enrollment is received by the Fund Office.

E. Termination of Coverage

Your coverage (and that of your covered family members) is subject to termination as follows:

- If you fail to meet the Fund's covered earnings requirement in a calendar year, your coverage and that of any covered family members will terminate the following June 30th.
- If you have not timely paid the self-pay premium or buy-up premium, your coverage and that of any covered family members will terminate as of the end of the last quarter for which you have paid the self-pay premium or buy-up premium.
- If you and your spouse legally separate or divorce, your spouse's coverage will terminate as of the end of the month in which your legal separation or divorce is final. If your eligibility for coverage was determined using combined covered earnings, your individual coverages will be based on your individual covered earnings beginning the first day of the month following your legal separation or divorce.
- If your child ceases to fall within the definition of an eligible child (as set forth in Section II.C above), that child's coverage will terminate as described in Section II.C.

If you legally separate or divorce . . .

You are required to immediately notify the Fund ....Office if you and your spouse legally separate or divorce. **If you fail to inform the Fund Office of such legal separation or divorce, the Fund may hold you responsible for the costs associated with extending coverage to your spouse after your legal separation/divorce became final, including, but not limited to, claims and/or COBRA premiums.** The Trustees reserve the right to terminate your Fund coverage and that of your covered family members for failure to notify the Fund of such legal separation or divorce.

If you or one of your covered family members is totally disabled (as defined below) or hospitalized on the date coverage is scheduled to terminate, coverage will be extended solely for treatment of such disability (provided you supply the Fund Office with the required proof of disability) for twelve (12) months or until you or your covered family member is no longer disabled, whichever occurs first. "Total disability" means a non-work related disability that prevents you from engaging in your regular or customary occupation or employment. For your covered family member, it means an illness or injury that keeps that family member from engaging in the normal activities of a person of like age and gender who is in good health.

With respect to Fund employees, your coverage and that of your covered family members will terminate according to the rules specified in the Fund Office Employee Handbook. With respect to Local One employees, your coverage and that of your covered family members will terminate according to the policies of Local One.

Coverage for you and your covered family members will also terminate if the Fund terminates or its group policies terminate.

Coverage of a Participant or covered family member who enters the armed forces will terminate on the day he/she enters the service except as required by law (see Section VII.C).

If your coverage is terminated, you and your affected family members may be eligible for COBRA continuation coverage (see Section VI).

F. Reinstatement of Coverage

If your Plan benefits are terminated because you failed to meet the covered earnings requirement or failed to pay the applicable self-pay or buy-up premium, you may seek to re-enroll in the Plan after a subsequent year in which you meet the Fund's covered earnings requirement. With respect to Fund employees, coverage is subject to reinstatement as set forth in the Fund Office Employee Handbook. With respect to Local One employees, reinstatement of coverage is determined in accordance with the policies of Local One.

G. Continuation of Benefits for Covered Family Members After Your Death

If you die while enrolled in the Plan, and at the time of death you were not eligible to receive a pension from the Pension Fund of Local No. One, IATSE (Pension Fund), your covered family members will continue to be covered for the balance of the Plan Year in which you died, provided that the applicable self-pay premium is paid to continue such coverage. In addition, your covered family members will continue to be covered for the following Plan Year if you satisfied the Fund's eligibility requirements for that subsequent Plan Year at the time of your death, provided that the applicable self-pay premium is paid to continue such coverage.

If you die while enrolled in the Plan, and at the time of death you were eligible to receive a pension from the Pension Fund, your covered family members will continue to be covered (in the tier in which they were covered at the time of your death) for sixty (60) months from the date of your death and no self-pay premiums will be charged. During the Annual Open Enrollment Period following your death, your covered family members may buy up to Tier III, provided the applicable buy-up premium is paid for all quarters in which they wish to receive Tier III benefits.

SECTION III

COVERAGE FOR RETIRED PARTICIPANTS

A. Coverage for You and Your Family Members

1. ELIGIBILITY

You and your eligible family members (see the definition of eligible family members in Section II.C) will be eligible for Fund benefits, provided that you meet all of the following criteria upon your retirement:

- You had **fewer than twelve (12)** Pension Credits **as of January 1, 2008**, and you have at least **twenty-five (25)** Pension Credits at retirement.

  - OR -

  You had **twelve (12)** or more Pension Credits **as of January 1, 2008**, and you have at least **twenty (20)** Pension Credits at retirement.

- You are eligible to receive a pension from the Pension Fund of Local No. One IATSE, and

- Your covered earnings (alone or combined with those of your spouse) were sufficient to qualify you for Fund benefits (whether you enrolled in the Plan or not) in at least three of the five Plan Years immediately preceding the year in which you retire.

If you do not meet all of the above requirements upon your retirement, your coverage under the Plan will terminate when your active coverage terminates. You and your family members may, however, be eligible for COBRA continuation coverage. Please refer to Section VI for information regarding your COBRA rights.

2. SELF-PAY PREMIUM

In addition to the eligibility requirements stated above, to receive Fund benefits as a retiree you must enroll in the Plan (see details in Section III.B below) and submit the applicable self-pay premium to the Fund Office. Effective July 1, 2016, the monthly self-pay premium for Fund retiree coverage, which is subject to change at the Board of Trustees' discretion, is as follows:

Monthly Self-Pay Premium

Medicare-Eligible Participants		
Medicare Eligible	Retiree	$25.00
	Retiree + One	$50.00
	Family (Retiree + More Than One)	$75.00

Early Retirees (not yet Eligible for Medicare)				
		Tier I	Tier II	Tier III
Participants who Retired PRIOR to July 1, 2008				
Age 60 thru 64	Retiree			$36.00
	Retiree + One			$71.00
	Family (Retiree + More Than One)			$107.00
Age 59 and Under	Retiree			$102.00
	Retiree + One			$163.00
	Family (Retiree + More Than One)			$214.00
Participants who Retired ON OR AFTER July 1, 2008				
Age 60 thru 64	Retiree	$31.00	$51.00	$92.00
	Retiree + One	$77.00	$107.00	$179.00
	Family (Retiree + More Than One)	$102.00	$148.00	$250.00
Age 59 and Under	Retiree	$56.00	$92.00	$163.00
	Retiree + One	$128.00	$179.00	$296.00
	Family (Retiree + More Than One)	$179.00	$255.00	$429.00

Your self-pay premium will be deducted from your monthly pension check. You must file a written authorization for the deduction with the Fund Office.

B. Enrollment in the Plan

1. **Except as provided in paragraph 2 below, the decision to elect retiree health coverage must be made before you receive your first pension check.** You will only be offered this coverage once at retirement. Failure to elect this coverage prior to receiving your first pension check will be regarded as a rejection of coverage and such rejection is irrevocable.

2. **Post-Retirement Enrollment:** If you decline Fund benefits at retirement because you are covered by another health plan, and you later become ineligible for that other coverage as described in this paragraph, you may be able to enroll in this Plan post-retirement. This option is available to you only where you have become ineligible under the other health plan due to legal separation, divorce, death, termination of employment, or reduction in hours. This option is not available if you become ineligible under the other plan due to a failure to pay premiums on a timely basis or termination of coverage for cause. You must request enrollment in this Plan within sixty (60) days of your coverage ending under the other health

plan, submit documentation verifying the loss of other coverage, and submit documentation verifying that you were continuously covered by the other health plan from the date of your retirement through the date you lost such coverage. If such enrollment is permitted, Fund benefits will begin on the first day of the first calendar month following the date your completed enrollment form is received by the Fund Office. You are required to pay any applicable self-pay premium.

C. Type of Coverage

1. IF YOU ARE ELIGIBLE FOR MEDICARE

If you are eligible to enroll in Medicare, you will receive the Fund's Medicare-Eligible benefits. Medicare will be your primary provider and the Fund will be your secondary provider, except as otherwise required by law**.** Please note that if you are *eligible* for Medicare, the Fund will treat you as if you are *enrolled* in Medicare. This means that **if you are not enrolled in Medicare at the time you become eligible, your Plan benefit may be much lower than you expect.**

2. IF YOU ARE NOT ELIGIBLE FOR MEDICARE

If you are **not** eligible to enroll in Medicare upon your retirement, you will receive the Fund's Tier I, II or III benefits. The tier of benefits you will receive will be the highest tier in which you were covered (based on earnings or earnings plus buy-up) in three of the five years immediately preceding your retirement. You will continue to receive that tier of benefits (assuming you continue to meet all other Fund requirements) until the earliest date you are eligible to enroll in Medicare, at which point you will receive the Fund's Medicare-Eligible benefits. Once you begin receiving the Fund's Medicare-Eligible benefits, Medicare will be your primary provider and the Fund will be your secondary provider, except as otherwise required by law**.** Please note that if you are *eligible* for Medicare, the Fund will treat you as if you are *enrolled* in Medicare. This means that **if you are not enrolled in Medicare at the time you become eligible, your Plan benefit may be much lower than you expect.**

Please remember that you are required to enroll in Medicare (Part A and Part B) as soon as you become eligible. Medicare rules require you to enroll a few months prior to attaining age 65 in order for benefits to become effective at age 65. If you have received a Social Security Disability Award, you may eventually become eligible for Medicare after you have been receiving Social Security Benefits for a period of time (generally two (2) years).

