I.A.T.S.E LOCAL 504 HEALTH AND WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION

PLAN DOCUMENT

EFFECTIVE FEBRUARY 1, 2014

INTRODUCTION

This Fund was established in 1958, as a result of collective bargaining between representatives of your Employer and your Union. Contributions are made by your Employer into a Trust Fund to provide Medical, Dental, Vision, and Life and Accidental Death and Dismemberment Benefits for Employees and their Dependents.

The benefits described herein are not guaranteed and will be provided only to the extent of the funds available. The benefits can be modified or terminated at any time by a revision of the applicable Collective Bargaining Agreements or by action of the Board of Trustees.

The Board of Trustees determines policies and benefits in keeping with the assets and income of the Benefit Fund. Benefits are subject to all of the terms and conditions of the Trust Agreement as well as to any rules and regulations the Trustees may adopt from time to time.

This Summary Plan Description (SPD) describes how you and your Dependents may use this Plan to the best advantage, when you are eligible. It is intended as a non-technical summary of the benefits, and does not contain a complete description of all Plan provisions. ***The SPD contains all Plan changes as of February 1, 2014***

PLEASE TAKE THE TIME TO READ THIS SPD FROM COVER TO COVER FOR A COMPLETE UNDERSTANDING OF THE HEALTH AND WELFARE PLAN. IF THERE ARE ANY QUESTIONS, PLEASE DO NOT HESITATE TO CONTACT THE ADMINISTRATIVE OFFICE.

Sincerely,

BOARD OF TRUSTEES

Administrative Office:

Benefit Programs Administration
13191 Crossroads Pkwy N, Suite 205
City of Industry, CA 91746-3434
(562) 595-6463 or (888) 806-8942

Fund Website: www.iatse504welfare.org

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IMPORTANT NOTICE TO
EMPLOYEES, SPOUSES AND DEPENDENTS

From time to time the Administrative Office may mail you updated material in order to inform you and your Dependents of any changes in benefits. It is important that you file all literature received with this SPD and note the affected sections.

The Trustees shall have the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply, interpret and/or terminate any provisions of the Plan, this Summary Plan Description, and any other Plan documents and to decide all matters arising in connection with the operation or administration of the Plan. Without limiting the foregoing, the Trustees shall have sole and absolute discretionary authority:

1. To take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;

2. To formulate, interpret and apply rules, and policies necessary to administer the Plan in accordance with its terms;

3. To decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;

4. To resolve and/or clarify any ambiguities, inconsistencies and/or omissions arising under the Plan or other Plan documents; and

5. To process, and approve or deny, benefit claims and rule on any benefit exclusions.

All determinations made by the Trustees with respect to any matter arising under the Plan, this Summary Plan Description, and any other Plan documents shall be final and binding on all parties.

DEFINITIONS

Wherever used in this Summary Plan Description, the following terms will be deemed to have the meaning described below:

The term "**Administrative Office**" or "**Fund Administrator**" means the third party administrator that the Board of Trustees has contracted with to handle the day-to-day administration of the Fund.

The terms "**Board of Trustees"** and "**Board"** mean the Board of Trustees established by the Trust Agreement.

"Dependent." The term Dependent means an Employee's lawful spouse (same or opposite sex) or Domestic Partner and (a) natural children under 26 years of age; and, (b) stepchild or legally adopted child, child of a covered Domestic Partner, or foster child under 26 years of age provided:

- Dependent shall include a child of the Employee who, upon attainment of the age limit specified above, is incapable of self-sustaining employment by reason of mental retardation or physical handicap (provided the condition of the child existed before attainment of the age limit and while eligible hereunder) and who is solely dependent upon the Employee for support.

- In no event shall a lawful spouse or child be eligible under the Plan both as an eligible Dependent and an Employee, nor shall a child be considered an eligible Dependent of more than one Employee.