3. TYPE OF COVERAGE YOUR FAMILY MEMBERS WILL RECEIVE

When you retire, the type of coverage your eligible family member(s) receive (Tier I, II, III or Medicare-Eligible) depends on whether each of them individually is eligible for Medicare. Those eligible for Medicare will receive the Fund's Medicare-Eligible benefits. If any of your eligible family members are not eligible for Medicare, they will receive either Tier I, II, or III coverage. The tier of benefits those family members receive will be equal to the highest tier in which you were covered (based on earnings or earnings plus buy-up) in three of the five years immediately preceding your retirement. As your covered family members become eligible to enroll in Medicare, they will receive the Fund's Medicare-Eligible benefits. Once a family member begins receiving the Fund's Medicare-Eligible benefits, Medicare will be the primary provider and the Fund will be the secondary provider for that family member, except as otherwise required by law**.** Please note that if your family member is *eligible* for Medicare, the Fund will treat that family member as if he/she is *enrolled* in Medicare. This means that **if your family member is not enrolled in Medicare at the time he/she becomes eligible, his/her Plan benefit may be much lower than expected.**

Please remember that your eligible family members are required to enroll in Medicare (Part A and Part B) as soon as they become eligible. Medicare rules require enrollment a few months prior to attaining age 65 in order for benefits to become effective at age 65. If they receive a Social Security Disability Award, they may eventually become eligible for Medicare after they have been receiving Social Security Benefits for a period of time (generally two (2) years).

ABOUT MEDICARE . . .

Medicare Part A (Hospital Insurance) *helps cover inpatient hospital, skilled nursing facility, hospice, and home health care. Most people don't pay a Part A premium because they paid Medicare taxes while working.*

Medicare Part B (Medical Insurance) *helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Anyone who is eligible for free Medicare hospital insurance (Part A) can enroll in Medicare medical insurance (Part B) by paying a monthly premium.*

PLEASE NOTE that the Fund requires that if you're eligible for Medicare, you must enroll in both Part A and Part B.

These programs are subject to changes by the federal government at any time. For more complete and current information about your Medicare benefits, including Medicare Part C and D benefits, go to ***www.medicare.gov*** *or call* ***1-800-MEDICARE (1-800-633-4227)****.*

D. Special Enrollment Options for Family Members

1. Loss of Other Health Coverage

If you are a retiree already enrolled in the Plan, you may be able to enroll an eligible family member you did not enroll when you retired if you declined Fund benefits for such family member because he/she was covered by another health plan and such family member later becomes ineligible for that other coverage as described in this paragraph. This option is available only where your eligible family member became ineligible under the other health plan due to legal separation, divorce, death, termination of employment, or reduction in hours. This option is not available if your eligible family member became ineligible under the other plan due to a failure to pay premiums on a timely basis or termination of coverage for cause. You must request enrollment in the Plan within sixty (60) days of coverage ending under the other plan, and submit documentation verifying the loss of other coverage. If enrollment is permitted, Fund benefits will begin on the first day of the first calendar month following the date your completed enrollment form is received by the Fund Office. You are required to pay any applicable self-pay premium.

2. Newly-Acquired Family Member

If you are a retiree already enrolled in the Plan, and you acquire a new family member as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll that new eligible family member in the Plan. You must request enrollment in the Plan within sixty (60) days after the marriage, birth, adoption, or placement for adoption, submit valid documentation verifying the new family member(s), and pay any self-pay premium required by the Plan. If enrollment is permitted, in the case of marriage, Plan benefits will begin on the first day of the first calendar month following the date a completed request for enrollment is received by the Fund Office, and in the case of birth, adoption, or placement for adoption, Plan benefits will begin on the date of such birth, adoption, or placement for adoption.

3. Additional Special Enrollment Rights

If you are a retiree already enrolled in the Plan, and either: (a) your family member's coverage under Medicaid or the Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility for such coverage, or (b) your family member becomes eligible for a state subsidy for enrollment in the Plan under Medicaid or CHIP, you may be able to enroll your eligible family member in the Plan if you request enrollment in the Plan within sixty (60) days after such termination or eligibility. If enrollment is permitted, Plan benefits will begin on the first day of the first calendar month following the month in which a completed request for enrollment is received by the Fund Office. You are required to pay any applicable self-pay premium.

E. Termination of Coverage

Your coverage (and that of your covered family members) is subject to termination as follows:

1. If you revoke your election or fail to pay the applicable monthly self-pay premium, your coverage and that of your covered family members shall terminate as of the end of the month in which the last monthly self-pay premium was paid. You and your family members will not be permitted to resume Plan coverage unless you re-qualify for Plan benefits as an active employee.

2. If you and your spouse legally separate or divorce, you spouse's coverage will terminate as of the end of the month in which your legal separation or divorce is final.

3. If your child ceases to fall within the definition of an eligible child (as set forth in Section II.C above), that child's coverage will terminate as described in Section II.C.

4. Your coverage and that of your covered family members will terminate if the Fund terminates or its group policies terminate.

If you legally separate or divorce . . .

You are required to immediately notify the Fund .... Office if you and your spouse legally separate or divorce. **If you fail to inform the Fund Office of such legal separation or divorce, the Fund may hold you responsible for the costs associated with extending coverage to your spouse after your legal separation/divorce became final, including, but not limited to, claims and/or COBRA premiums.** The Trustees reserve the right to terminate your Fund coverage and that of your covered family members for failure to notify the Fund of such legal separation or divorce.

If your coverage is terminated, you and your affected family members may be eligible for COBRA continuation coverage (see Section VI).

F. Return to Employment Following Retirement

Should you choose to return to work after you have retired, the following special rules will apply to your eligibility for Plan benefits.

If you are receiving the Fund's Medicare-Eligible benefits and you return to work and earn more than the required covered earnings for Tier I, II or III benefits, your Medicare-Eligible benefits will be terminated on the following June 30th and beginning the next day, July 1, you will have the option to either: (1) elect the tier of benefits you earned based on your covered earnings in the prior calendar year (Tier I, II, or III) as your primary coverage with the option to have Medicare as your secondary coverage or (2) retain Medicare as your primary coverage and therefore reject any coverage from the Fund.

For example, if you had Medicare as your primary coverage and the Plan's Medicare-Eligible benefits as secondary coverage, and you earned $37,500 in 2016, on July 1, 2017 you must elect either: (1) Tier I benefits through the Plan as your primary coverage and optionally have Medicare as your secondary coverage, or (2) Medicare as your primary coverage with no secondary coverage under the Plan.

If in a subsequent year you earn less than the required covered earnings for Tier I benefits, and you had chosen to keep Medicare as your primary coverage, you will once again become eligible for the Plan's Medicare-Eligible benefits as your secondary coverage on the following July 1. If you had chosen to have Tier I, II or III as your primary coverage, that coverage will terminate on the following June 30th and beginning the next day, July 1, you will again be eligible for the Fund's Medicare-Eligible benefits as your secondary coverage. **Please note that it is your responsibility to give Medicare timely notification of the loss of your Tier I, II or III coverage to ensure that your Medicare coverage is in place on July 1, and to prevent any gaps in your Medicare coverage.** Please contact the Fund Office if you have any questions.

Only your covered earnings, not those of your spouse, shall be considered for purposes of this Section F.

G. Continuation of Benefits for Covered Family Members After Your Death

If you die while enrolled in the Plan and before you have received sixty (60) months of benefits from the Pension Fund of Local No. One, IATSE, your covered family members will continue to be covered (in the tier in which they were covered at the time of your death) for sixty (60) months from your date of retirement and no self-pay premiums will be charged.

SECTION IV

MEDICAL AND PRESCRIPTION DRUG BENEFITS

A. Medical Benefits

The details of your Fund-provided medical benefits plan can be found in the Medical Benefits Booklet provided to you with this SPD. The Booklet includes information for each Tier of benefit. It explains which medical services are covered and to what extent, and includes information about coverage exclusions. It also provides information regarding applicable copayments, coinsurance, and deductibles.

It is your obligation to understand the terms of the Booklet and all subsequent changes to information contained in that Booklet, which will be provided to you in writing. If you don't have a copy of the Medical Benefits Booklet, please contact the Fund Office at (212)247-5225, or visit the Fund's website at **www.FundOneIATSE.com**.

B. Prescription Drug Benefits

1. SCHEDULE OF BENEFITS

The Plan provides benefits for prescription drugs and related supplies provided by pharmacies. These prescription benefits are administered on behalf of the Welfare Fund by a Pharmacy Benefit Manager (PBM). **Contact information for the PBM can be found on an insert included with this SPD, the Fund's website at www.FundOneIATSE.com, on your pharmacy benefit ID card, or by contacting the Fund Office.**

Participants are required to pay a portion of the covered expenses, including any applicable copayment or deductible. A copayment is the portion of the expense paid by you for covered prescription drugs and related supplies. A deductible is the amount you must pay towards your covered benefits during a calendar year before the plan begins to pay.

The drugs which are covered by your prescription plan are listed in the formulary maintained by the Fund's PBM. (A formulary is simply the list of prescription drugs which are covered by the Plan.) Since this list changes frequently, it is not included in this SPD. If you wish to obtain a current copy of the formulary, please contact the PBM or the Fund Office for assistance.

The amount of the copayment for a particular drug depends on whether it is categorized as Generic, Brand Name Preferred, or Brand Name Non-Preferred on the PBM's formulary.

A **Generic** drug is a lower-cost equivalent of a brand-name drug which is approved by the U.S. FDA and includes the same active ingredients as its brand-name equivalent. The Fund offers a very low $5 copay for generic drugs since they are generally much less expensive for the Fund than their Brand-Name equivalents.

Brand Name Preferred drugs are generally those drugs for which there is currently no Generic equivalent.

Brand Name Non-Preferred drugs are generally those Brand Name drugs for which there is a less expensive therapeutic equivalent alternative in either the Generic or Brand Name Preferred categories. These drugs have the highest copay since there are less expensive alternatives available to participants.

Medications required as part of preventive care services (detailed information is available at www.healthcare.gov/center/regulations/ prevention/recommendations.html) are covered at 100% with no copayment or deductible.

Following are the copayments and deductibles for each of the benefit plans by formulary category. **Please note that there are substantial savings in copay expense if you participate in the PBM's 3-Month Home Delivery Mail Order program.** (For more details, please contact the PBM or the Fund Office.)

	Generic	Brand Name Preferred	Non-Preferred
Tier III			
Copay for Purchase at Participating Pharmacy	$5	$35	$50
Copay for Mail Order (3 month supply)	$10	$70	$100
Individual Deductible	None		
Tier II			
Copay for Purchase at Participating Pharmacy	$5	$40	$55
Copay for Mail Order (3 month supply)	$10	$80	$110
Individual Deductible	$50		
Tier I			
Copay for Purchase at Participating Pharmacy	$5	$45	$60
Copay for Mail Order (3 month supply)	$10	$90	$120
Individual Deductible	$100		
Medicare-Eligible			
Copay for Purchase at Participating Pharmacy	$5	$25	$35
Copay for Mail Order (3 month) Copay	$10	$50	$70
Individual Deductible	None		

2. COVERED EXPENSES

If you or any one of your covered family members, while insured for prescription drug benefits, incurs expenses for charges made by a participating pharmacy for medically necessary prescription drugs or related supplies ordered by a physician, the PBM will provide coverage for those expenses as shown in the schedule of benefits above. Coverage also includes medically necessary prescription drugs and related supplies dispensed for a prescription issued by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or any one of your covered family members is issued a prescription for medically necessary prescription drugs or related supplies as part of the rendering of emergency services and that prescription cannot reasonably be filled by a participating pharmacy, the prescription will be covered by the PBM as if filled by a participating pharmacy.

Covered expenses include charges for a drug that has been prescribed for the treatment of a type of cancer for which it has not been approved by the Food and Drug Administration (FDA) only if such drug is recognized for the treatment of the specific type of cancer for which the drug has been prescribed in one of the established reference compendia: the American Hospital Formulary Service-Drug Information (AHFS-DI); the National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services (CMS); or recommended by a review article or editorial comment in a major peer-reviewed professional journal.

3. LIMITATIONS

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a **retail** Participating Pharmacy unless limited by the drug manufacturer's packaging or the PBM drug quantity limit program: or
- up to a consecutive 90-day supply at a **home delivery** Participating Pharmacy, unless limited by the drug manufacturer's packaging or the PBM drug quantity limit program: or
- to a dosage and/or dispensing limit as determined by the PBM.

Coverage for certain prescription drugs and related supplies requires your physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your physician wishes to request coverage for prescription drugs or related supplies for which prior authorization is required, your

physician may call or complete the appropriate prior authorization form and fax it to the PBM to request a prior authorization for coverage. Your physician should make this request before writing the prescription.

If the request is approved, your physician will receive confirmation. The authorization will be processed in the PBM's claim system to allow you to have coverage for those prescription drugs or related supplies. The length of the authorization will depend on the diagnosis and prescription drugs or related supplies. When your physician advises you that coverage for the prescription drugs or related supplies has been approved, you should contact the pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the prescription drugs or related supplies is not authorized. If you disagree with a coverage decision, you or your physician may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the prescription drugs or related supplies should be covered.

If you have questions about a specific prior authorization request, you should call the PBM at the phone number on your pharmacy ID card.

All drugs newly approved by the Food Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the PBM clinically evaluates the prescription drug for a different designation. Prescription drugs that represent an advance over available therapy according to the FDA will be reviewed by the PBM within six months after FDA approval. Prescription drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the PBM for at least six months after FDA approval.

4. YOUR PAYMENTS

Coverage for prescription drugs and related supplies purchased at a pharmacy is subject to the copayment shown in the schedule above (Section IV.B.1.), after you have satisfied your prescription drug deductible, if applicable. Please refer to the schedule and any subsequent notices announcing changes related to copayments, coinsurance, deductibles or maximums.

When a treatment regimen contains more than one type of prescription drug packaged together for the sake of convenience, a copayment will still apply to each prescription drug.

In no event will the copayment for the prescription drug or related supply exceed the amount paid by the plan to the pharmacy, or the pharmacy's Usual and Customary (U&C) charge. Usual & Customary (U&C) means the established pharmacy retail cash price, less all applicable customer discounts that the pharmacy usually applies to its customers regardless of the customer's payment source.

5. EXCLUSIONS

No payment will be made for the following expenses:

- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the PBM, unless medically necessary and approved by the PBM;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription and nonprescription supplies (such as ostomy supplies), devices (other than FDA approved medicines or devices prescribed to detect or treat bone mineral density conditions), and appliances other than Related Supplies;
- implantable contraceptive products;
- prescription vitamins (other than prenatal vitamins), dietary supplements, unless state or federal law requires coverage of such drugs;
- prescription smoking cessation products, unless determined to be medically necessary and approved by the PBM;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products, unless determined to be medically necessary and approved by the PBM;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of prescription drugs and related supplies due to loss or theft;
- drugs used to enhance athletic performance, unless determined to be medically necessary and approved by the PBM;
- drugs which are to be taken by or administered to you while you are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;

- prescriptions more than one year from the original date of issue;
- any drugs that are experimental or investigational as described under the Medical "Exclusions" section of the Medical Benefits Booklet.

Other limitations are shown in the "Exclusions" section of the Medical Benefits Booklet.

6. FILING A PRESCRIPTION CLAIM

When you or a covered family member purchases prescription drugs or related supplies through a retail participating pharmacy, you pay any applicable copayment or deductible (see Section IV.B.1.) at the time of purchase. You don't need to file a claim form unless you are unable to purchase prescription drugs at a participating pharmacy for emergency services. Claim forms are available on the Fund's web site: www.FundOneIATSE.com.

To purchase prescription drugs or related supplies from a home delivery participating pharmacy, contact the PBM at the phone number on the back of your pharmacy ID card or contact the Fund Office for assistance.

SECTION V

PARTICIPANT ASSISTANCE BENEFITS
(The Actors' Fund)

The Fund is committed to your health and well-being. Our Participant Assistance Program (PAP), offered through The Actors' Fund, is here to confidentially help you and your family members obtain support and assistance when you need it.

Benefits can be accessed by contacting The Actors' Fund directly:

- During normal business hours call **(212) 221-7300 (ext. 119)** or **(800) 221-7303 (ext. 119)**;
- In case of **emergency or after hours or on weekends** call **(212) 621-7780**;

or by visiting The Actors' Fund offices located at **729 Seventh Avenue (at 49th Street)**, New York, New York.

Benefits/Services available include:

- **Counseling Services**: PAP counselors offer help with emotional, family related, marital, stress, financial, substance abuse, and workplace problems faced by you and your family members. PAP counselors provide short-term counseling and support, identify problems and, when appropriate, provide referrals to outside specialists and community agencies. Counseling can be done in person or by phone, if necessary.

  If outside specialists are necessary, PAP counselors will coordinate with the Medical Benefit Manager directly to identify in-network providers and services.

- **Government and Community Benefits**: Assessment and advocacy for public and other community benefits programs.

- **Work Program**: Career counseling, training and employment services for obtaining sideline and second careers. The program also assists participants and their family members who are making the transition from Workers' Compensation or disability to identify and obtain new work. To learn more about seeing a career counselor call the Actors' Work Program at (212) 354-5480.

- **Legal Services**: Referrals to attorneys in private practice or sliding scale organizations for issues such as wills, landlord/tenant disputes, disability, family law or more.