"Domestic Partner." A Domestic Partner is a person who is has entered into a committed same-sex or opposite sex relationship similar to marriage that has been in existence for at least six months in which there is financial interdependence. The intent of both partners is that the relationship be permanent and that neither partner has a spouse or another Domestic Partner. The Domestic Partners must not be related by blood closer than the laws of the state would permit for a legal marriage. Each Domestic Partner must be at least eighteen years or older. Each Domestic Partner must be mentally competent to consent to a legal contract at the time the Domestic Partnership began and if the Domestic Partner resides in a jurisdiction which permits registration as Domestic Partners**,** the Domestic Partnership must be registered.

"Employee." The term Employee means any person employed by any Individual Employer who performs one or more hours of work covered by any of the Collective Bargaining Agreements or any person employed by an Individual Employer who performs one or more hours of work, pursuant to a written acceptance of the Trust Agreement or any Individual Beneficiary who has made contributions under the "Self Payment Rule" adopted by the Board of Trustees.

"Eligible Individual." The term Eligible Employee means each Employee and each of his Dependents, if any.

"Individual Employer." The term Individual Employer means any Individual Employer who is required by any of the Collective Bargaining Agreements to make contributions to the Health and Welfare Trust Fund on behalf of its Employees

"He", "His" and **Himself"** shall apply to both genders whenever used.

"Medicare." The program established under Title XVII of the Social Security Amendments Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended.

"Plan" or "Fund." The terms Plan and Fund mean the I.A.T.S.E Local 504 Health and Welfare Trust Fund established by the Trust Agreement.

"Trust Agreement." The term Trust Agreement means the I.A.T.S.E Local 504 Health and Welfare Trust Agreement and any modification, amendment, extension or renewal thereof.

"Trustee." The term Trustee means any person designated as a Trustee pursuant to the terms of the Trust Agreement, and the successor of such person from time to time in office.

"Union." The term Union means the International Alliance of Theatrical Stage Employees and Moving Picture Machine Operators of the United States and Canada, Local Union 504.

ELIGIBILITY RULES

INITIAL ELIGIBILITY FOR NEW EMPLOYEES

If you are a new Employee, you will become eligible for benefits after you have worked for an Employer under contract with the Union a total of 450 work hours in a twelve-month period for which Health and Welfare contributions were paid to the Fund. Your eligibility becomes effective on the first day of the month following the month the employer reports and pays for the 450 hours or more worked (generally hours are reported and paid for the month following the month in which the hours are worked) . These hours shall become the Employee's bank out of which the first hours for eligibility will be deducted.

CONTINUING ELIGIBILITY

If an Employee becomes eligible for benefits in the second or third month of a Benefit Quarter and does not have the required 350 hours in his hours bank to provide eligibility for the following full benefit quarter, he may pay the Fund the hourly contribution rate set by the Trustees for the number of hours necessary to bring his account balance up to 350 hours for that Benefit quarter. However, eligibity for subsequent Benefit Quarters will be contingent on the Employee's employer submitting a minimum of 350 hours or the Employee's payment of the full cost of benefits (COBRA).

You will maintain eligibility if Health and Welfare contributions are received for 350 hours worked per quarter. If you work less than 350 hours (effective with hours worked on or after January 1, 2012) but greater than 200 hours in a calendar quarter and contributions do not cover the premium cost, you may continue to maintain your eligibility during the subsequent quarter provided you pay the Fund the rate for the number of hours necessary to bring your hours bank up to 350 hours for the quarter. The rate will be determined by the Board of Trustees.

If you work less than 200 hours during a calendar quarter or less than 350 hours during two consecutive quarters, in order to continue your eligibility, you must pay the full cost of your benefits.

Eligibility Table for Continuing Eligibility:

After Initial Eligibility If You Work 350 or More Hours During This Eligibility Quarter	**You Will Be Eligible During This Benefit Quarter**
January – February – March	May – June – July
April – May – June	August – September – October
July – August – September	November – December – January
October – November – December	February – March – April

BANK RESERVE HOURS

You may bank hours in excess of 350 hours per quarter up to a maximum of 400 hours. Bank reserves in excess of those allowed will automatically revert to the Fund's general reserves.

Bank reserves will revert to the general fund one year after you discontinue coverage for any reason, and do not reinstate coverage within said year.

Your bank reserve will apply only to Fund eligibility and cannot be converted to cash or otherwise encumbered.

SELF-PAYMENTS

Self-payments for all coverage can be made for a maximum of six months as long as a minimum of 200 hours per quarter are reported and paid for on your behalf and you remain active in the industry. Your self-payment includes all benefits. Any Employee who chooses to self-pay to continue coverage must make payments in a timely manner.

All self-payments are due and payable upon receipt of a the billing notice and are delinquent after ten days. The right to self-pay ceases when there have been no Employer contributions in the preceding 12-month period and the Employee's Hour Bank has been exhausted. You may be able to continue your coverage if you are disabled or under COBRA continuation, FMLA or USERRA. See pages 8 through 18 for additional information.

BENEFITS FOR ACTIVE EMPLOYEES

Employees are eligible for hospital, medical, prescription drugs, dental benefits, vision benefits, life and accidental death and dismemberment benefits. The medical plan selected by the employee will apply to covered Dependents.

ELIGIBILITY FOR DEPENDENTS

Your Dependents (as defined in the section of this SPD entitled Definitions) will become eligible for benefits the same date you first become eligible. If you are eligible as both an Employee and a Dependent, you will be covered as an Employee and not both. When both husband and wife are covered as Employees, their children are eligible as a Dependent of only one Employee.

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

Domestic Partner Coverage

If you wish to add coverage for your Domestic Partner and the children of your Domestic Partner, you must complete an application for coverage that is available from the Trust Fund Administrative office. To qualify for such coverage, the two adults must have chosen to share one another's lives in an intimate and committed relationship of mutual caring, and:

a. Both persons must have a common residence;
b. Both persons must agree to be jointly responsible for each other's basic living expenses incurred during the Domestic Partnership;
c. Neither person can be married or a member of another Domestic Partnership;
d. The two persons cannot be related by blood in a way that would prevent them from being married to each other in the state of California;
e. Both persons must be at least 18 years of age;
f. Both person must be capable of consenting to the Domestic Partnership;
g. Neither person has previously filed a Declaration of Domestic Partnership that has not been terminated; and
h. Both must have filed a Declaration of Domestic Partnership with the Secretary of State (see www.ss.ca.gov/dpregistry/index.htm).

QUALIFIED MEDICAL CHILD SUPPORT ORDER

Under the Omnibus Budget Reconciliation Act of 1993, the Trust must recognize any Qualified Medical Child Support Order (**"**QMCSO**"**), and enroll any child of a Trust Eligible Individual specified by the QMCSO**.** A QMCSO is any judgment, decree, or order (including approval of a settlement agreement) issued by a court which:

- provides the child of a Trust Eligible Individual with child support or health benefits under the Trust; or

- enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the employee parent does not enroll the child, the non-employee parent or State agency may enroll the child.

To be qualified, a Medical Child Support Order must clearly specify:

- the name and last known mailing address of the Eligible Individual and the name and mailing address of each child covered by the order;

- a reasonable description of the type of coverage to be provided by the Plan to each such child, or the manner in which such type of coverage is to be determined; and

- the period to which such Order applies.

In addition, a properly completed National Medical Support Notice will be deemed to be a QMCSO.

Further, a Medical Child Support Order will not qualify if it would require the Trust to provide any type or form of benefit or any option not otherwise provided under the Trust, except to the extent necessary to comply with Section 1908 of the Social Security Act.

Upon receipt of a Medical Child Support Order, the Fund Administrator will notify the Eligible Individual and each child of the receipt of the Order and the Trust's procedures for determining whether the Medical Child Support Order is qualified. Each child will also be notified of his or her right to designate a representative to receive copies of all notices sent to the child with respect to a Medical Child Support Order.