- **Work/Life Enrichment**: Workshops are provided FREE of charge on a variety of topics to support participants and their family members in balancing their work and personal life:
    - Financial planning workshops on debt management and credit consolidation, managing medical debt, budgeting strategies, taxes and estate planning
    - Housing seminars to assist in finding affordable housing, home buying, managing landlord/tenant disputes, and understanding tenant rights
    - Stress and time management
    - Support groups that address various issues including addiction recovery, career transition and bereavement

- **Health Related Services**: Assistance on choosing and talking to health care providers about women's health issues, aging and health, smoking cessation, nutrition and exercise. Counselors also provide information on wellness, patient rights and protections.

- **Health Fairs:** Offering free screenings for cholesterol, blood pressure, skin cancer, glaucoma, flu vaccinations and more.

- **Al Hirschfeld Free Health Clinic** provides free health care to uninsured and underinsured entertainment professionals. Appointments can be made by calling (212) 489-1939. The Clinic is located at 475 West 57th Street (at 10th Avenue), New York, New York.

- The **Health Insurance Resources Center** is a comprehensive health insurance information and referral service. Through the internet at www.ahirc.org or over the phone, participants and their family members can receive health insurance counseling.

- **Housing Services** through The Actors' Fund include:
    - A **Housing Information and Referral Center** to assist working professionals in locating affordable housing
    - Assisted living and skilled nursing through the Lillian Booth Actors' Home in Englewood, NJ
    - Shared apartments for working professionals, seniors and people with AIDS at the Aurora residence in New York City. Schermerhorn House in Brooklyn offers small studio apartments for single adults.
    - Housing for people with AIDS at the Palm View residence in West Hollywood

SECTION VI

COBRA CONTINUATION COVERAGE

A. Generally

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), employers sponsoring group health plans must offer employees and their families a temporary extension of health coverage (COBRA coverage) at group rates in certain instances where coverage under the Plan would otherwise end (called "qualifying events"). This section is intended to inform you, in a summary fashion, of your rights and obligations with respect to COBRA coverage under the Plan. **If you have additional questions regarding your rights under COBRA, contact the Director of Fund Administration at: 320 West 46th Street, 6th Floor, New York, New York 10036, (212) 247 5225 or (800) WP-IATSE (974-2873).**

You may have other options available to you when you lose group health coverage. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for Medicaid or a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. You can learn more about many of these options at ww.healthcare.gov.

If you are employed by a contributing employer and are covered by the Plan, you have a right to choose COBRA coverage if you lose your group health coverage under the Plan due to either of the following reasons:

1. a reduction in your hours of employment, or
2. termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Plan, you have the right to choose COBRA coverage for yourself if you lose group health coverage under the Plan for <u>any</u> of the following reasons:

1. death of your spouse,
2. termination of your spouse's employment (for reasons other than gross misconduct),
3. a reduction in your spouse's hours of employment with a contributing employer,
4. divorce or legal separation from your spouse, or
5. your spouse becomes enrolled in Medicare (Part A, B or both).

Dependent children of an employee covered under the Plan have the right to choose COBRA coverage if group health coverage under the Plan is lost for any of the following reasons:

1. death of the employee-parent,
2. termination of the employee-parent's employment (for reasons other than gross misconduct),
3. a reduction in the employee-parent's hours of employment with a contributing employer,
4. parents' divorce or legal separation,
5. employee-parent becomes enrolled in Medicare (Part A, B or both), or
6. dependent child ceases to be an "eligible family member" (See Section II.C for definition of eligible family member).

In addition, there may be a right to COBRA coverage for certain eligible retirees and their spouses, surviving spouses and dependent children if a Title 11 bankruptcy proceeding is commenced with regard to the retiree's contributing employer. If this occurs, you should contact the Director of Fund Administration concerning your rights.

A child who is born to or placed for adoption with a covered employee during the period of the employee's COBRA coverage is a "qualified beneficiary" and generally is eligible to be enrolled immediately for COBRA coverage under the Plan. Once the child is enrolled pursuant to the Fund's rules, he or she will be treated like all other COBRA qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a child is measured from the same date as other qualified beneficiaries with respect to the same qualifying event (and not from the date of the birth or adoption). A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

B. Giving Notice of Qualifying Events

Your employer is responsible for notifying the Fund Office of your death, termination of employment, reduction in hours of employment or Medicare enrollment (Part A, B or both) or of commencement of a proceeding in bankruptcy with respect to the employer, no later than sixty (60) days after your loss of coverage due to one of these events. You or your covered family member must inform the Fund Office of a divorce, legal separation or a child's loss of dependent status under the Plan. Such notice must be provided within sixty (60) days of the later of: (i) the date of the event or (ii) the date on which coverage would end under the Plan because of the event. This notice must be in writing and must be sent to the Director of Fund Administration at the Fund Office: 320 West 46th Street, 6th Floor, New York, NY 10036. **If you or your covered family member does not provide the required notice during this 60-day notice period, group health insurance coverage under the Fund will end for you and/or your covered family member and YOU AND/OR YOUR COVERED FAMILY MEMBER WILL LOSE THE RIGHT TO ELECT COBRA.**

C. How COBRA Coverage is Provided

When the Director of Fund Administration is notified that a qualifying event has happened, you will in turn be notified that you have the right to choose COBRA coverage. You must inform the Fund Office that you want COBRA coverage. Such notice must be provided within sixty (60) days of the later of: (i) the date you ordinarily would have lost coverage because of one of the events described above, or (ii) the date of the notice of your right to elect COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage. Covered employees may elect COBRA coverage on behalf of their spouse, and parents may elect COBRA coverage on behalf of their children.

If you do not choose COBRA coverage during this 60-day period, your group health insurance coverage under the Fund will end. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

D. Duration of Continuation Coverage

If you choose COBRA coverage, you are entitled to coverage that is identical to the coverage being provided under the Fund to similarly situated employees (or their family members). COBRA coverage is a temporary continuation of coverage.

If group health coverage is lost because of a termination of employment or reduction in hours of employment, the law requires that qualified beneficiaries be afforded the opportunity to maintain COBRA coverage for up to eighteen (18) months. In the case of other qualifying events, qualified beneficiaries will be afforded the opportunity to maintain COBRA coverage for up to thirty-six (36) months. Please note that the 18-, 29- and 36-month periods described throughout this section are all measured from the date on which coverage is lost.

E. Disability Extension of 18-month COBRA Coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Fund Office in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the COBRA coverage period that would be available without the disability extension (usually 18 months, as described above). This disability extension is only available if you notify the Fund Office of the disability within 60 days of the later of: (i) the date of the Social Security Administration's disability determination, (ii) the date of the covered employee's termination of employment or reduction of hours, and (iii) the date on which the qualified beneficiary loses or will lose coverage under the Plan as a result of the

covered employee's termination of employment or reduction of hours. You must also provide notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. This notice must be in writing and must include a copy of the disability award letter from the SSA. Please send the notice to the Director of Fund Administration at the address listed at the beginning of this section. **If these procedures are not followed or if notice is not provided to the Fund Office within the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

F. Second Qualifying Event Extension of 18-month COBRA Coverage

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or in the case of a disability extension, 29 months) following the covered employee's termination of employment or reduction of hours. **The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months.** A second qualifying event may include the death of a covered employee, the cover employee becoming enrolled in Medicare (Part A, B or both), divorce or legal separation from the covered employee, or a dependent child no longer qualifying as an "eligible family member" (as defined in Section II.C). These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. This extension due to a second qualifying event is available only if you notify the Fund Office in writing of the second qualifying event within 60 days after the date of the second qualifying event. This notice must be in writing and must be sent to the Director of Fund Administration at the Fund Office: 320 West 46th Street, 6th Floor, New York, NY 10036. **If these procedures are not followed or if the notice is not provided to the Fund Office during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

G. Termination of COBRA Coverage Before End of Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period for any of the following reasons:

1. Any required premium is not paid in full on time.
2. The qualified beneficiary becomes covered under another group health plan (but only after any exclusions of that other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied). The qualified beneficiary is required to notify the Fund Office within thirty (30) days of becoming covered under another group health plan.
3. The qualified beneficiary becomes enrolled in Medicare (Part A, B or both). The qualified beneficiary is required to notify the Fund Office within thirty (30) days of becoming enrolled in Medicare.
4. During the disability extension period, the disabled qualified beneficiary receives a final determination from the Social Security Administration that he/she is no longer

disabled (COBRA coverage for all qualified beneficiaries, not just the disabled beneficiary, will terminate). The disabled qualified beneficiary is required to notify the Fund Office within thirty (30) days of any such final determination.

5. The Fund no longer provides group health coverage.

COBRA coverage can also be terminated for any reason the Fund would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

Once your COBRA coverage terminates for any reason, it cannot be reinstated.