Upon receipt of a Medical Child Support Order, the Fund Administrator will review the Order to verify that it meets the standards set forth above. The Fund Administrator will make such a determination within a reasonable period, and notify the Eligible Individual and each child of the determination. If the Order is a qualified Order, the child will be enrolled in the Plan.

Any payment for benefits by the Trust under the Medical Child Support Order to reimburse expenses advanced by an alternate recipient, or his/her custodial parent or legal guardian shall be made to the alternative recipient or his/her custodial parent or legal guardian.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your Dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan,

you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

NEW DEPENDENTS

If you acquire a new Dependent (for example you get married, have a baby, or adopt a child), you must notify the Administrative Office within 30 days. You must supply the Fund with evidence that the Dependent qualifies for coverage under the terms of the Plan. Failure to do so will delay the Dependent's coverage. The effective date of coverage for a new spouse will be the first of the month following receipt of the enrollment form. The effective date of a newborn or adopted child will be the date of birth or placement date for adoption.

If your Dependent becomes eligible for Medicare and you remain actively at work for an Employer with 20 or more full-time or part-time Employees, he or she must elect one of the following to be his or her primary health plan:

1. This Plan, in which case Medicare will be his or her secondary plan; or

2. Medicare, in which case his or her coverage under this Plan must, by law, is terminated.

TERMINATION OF COVERAGE

Employee coverage under the Plan will terminate upon the earliest of:

1. The date the Plan terminates; or

2. The date of expiration of the period for which the last contribution was made on your behalf; or

3. The date your Employer ceases to be a Contributing Employer to the Trust Fund; or

4. The date you enter full-time military service unless you elect to continue coverage; or

5. The end of the month in which you retire or are pensioned; or

6. The date a self-payment, if required, is not made in a timely manner.

Dependent coverage will cease upon the earliest of:

1. The date on which your (the 'Employee's') coverage ceases; or

2. The end of the month in which your dependent ceases to qualify as a Dependent (for example, the month a Dependent child turns age 26); or

3. The date your Dependent enters full-time military service; or

4. The date the Plan terminates.

When coverage ends, you may qualify for continued coverage under COBRA (refer to page 13). However, you or any family member who is not eligible for Medicare may find comparable medical benefits are available through the Exchange (Covered California). Before making a decision to enroll in COBRA check out Covered California options, the cost and see if you qualify for a federal subsidy that will lower your premiums. The website is: (***www.coveredca.com***)

CERTIFICATE OF CREDITABLE COVERAGE UNDER HIPAA

Changes in Federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for pre-existing medical conditions. Coverage under the medical plans is not subject to any pre-existing condition limitations. However, if your coverage terminates under one of these plans, you will receive a Certificate of Creditable Coverage for the period of time you were covered under the Plan, including any period of coverage under COBRA. If all of your Dependents were covered for the same period of time, one certificate will be issued; otherwise, separate certificates will be issued for each Eligible Individual.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, pre-existing condition exclusions generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through an Employer group health Plan, a certificate of prior coverage may help you obtain coverage without pre-existing condition exclusions. The law stipulates that coverage is deemed to be creditable continuous coverage only if there has been no lapse in coverage of more than 63 days. You may request a copy of your Certificate of Creditable Coverage at any time within 24 months of the date of your loss of coverage. Contact the State of California Department of Insurance for further information.

Check with the administrator of your new plan to see if your new plan excludes coverage for pre-existing conditions and if you need to provide a certificate of other documentation of your previous coverage.

SPECIAL ENROLLMENT RIGHTS UNDER HIPAA

If you did not enroll yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

EXCEPTIONS TO TERMINATION OF COVERAGE

EXTENSION OF BENEFITS FOR TOTAL DISABILITY

Employees who are unable to work because of a doctor's certification and state certified disability shall, upon written proof thereof, have their premiums paid from the Fund for a period of one year. Dependents will be covered for a six month period only and will be offered an extension of coverage under COBRA, see page 13. Eligible Individuals on social security disability Medicare will be eligible for supplemental insurance provided they have participated in this plan for a minimum of 20 years prior to their injury or illness.