You do not have to show that you are insurable to choose COBRA coverage. However, COBRA coverage under the law is provided subject to your eligibility for coverage under the Fund. The Board of Trustees and the applicable Fund insurer reserve the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

H. Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed one hundred two percent (102%) (or in the case of an extension of COBRA coverage due to disability, 150%) of the cost to the group health plan for coverage of a similarly situated Plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

The COBRA premium you must pay may be reduced in accordance with one of the following programs:

1. HEALTH COVERAGE TAX CREDIT

Certain individuals may be eligible for a Federal income tax credit that can help with qualified monthly COBRA premium payments. The Health Coverage Tax Credit (HCTC), while available, is a refundable tax credit to pay for specified types of health insurance coverage (including COBRA coverage). Those potentially eligible for the HCTC include workers who lose their jobs due to the negative effects of global trade and who are eligible to receive certain benefits under the Trade Adjustment Assistance (TAA) Program. The HCTC pays 72.5% of qualified health insurance premiums. For more information on TAA, visit doleta.gov/tradeact/. For questions about the Health Coverage Tax Credit visit IRS.gov/HCTC.

2. COBRA PREMIUM PAYMENT ASSISTANCE (ENTERTAINMENT INDUSTRY SUBSIDY)

If you are a New York State resident, you may be eligible for a subsidy to defray fifty percent (50%) of the cost of COBRA premiums. The New York State Legislature has adopted a

law to provide a fifty percent (50%) subsidy to New York State residents in the entertainment industry whose current income is below a certain threshold.

If you believe you may be eligible, you should complete the application and send it to the State Insurance Department as soon as possible following the occurrence of a COBRA qualifying event. Once the Fund Office hears from the State Insurance Department that your application has been approved, it will notify you that you need only pay fifty percent (50%) of the COBRA premium; the State of New York will pay the other fifty percent (50%) directly to the Fund. But until the Fund Office advises you that your application was approved, you must pay the full COBRA premium. Therefore, you should submit your application to the State Insurance Department as soon as possible. If for any month you have already paid the full premium and the Fund then receives fifty percent (50%) from the State, you will, of course, be entitled to a refund of the overpayment. But the State of New York will not approve payments retroactively, so apply as early as possible. Please also note that an applicant cannot receive more than twelve (12) months of premium assistance in a lifetime.

Please note that in determining whether you are eligible, the State Insurance Department is interested only in your current monthly income (or, if you do not have information for the current month, they will accept information about the previous month). Therefore, you may be eligible even if your earnings were substantial during the previous year.

If you have any questions about this program you may contact the Consumer Services Bureau of the State Insurance Department at (800) 342-3736.

Please remember that until an application is approved you must continue to pay your full COBRA premium on time in order to maintain your coverage under the Plan.

I. If You Have Questions

Questions concerning your COBRA coverage rights should be addressed to the Director of Fund Administration at the address above. For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

J. Keep the Fund Informed of Address Changes

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notice you send to the Fund Office.

SECTION VII

FAMILY AND MEDICAL LEAVE, QUALIFIED MEDICAL CHILD SUPPORT ORDERS, AND MILITARY SERVICE

A. Family and Medical Leave

The Family and Medical Leave Act (FMLA) allows you to take up to twelve (12) weeks of unpaid leave from your employer during any 12-month period for:

- the birth, adoption, or placement with you for adoption of a child,
- providing care for a spouse, child, or parent who is seriously ill, or
- your own serious illness.

You are generally eligible for a leave under the FMLA if you:

- have worked for a covered employer for at least twelve (12) months,
- have worked at least 1,250 hours for that covered employer over the previous twelve (12) months, and
- work at a location where at least fifty (50) employees are employed by the employer within seventy-five (75) miles.

If you satisfy these conditions and take an approved FMLA leave from a contributing employer, your employer will be required to contribute to the Fund on your behalf. You will then be credited during your leave as if you were working in covered employment, provided your employer makes the required notification to the Fund. Any changes in the Fund's terms, rules or practices that go into effect while you are on leave apply to you and your covered family members, the same as to active employees and their covered family members. If you do not return to covered employment after your leave ends and you lose coverage as a result, you are entitled to COBRA coverage when your leave ends. See Section VI for more information regarding COBRA coverage.

Call your employer to determine whether you are eligible for FMLA. Call the Fund Office regarding coverage during FMLA leave.

B. Qualified Medical Child Support Orders

The Fund will extend benefits to a participant's non-custodial child, as required by any qualified medical child support order (QMCSO), under ERISA § 609(a). The Fund has procedures for determining whether an order qualified as a QMSCO. Participants and covered family members can obtain, without charge, a copy of such procedures from the Director of Fund Administration. A child covered under the Fund pursuant to a QMCSO will be treated as a dependent under the Fund. Please refer to the Medical Benefits Booklet for further information related to payment of Fund benefits pursuant to a QMCSO.

C. Effect of Military Service on your Fund Benefits

Please refer to the Medical Benefits Booklet for information relevant to the effect of military service on your Fund benefits.

SECTION VIII

REPAYMENT OF MEDICAL BENEFITS, RECOVERY OF OVERPAYMENTS, AND FALSE OR FRAUDULENT CLAIMS

A. Repayment of Medical Benefits (Subrogation)

The Fund has the right to recover from you, your family members (and any other person, entity or trust in possession of funds sought by the Plan) all benefits paid on your or your family members' behalf by the Fund for injuries or disabilities that you or your family members have suffered for which you or they recover money in a "third party" claim or lawsuit or settlement thereof. The Fund may seek such recovery through subrogation and/or any other equitable or legal relief available under state or federal law.

If you or any of your covered family members is injured as a result of the negligence or other wrongful acts of a third party and you seek recovery of any monies from the third party who caused the injuries, the Fund has a first priority lien for the full amount of Fund benefits paid on behalf of you and your covered family members in connection with such injuries.

We strongly recommend that, if you are injured as a result of the negligence or wrongful act of a third party, you contact your attorney for advice and counsel. However, the Fund cannot and does not pay for the fees your attorney might charge.

Should you seek to recover any monies from the third party that caused your injuries, it is a rule of the Fund that you must give notice of that action to the Fund Office within ten (10) days after either you or your attorney first attempt to recover such monies; and if litigation has commenced, you are required to give notice to the Fund Office of any pretrial conferences within five (5) days of the same. Representatives of the Fund reserve the right to attend such pretrial conferences.

The Fund's lien arises through operation of the Plan. No additional reimbursement agreement is necessary. However, the Fund may require you or your attorney to execute documents confirming the rights of the Fund. The Fund's lien is a lien on the proceeds of any compromise, settlement, judgment and/or verdict received from the third party, his insurance carrier and/or any other party settling on his behalf. By applying for and receiving benefits from the Fund in such third-party situations, you agree to reimburse the Fund the full amount of the benefits that are paid on behalf of you and your family members from the proceeds of any such compromise, settlement, judgment and/or verdict, to the extent permitted by law.

By applying for benefits, you agree that the proceeds of any compromise, settlement, judgment and/or verdict received from the third party, the insurance carrier and/or any other party settling on the third party's behalf, if paid directly to you, will be held by you in constructive trust for the Fund. The receipt of such funds makes you a fiduciary of the Fund with respect to such funds and therefore subject to the fiduciary provisions and obligations of ERISA.

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

The Fund does not require you to seek any recovery whatsoever against the third party; and if you do not receive any recovery from the party, you are not obligated in any way to reimburse the Fund for any of the benefits that you applied for and accepted.

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

Any and all amounts received from a third party by judgment, settlement, or otherwise must be applied first to reimburse the Fund for the amount of medical expenses paid on behalf of you and your family members. The Fund's lien is a lien of first priority for the entire recovery of funds paid on behalf of you and your family members. Where the recovery from the third party is partial or incomplete, the Fund's right to reimbursement takes priority over the rights of you and your family members to recover, regardless of whether or not you or your family members have been made whole for injuries or losses. The Fund does not recognize and is not bound by any application of the "make whole" doctrine.

Please refer to the Medical Benefits Booklet for additional information regarding the Fund's subrogation rights.

B. Recovery of Overpayments

If, for any reason, the Fund pays you or your family members (including your surviving family members) an amount in excess of the benefit that you or they are entitled to receive under the Plan, the Fund is authorized to recover the amount of the benefit overpayments, plus interest and costs, from you and your family members, including reduction or suspension of future benefits payable.

C. False or Fraudulent Claims

The Fund does not cover claims based on misrepresentations or false, incomplete or misleading information. Filing a false or fraudulent claim for benefits with the Fund is a crime punishable by fine and imprisonment. Moreover, if a false or fraudulent claim is filed, full restitution plus interest and reimbursement of any expenses incurred by the Fund will be required. In addition, the Trustees may suspend the benefits to which you and your family members would otherwise be entitled for a period of up to five (5) years. In no event will such suspension of benefits be lifted until full restitution has been made. The Trustees reserve the right to turn any such matter over to the proper authorities for prosecution.

SECTION IX
CLAIMS & APPEALS

A. Claim Procedures

This Section describes the procedures for filing claims for benefits. It also describes the procedures to follow if your claim is denied in whole or in part, or if any adverse determination is made with respect to your claim, and you wish to appeal the decision. In addition to the information provided in this Section, please also familiarize yourself with those sections of the Medical Benefits Booklet containing claims and appeals procedures.

1. DEFINITIONS

A **claim for benefits** is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures including filing a claim (where necessary). When the procedures require that you file a claim for benefits offered under this Plan, you must submit a completed claim form. Simple inquiries about the Plan's provisions or about Plan eligibility that are unrelated to any specific benefit claim will not be treated as a claim for benefits. A request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits. In addition, the presentation of a prescription to a pharmacy which exercises no discretion on behalf of the Plan is not considered a claim.

An **adverse determination** is a communication that reduces or denies benefits, terminates or fails to provide payment for a benefit, or rescinds coverage.

2. AUTHORIZED REPRESENTATIVES

If you are unable to complete the claim form yourself, you may designate an individual to act as your authorized representative and complete the form for you. You must designate an authorized representative in writing on a form which can be obtained from the Fund Office. In addition to a completed form, the Fund may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an urgent care claim (defined below) without you having to complete an authorization form.

3. WHERE AND WHEN TO FILE CLAIMS

(a) Medical and Hospital Claims

The Medical Benefit Manager (MBM) pays service providers directly when you stay in-network. Therefore, when you receive care from a provider or facility in the MBM's network, you generally do not have to file a claim. However, if you receive services out-of-network or have a medical emergency out of the MBM's service area, you will have to file a claim for reimbursement of covered services (unless the out-of-network provider is able and willing to file on your behalf).

A claim form is available online at the MBM's web site shown on your medical insurance ID card or www.FundOneIATSE.com, or by calling the toll-free number on your

medical ID card or the Fund Office at (212) 247-5225. Send completed claims to the address provided on the claim form.

These claims are handled in accordance with the procedures described in Section IX.4 below depending on whether the claim is one for pre-service, urgent care, concurrent care or post-service. In order to ensure proper processing of your claim, please make sure to carefully follow the claim form instructions and keep a copy of your completed claim form and any attachments for your records. A claim must be submitted to the MBM within **twelve (12) months** of the date charges are incurred. If the claim is not submitted on time, the claim will be denied unless it is shown that written proof of loss was given as soon as was reasonably possible. Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time.

(b) Prescription Drug Claims

Most prescriptions are filled directly by an in-network pharmacist. However, if an in-network pharmacist rejects your prescription request, in whole or in part, or if you purchase medication without your pharmacy ID card, you may file a claim for reimbursement.

A claim form is available online at the PBM's web site shown on your pharmacy ID card or www.FundOneIATSE.com, or by calling the toll-free number on your pharmacy ID card or the Fund Office at (212) 247-5225. Send completed claims to the address provided on the claims form.

These claims are handled under the post-service claims procedures described in Section IX.4.d below. In order to ensure proper processing of your claim, please make sure to carefully follow the claim form instructions and keep a copy of your completed claim form and any attachments for your records. A claim must be submitted to PBM within **twelve (12) months** of the date charges are incurred. If the claim is not submitted on time, the claim will be denied unless it is shown that written proof of loss was given as soon as was reasonably possible. Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time.

(c) Medicare-Eligible Retiree Claims

All claims for Medicare-Eligible Retiree benefits are handled under the post-service procedures described in Section IX.4.d below. A claim form for secondary coverage (the portion of your claim not covered by Medicare) is available online at the web site shown on your ID card or www.FundOneIATSE.com, or by calling the toll-free numbers on your ID cards or the Fund Office at (212) 247-5225. Send completed claims to the address provided on the claim form.

(d) Eligibility Claims

An **eligibility claim** is a specific request for eligibility for Fund benefits relating to a particular person or period. Submit eligibility claims directly to the Fund Office at (212) 247-5225. You do not have to fill out a claim form. However, you must provide the Fund

Office with a written description of the circumstances surrounding your claim so that your claim can be adjudicated properly.

4. CLAIM PROCEDURES

You claim will be handled in accordance with the procedures described below depending on whether it is a **pre-service claim**, an **urgent care claim**, a **concurrent care claim**, a **post-service claim**, or an **eligibility claim**. Read each section below carefully to determine which procedure is applicable to your request for benefits. If you have any questions regarding what type of claim and/or what claim procedure to follow, contact the MBM at the phone number provided on your ID card or the Fund Office at (212) 247-5225.

(a) Pre-Service Claims

A **pre-service claim** is a claim for a benefit that requires approval (in whole or in part) before medical care is obtained. Tier I, II and III benefits provided through the Fund's MBM include certain services that are covered only if you obtain pre-certification. You must follow the MBM's pre-service rules to obtain such benefits. In general, pre-certification determines the medical necessity of a particular service or supply.

For Tier I, II and III benefits, there is a Pre-Admission Certification (PAC) and Continued Stay Review (CSR) for out-of-network coverage. There is a fifty percent (50%) penalty if you fail to pre-certify prior to your scheduled admission date or, in the case of emergency, by the end of the first scheduled work day after the date of admission. To file a pre-service claim, you or your medical provider must call the MBM at the phone number provided on your ID card.

If you improperly file a pre-service claim, the MBM will notify you of the proper procedures to be followed in filing a claim as soon as possible but not later than five (5) days after receipt of the claim. This notification may be oral, unless you (or your representative) request written notification. You will only receive notification of a procedural failure if your claim is received by the MBM and it includes: (1) your name, (2) your specific medical condition or symptom, and (3) a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim under these procedures.

For properly filed pre-service claims, you and/or your provider will be notified of a decision within fifteen (15) days from receipt of the claim unless additional time is needed. The time for response may be extended for an additional fifteen (15) days if necessary due to matters beyond the control of the MBM, as long as you are notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is required because the MBM needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have forty-five (45) days from receipt of the notification to supply the additional information. The normal period for making a decision on the claim will be suspended until the date you respond to the request. The MBM then has fifteen (15) days from the date it receives your response to make a decision and notify you of its determination.

(b) Urgent Care Claims

An **urgent care claim** is any claim for medical, hospital, or prescription care or treatment which if subject to the time period for making a pre-service claim determination: (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether or not your claim is an urgent care claim is determined by the MBM, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an urgent care claim within the meaning described above, shall be treated as an urgent care claim. The Plan will defer to the attending provider with respect to whether a claim constitutes an urgent care claim.

If you improperly file an urgent care claim, the MBM will notify you and/or your service provider of the proper procedures to be followed in filing a claim as soon as possible but not later than twenty-four (24) hours after receipt of the claim. This notification may be oral, unless you (or your representative) request written notification. You will only receive notification of a procedural failure if your claim is received by the MBM and it includes: (1) your name, (2) your specific medical condition or symptom, and (3) a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim under these procedures.

If an urgent care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the MBM will notify you and/or your service provider as soon as possible, but not later than twenty-four (24) hours after receipt of the claim, of the specific information necessary to complete the claim. You will then have a period of no less than forty-eight (48) hours, taking into account the circumstances, to provide the specified information. The MBM will then notify you of the benefit determination no later than forty-eight (48) hours after the earlier of its receipt of the specified information or the end of the period afforded to you to provide the specified additional information.

For properly filed urgent care claims, the MBM will respond to you and/or your service provider with a determination by telephone as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim by the MBM. The determination will also be confirmed in writing.

(c) Concurrent Care Claims

A **concurrent care claim** is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. An example of this type of claim would be an inpatient hospital stay originally certified for five (5) days that is reviewed at three (3) days to determine if the full 5 days is appropriate. In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

If you are receiving concurrent care benefits and the MBM determines to reduce or terminate the course of treatment before the end of the previously approved treatment period (other than by Plan amendment or termination), you will be notified of the adverse benefit determination sufficiently in advance of the reduction or termination to allow you ample time to request a review of the decision and obtain a determination on appeal before the benefit is reduced or terminated.

If you make a claim to extend approved treatment involving urgent care, the MBM will make a determination on your claim as soon as possible, taking into account medical exigencies, and will notify you of the decision within twenty-four (24) hours of receipt of your claim, provided that your claim was filed at least 24 hours prior to expiration of the approved treatment.

(d) Post-Service Claims

A **post-service claim** is a claim submitted for payment after health services and treatment have been obtained. Generally, in-network providers of Tier I, II, and III benefits will submit claims directly to the MBM on your behalf. You must submit a post-service claim to obtain out-of-network benefits and Medicare-Eligible Retiree benefits. A claim regarding rescission of coverage will be treated as a post-service claim.

You will be notified of the decision on your post-service claim within thirty (30) days from receipt of the claim by the MBM. This period may be extended one time for up to an additional fifteen (15) days if the extension is necessary due to matters beyond the control of the MBM. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the MBM expects to render a decision.