Coverage will be extended until the earliest of the following:

1. The date you cease to be totally disabled;

2. The date the maximum benefit under this Plan has been paid; or

3. The end of a 12 month period from the date your coverage terminated under this Plan.

As used here, "Totally Disabled" means a state of incapacity due to an injury or illness, and the Employee's inability to work at his or her normal job.

NOTE: This extension of benefits for total disability provision does not extend the period of time during which an individual is covered under this Plan. The 12 months disability coverage will be deducted from the number of months you are eligible for under COBRA continuation coverage.

LEAVE FOR MILITARY SERVICE (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USSERA) was enacted by Congress to provide protections to individuals who are Eligible Individuals of the

"Uniformed Services." "Uniformed Services" is defined as the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Services, and any other category of persons designated by the President in time of war or national emergency**.**

1. Military Leaves of Absence for a Period Less Than 31 Days

   USERRA provides that if an Employee is on a military leave of absence from his employment, and the period of military leave is less than thirty-one (31) Days, he will continue to be eligible for health care coverage under this Plan during the leave with no self-payment required, provided he is eligible for benefits under this Plan at the time his military leave begins.

2. Military Leaves of Absence for Periods More Than 30 Days

   a. If an Employee is on a military leave of absence from his employment, and the period of military leave is for more than thirty (30) Days, USERRA permits the Employee to continue coverage for himself and his Dependents at his own expense at a cost of 102% of the cost of coverage for up to 24 months so long as he gives his Employer advance notice (with certain exceptions) of the leave, and so long as his total leave when added to any prior periods of leave does not exceed 5 years. In addition Dependents may be eligible for coverage under TRICARE formerly CHAMPUS (Civilian health and Medical Program of the Uniformed Services).

   b. The maximum period of continuation coverage for health care under USERRA is 24 months.

3. Upon release from active service, the Employee's coverage will be reinstated on the Day he returns to work as if he had not taken leave, provided he is eligible for re-employment under the terms of USERRA and provided he returns to work within:

   a. Ninety (90) Days from the date of discharge if the period of service was thirty-one (31) Days or more;

   b. At the beginning of the first full regularly scheduled working period on the first calendar Day following discharge (plus travel time and an additional eight hours) if the period of service was less than thirty-one (31) Days;

   c. If the Employee is Hospitalized or convalescing from an Injury caused by active duty, these time limits are extended for up to two (2) years.

   A copy of the Employee's separation papers must be submitted to the Fund Administrative Office to establish his period of service.

4. If the Employee continues coverage under USERRA, he will be required to submit any required self-payment necessary, which may include Fund Administrative costs, to his Employer. If the Employee does not elect to continue coverage during his military leave, upon his return to work his coverage will be reinstated at the same benefit level immediately preceding his service before his leave if he is eligible for re-employment under the criteria established under USERRA.

5. If the Employee does not return to work at the end of his military leave, he may be entitled to purchase COBRA continuation coverage as provided in the section above. Coverage will not be offered for any illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service connected injuries or illness.

The rights to self pay are governed by the same conditions described in the COBRA section. If election is made for continuation coverage under USERRA, the COBRA and USERRA coverage periods will run concurrently.

FAMILY MEDICAL LEAVE ACT (FMLA)

Under the federal Family and Medical Leave Act (FMLA), your employer must continue to pay for your health coverage during any approved leave. In general, you may qualify for up to 12 weeks of unpaid FMLA leave each year. Effective January 16, 2009 the Act is amended to permit a spouse, son, daughter, parent, or next of kin to take up to 26 weeks of leave to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on a temporary disability retired list, for a serious injury or illness. An Employee is permitted to take FMLA leave for "any qualifying exigency" (as defined by the Secretary of Labor) arising out of the fact that the spouse, son, daughter, or parent of the Employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. You may qualify for this leave if:

1. Your employer has at least 50 employees;

2. You worked for the employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and

3. You require leave for one of the following reasons:

    a. birth or placement of a child for adoption or foster care,
    b. to care for your child, spouse or parent with a serious medical condition, or
    c. your own serious health condition.