If an extension is required because additional information is needed from you, the extension notice will specify the information needed. In that case you will have forty-five (45) days from receipt of the notification to supply the additional information. The normal period for making a decision on the claim will be suspended until the date you respond to the request. the MBM then has fifteen (15) days from the date it receives the requested information to make a decision on a post-service claim and notify you of the determination.

(e) Eligibility Claims

The Fund Office will make a decision on your eligibility claim and notify you within ninety (90) days of receipt. If the Fund Office requires an extension of time due to matters beyond its control, it will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 90-day period. A decision will be made within 90 days of the time the Fund Office notifies you of the delay. If an extension is required because additional information is needed from you, the extension notice will specify the information needed. Until you supply this additional information, the normal period for making a decision on the claim will be suspended.

5. NOTICE OF DENIED CLAIM

In the event your claim is denied, you will be provided with written notice of the denial (whether denied in whole or in part) or any other adverse benefit determination. This notice will include:

- Information sufficient to identify the claim involved (including, if applicable, the date of service, the health care provider, and the claim amount)
- The specific reason(s) for the determination, and upon request and free of charge, the denial code, if applicable (however, a request for the denial code will not be treated as a request for an internal appeal or an external review)
- A description of the Plan's standard, if any, that was used in denying the claim
- Reference(s) to the specific Plan provision(s) on which the determination is based
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary
- A description of the appeal procedures and applicable time limits
- The availability of, and contact information for, any office of health insurance consumer assistance or ombudsman established per PHS Section 2793 to assist you with claims and appeals
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review

If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

For urgent care claims, the notice will describe the expedited review process applicable to urgent care claims. For urgent care claims, the required determination may be provided orally and followed with written notification.

For all pre-service claims (including urgent care claims), you will receive notice of the determination even when the claim is approved.

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse

benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

If you do not understand English and have questions about a claim denial, contact the MBM or PBM to find out if assistance is available.

- SPANISH (Español): Para asistencia en español, por favor llame el número en la parte posterior de su tarjeta de identificación.
- CHINESE (中文): 如需要中文服务, 请致电会员卡背面号码

B. Appeal Procedures

If your claim is denied in whole or in part, or any adverse benefit determination is made with respect to your claim, you may file an appeal.

All appeals are made to the MBM or PBM, except for appeals of eligibility claims, which are made to the Fund Office for review by the Fund's Board of Trustees.

1. Medical Insurance Provider (MBM) and Pharmacy Benefit Manager (PBM) Appeals

The MBM handle all appeals for medical and hospital claims, and the PBM handles all appeals for prescription drug claims. The appeal procedures for medical claims are described in detail in the Medical Benefits Booklet included with this SPD.

You may also be eligible for an independent External Review pursuant to federal law if you meet certain requirements. The details of the External Review process and who is eligible to participate in that process are described in the Medical Benefits Booklet included with this SPD.

You may also choose a voluntary appeal to the Fund's Board of Trustees after you have exhausted the appeal process required by the MBM or the PBM. The Board of Trustee appeal is completely voluntary; it is not required by the Plan and is only available if you (or your representative) request it.

2. Board of Trustee Appeals

The Fund's Board of Trustees hears appeals of eligibility claim denials and appeals of medical and pharmacy claim denials where the MBM or PBM appeals processes have been exhausted.

(a) Appeal of Eligibility Determinations

Appeals of eligibility determinations are handled by the Board of Trustees. Your appeal must be submitted in writing to:

Board of Trustees
Welfare Fund of Local No. One, IATSE
320 West 46th Street, 6th Floor
New York, NY 10036

within **one hundred eighty (180) days** of the date you are notified of the determination in order to be timely and considered. Ordinarily, a decision regarding an eligibility claim will be made at

the next regularly scheduled meeting of the Board of Trustees following receipt of your appeal. However, if your appeal is received by the Fund within thirty (30) days of the next regularly scheduled meeting, your appeal may be considered at the second regularly scheduled meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. You will receive a notice of decision on the appeal within five (5) days after the decision has been reached.

(b) Appeal of MBM and PBM Benefit Determinations

If you have exhausted the MBM or PBM mandatory appeals processes and you have not obtained the relief you sought, you may file an appeal to be decided by the Board of Trustees.

Should you choose to file a Board of Trustee appeal, it must be filed within **one hundred eighty (180) days** of notification of denial of the last mandatory appeal, in writing to:

Board of Trustees
Welfare Fund of Local No. One, IATSE
320 West 46th Street, 6th Floor
New York, NY 10036

With regard to claim procedures pertaining to this voluntary Board of Trustee appeal:

- The Plan will not assert a failure to exhaust administrative remedies where you or your authorized representative elect to pursue a claim in court rather than through the Board of Trustee appeal
- Where you or your authorized representative choose to pursue a claim in court after completing the Board of Trustee appeal, the Plan agrees that any statute of limitations applicable to your claim in court will be tolled (suspended) during the Board of Trustee appeal process
- The Board of Trustee appeal is available only after you (or your representative) have pursued the appropriate mandatory appeals process required by the Plan, as indicated previously in this Section. Please note that the statute of limitations starts to run when the decision on the last mandatory appeal is issued and is only suspended from the date the Fund Office receives your written request for a Board of Trustee Appeal until the decision on the Board of Trustee Appeal is issued
- Upon your request, the Plan will provide you (or your representative) with sufficient information to make an informed judgment about whether to submit a claim through the Board of Trustee appeal process, including your right to representation, specific information regarding the process for selecting a decision-maker and any circumstances that may affect the impartiality of the decision-maker

The Plan will not impose fees or costs on you (or your representative), should you or your authorized representative choose to invoke the Board of Trustee appeal process.

Your decision as to whether or not to submit a benefit dispute to the Board of Trustee appeal will have no effect on your rights to any other benefits under the Plan.

If you have any questions regarding the Board of Trustee appeal, please contact the Fund Office.

For urgent care and applicable concurrent care voluntary appeals, the Board of Trustees, or its designee, will review your appeal and notify you of a decision within seventy-two (72) hours after receipt of your appeal.

For required pre-service and applicable concurrent care coverage determinations, the Board of Trustees, or its designee, will review your appeal and notify you of a decision within fifteen (15) days after receipt of your appeal.

For post-service and applicable concurrent care appeals, the Board of Trustees, or its designee, will review your appeal at the next regularly scheduled meeting following receipt of your appeal. However, if your appeal is filed within thirty (30) days before such meeting, a determination will be made no later than the date of the second regularly scheduled meeting following the Plan's receipt of your appeal. If special circumstances require a further extension of time, you will be notified of the extension and the date as of which the determination will be made. You will receive a notice of decision on review within five (5) days of the Board of Trustees making the determination.

(c) Notice of Board of Trustee Decision on Appeal

Notice of the decision on your Board of Trustee appeal will be given to you in writing. Should your appeal be denied, in whole or in part, the notice will include:

- Information sufficient to identify the claim involved (including, if applicable, the date of service, the health care provider, and the claim amount)
- The specific reason(s) for the determination, and upon request, the denial code, if applicable
- A description of the Plan's standard, if any, that was used in denying the claim (in the case of notice of final internal adverse benefit determination, this description will include a discussion of the decision)
- Reference(s) to the specific plan provision(s) on which the determination is based
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- A statement describing available voluntary appeal procedures and your right to obtain information about such procedures
- The availability of, and contact information for, any office of health insurance consumer assistance or ombudsman established per PHS Section 2793 to assist you with claims and appeals

- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review

If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Please note that Board of Trustee determinations are not subject to external review.

C. Limitation on When a Lawsuit May be Started

You may not start a lawsuit to obtain benefits until after you have requested all *mandatory* levels of appeal/review, and a final decision has been reached on your appeals/reviews, or until the appropriate timeframe described above or in the Medical Benefits Booklet has elapsed since you filed a request for review/appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act without exhausting these appeals procedures if the Plan has failed to follow them. No lawsuit may be started more than one year after the earlier of the year in which medical services were provided or the Fund rendered its final decision on eligibility. Any legal or equitable action for benefits under the Plan must be brought in the United States District Court for the Southern District of New York.

SECTION X

COORDINATION OF BENEFITS, EXCLUSIONS AND GENERAL LIMITATIONS

Please refer to your Medical Benefits Booklet for information regarding coordination of benefits, exclusions, and expenses not covered by the Fund and general limitations.

SECTION XI

YOUR RIGHTS UNDER HIPAA AND ERISA

A. Health Insurance Portability and Accountability Act

1. PRIVACY

A complete description of your privacy rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is found in the Fund's Notice of Privacy Practices, which was separately distributed to you. Another copy is available upon request from the Fund Office. The statement that follows is not intended to be the Fund's Notice of Privacy Practices. The following statement was adopted by the Board of Trustees in accordance with the requirements of HIPAA.

Since the Fund is required to keep your health information confidential, before the Fund can disclose any of your health information to the Trustees, which act as the sponsor of the Plan, the Trustees must also agree to keep your health information confidential. In addition, the Trustees must agree to handle your health information in a way that enables the Fund to follow the rules in HIPAA. The health information that the Trustees receive about you from the Fund (except for any information that is received in connection with death benefits) is referred to below as protected health information (PHI). The Trustees agree to the following rules in connection with your PHI:

- The Trustees understand that the Fund will only disclose health information to the Trustees for the Trustees' use in plan administration functions.
- Unless it has your written permission, the Trustees will only use or disclose that PHI for that plan administration, or as otherwise permitted by this Summary Plan Description, or as required by law.
- The Trustees will not disclose your PHI to any of its agents or subcontractors unless the agents and subcontractors agree to handle your PHI and keep it confidential to the same extent as is required of the Trustees in this Summary Plan Description.
- The Trustees will not use or disclose your PHI for any employment-related actions or decisions, or with respect to any other pension or other benefit plan sponsored by the Trustees without your specific written permission.
- The Trustees will notify the Fund's Privacy Officer if the Trustees become aware of any use or disclosure of PHI that is inconsistent with the provisions set forth in this Summary Plan Description.
- The Trustees will allow you, through the Fund, to inspect and photocopy your PHI, to the extent, and in the manner, required by HIPAA.
- The Trustees will make available PHI for amendment and incorporation of any such amendments to the extent, and in the manner required by HIPAA.

- The Trustees will keep a written record of certain types of disclosures it may make of PHI, so that it may make available the information required for the Fund to provide an accounting of certain types of disclosures of PHI.
- The following categories of employees under the control of the Trustees are the only employees who may obtain PHI in the course of performing the duties of their job with or for the Trustees who obtained such health information: Fund Management, the Health and Welfare Fund staff, Operations Manager and Accounting staff. These employees will be permitted to have access to and use the PHI only to perform the plan administration functions that the Board of Trustees provides for the Fund.
- The employees listed above will be subject to disciplinary action and sanctions for any use or disclosure of PHI that violates the rules set forth in this Summary Plan Description. If the Trustees becomes aware of any such violations, the Board of Trustees will promptly report the violation to the Fund and will cooperate with the Fund to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the participants whose privacy has been violated.
- The Trustees will make available, upon request, to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of PHI received from the Fund in order to allow the Secretary to determine the Fund's compliance with HIPAA.
- The Trustees will return to the Fund or destroy all of your PHI received from the Fund when there is no longer a need for the information. If it is not feasible for the Trustees to return or destroy the PHI, then the Trustees will limit their further use or disclosures of any of your PHI that they cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

2. SECURITY

The Trustees shall take additional action with respect to the implementation of security measures pertaining to the standards for the security of electronic PHI as required by HIPAA (as set forth in 45 C.F.R. Parts 160 and 164) (Security Rule). Accordingly, the Trustees shall:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Fund;
- Ensure that the adequate separation required to exist between the Fund and the Trustees is supported by reasonable and appropriate administrative, physical and technical safeguards in its information systems;

- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect that information;
- Report to the Fund if they become aware of any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in its information system; and
- Comply with any other requirements that the Secretary may require from time to time with respect to electronic PHI by the issuance of additional regulations or other guidance pursuant to HIPAA.

3. BREACH OF UNSECURED PHI NOTIFICATIONS

If the Fund learns of an actual or suspected acquisition, use or disclosure of PHI that is not encrypted or otherwise rendered unusable or unreadable in a manner not permitted by the regulations promulgated by the Department and Health and Human Services (HHS) at 45 CFR Parts 160 and 164, an investigation will immediately be undertaken by the Director of Fund Administration. If it is determined that an actual breach of unsecured PHI has taken place and the nature of the breach requires notification of affected Participants, the Fund Office or the appropriate third party will send the notifications by 1st Class mail, and/or by telephone in cases where the notification is considered to be urgent.

B. Employee Retirement Income Security Act

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

1. RECEIVE INFORMATION ABOUT THE FUND AND FUND BENEFITS

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Director of Fund Administration, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Director of Fund Administration may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Trustees are required by law to furnish each participant with a copy of this summary annual report.

2. CONTINUE GROUP HEALTH PLAN COVERAGE (COBRA)

Continue health coverage for yourself and your eligible family members if there is a loss of coverage under the Plan as a result of a qualifying event. You and your eligible family members may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

3. PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

4. ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the Plan's latest annual report 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 Director of Fund Administration 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 Director of Fund Administration.

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

5. ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Director of Fund Administration. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Director of Fund

Administration, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION XII

ADMINISTRATIVE INFORMATION

A. Board of Trustees

The Fund is administered by a joint Board of Trustees consisting of Union representatives and representatives of Contributing Employers. The names, titles, and business addresses of the Trustees are:

UNION TRUSTEES

JAMES J. CLAFFEY, Jr.
President
Theatrical Protective Union,
Local No. One, IATSE
320 West 46th Street
New York, NY 10036
(212) 333-2500

ROBERT (TOBY) MCDONOUGH
Treasurer
Theatrical Protective Union,
Local No. One, IATSE
320 West 46th Street
New York, NY 10036
(212) 333-2500

ROBERT SCORE
Secretary
Theatrical Protective Union,
Local No. One, IATSE
320 West 46th Street
New York, NY 10036
(212) 333-2500

EMPLOYER TRUSTEES

CHRISTOPHER J.G. BROCKMEYER
Director of Employee Benefit Funds
The Broadway League
729 Seventh Avenue, 5th floor
New York, NY 10019
(212) 703-0201

ANN MARIE HACKETT
Director of Human Resources/
Labor Relations
The Metropolitan Opera
Lincoln Center
New York, NY 10023
(212) 799-3100

SEAN QUINN
Vice President for Labor Relations
ABC, Inc.
77 West 66th Street, 15th Floor
New York, NY 10023
(212) 456-6657

B. Type of Administration

Although the Board of Trustees is legally designated as the Plan Administrator of the Fund, the Trustees have delegated many of the day-to-day administrative functions to the Director of Fund Administration and the Fund Office staff. The Fund Office is located at:

Welfare Fund of Local No. One, IATSE
320 West 46th Street, 6th Floor
New York, NY 10036

Tel: (212) 247-5225
Fax: (212) 977-9319
Toll Free (outside NYC): (800) 974-2873
www.FundOneIATSE.com

The MBM and the PBM provide administrative services to the Fund by handling certain claims and claims review. You can find the contact information for the MBM and the PBM on a separate directory provided with this SPD and updated as necessary, or using the information provided on your medical and pharmacy ID cards.

C. Source of Contributions

The financing for Plan benefits and Fund operations and expenses is provided by both employer contributions and participant self-pay and buy-up premiums. The required participant premiums are set forth in this document. The Trustees reserve the right, in their sole and absolute discretion, to increase or decrease participant premiums at any time. The rate of each employer's contribution to the Fund is indicated in the applicable collective bargaining agreement negotiated between the Union and each employer. A portion of the Fund's assets are invested producing additional income for the Fund.

D. Plan and Employer Identification Numbers

The Employer Identification Number assigned by the Internal Revenue Service to the Trustees is EIN 13-6174166. The Plan number assigned by the Trustees is 501.

E. Plan Year

For purposes of maintaining the Fund's fiscal records, the Plan Year end date is June 30.

F. Service of Process

The Board of Trustees has been designated as the agent for the service of legal process and may be served at the Fund Office address set forth on the preceding page. Each of the Trustees may also be served individually at the Fund Office.

G. Collective Bargaining Agreements

The Fund is established and maintained and contributions to the Fund are made by employers pursuant to the terms of collective bargaining agreements between the Theatrical Protective Union Local No. One, IATSE and employers in the industry. These agreements set forth the conditions under which employers are required to contribute to the Fund and the rate(s) of contribution. In general, the collective bargaining agreements require contributions to the Fund based on fixed percentage of earnings. Upon written request, you may examine the collective bargaining agreements at the Fund Office or at other specified locations. Copies of the collective bargaining agreements may be obtained by participants and beneficiaries upon written request to the Director of Fund Administration. There will be a reasonable charge made for the copies, as permitted by law.

H. Contributing Employers

The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to the Fund on behalf of participants working under a collective bargaining agreement and the employer's address. The Union and the Fund Office are also contributing employers, making fund contributions on the basis of written participation agreements.

I. Funding Medium for the Accumulation of Plan Assets

Benefits are provided from Fund assets which are accumulated under the provisions of a Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and their beneficiaries and defraying reasonable administrative expenses.

The Fund's reserves are invested in various securities and are deposited or invested with banks, according to guidelines and objectives adopted by the Board of Trustees.

J. Circumstances that May Result in Loss of Eligibility or Benefits

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are fully described throughout this document and the Medical Benefits Booklet. If you are ever uncertain as to how a particular circumstance may affect your benefits, please contact the Fund Office at (212)247-5225.

All of the types of benefits provided by the Fund are set forth in this document. The complete terms of the benefits are set forth in the group insurance policies or contracts between the Fund and the Fund's MBM and PBM.