Details concerning FMLA leave are available from your employer.

Requests for FMLA leave must be directed to your employer; the Administrative Office cannot determine whether or not you qualify. If a dispute arises between you and your employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments. If the dispute is resolved in your favor, the Administrative Office will obtain the FMLA-required contributions from your employer and will refund the corresponding COBRA payments to you.

If your employer continues your coverage during FMLA leave and you fail to return to work, you may be required to repay the employer for all contributions paid to the health plan for your coverage during the leave.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

COBRA continuation coverage is a temporary extension of coverage under the Plan. The right to COBRA continuation was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other Eligible Individuals of your family who are covered under the Plan when you would otherwise lose your group health coverage.

The Plan Administrator is the Board of Trustees of I.A.T.S.E Local 504 Health and Welfare Trust Fund. The Board has contracted with a third party, Benefit Programs Administration, to administer the day-to-day matters of the Fund, including COBRA. If you have questions about this program, you should contact the Fund Administrative Office at:

I.A.T.S.E Local 504 Health and Welfare Trust Fund
c/o Benefit Programs Administration – COBRA
13191 Crossroads Pkwy N, Suite 205
City of Industry, CA 91746-3434
(562)595-6463 or (888)806-8942

COBRA Continuation Coverage and Qualifying Events

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, Active Employees, their spouses and the dependent children of Active Employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Active Employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Active Employee, you will become a qualified beneficiary and you will lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for reason other than his or her gross misconduct;

(4) Your spouse becomes enrolled in Medicare (Part A, Part B or both); or

(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries and they will lose coverage under the Plan if any of the following qualifying events happens:

(1) The parent-Active Employee dies;

(2) The parent-Active Employee's hours of employment are reduced;

(3) The parent-Active Employee's employment ends for any reason other than his or her gross misconduct;

(4) The parent-Active Employee becomes enrolled Medicare (Part A, Part B, or both);

(5) The parents become divorced or legally separated; or

(6) The child stops being eligible for coverage under the plan as a "Dependent child."

Notification Requirements – Employee's, Your Employer's and the Fund Administrator's

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred.

Employer's Notification Requirements

When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the Employee in Medicare (Part A, Part B, or both), the employer must notify the Fund Administrator of the qualifying event within 30 days of any of these events.

Employee's Notification Requirements

For the other qualifying events (divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a Dependent child, you must notify the Fund Administrator. The Plan requires you to notify the Fund Administrator within 60 days after the qualifying event occurs. You must send this notice to:

I.A.T.S.E Local 504 Health and Welfare Trust Fund
c/o Benefit Programs Administration – COBRA
13191 Crossroads Pkwy N, Suite 205
City of Industry, CA 91746-3434
(562)595-6463 or (888)806-8942

Depending upon the type of qualifying event, you will be required to provide: a copy of your divorce decree or legal separation; a certified copy of the death certificate; or, a child losing eligibility because he or she no longer satisfies the rules for Dependent eligibility.

The Fund Administrator's Notification Requirements

Once the Fund Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries; notification of your rights will be made to you within 14 days of the date the Fund Administrator receives notice of a qualifying event.

When COBRA Continuation Coverage Begins and Duration of Coverage

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date Plan coverage would otherwise have been lost.

COBRA continuation coverage is temporary continuation coverage. When the qualifying event is the death of the Employee, enrollment of the Employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

You will be charged 102% of the cost of coverage as provided by federal law during a COBRA period of 18 or 36 months.

11-Month Disability Extension

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Fund Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. During the extension period for total disability, you will be charged 150% of the cost of coverage as provided by federal law.

You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to:

I.A.T.S.E Local 504 Health and Welfare Trust Fund
c/o Benefit Programs Administration – COBRA
13191 Crossroads Pkwy N, Suite 205
City of Industry, CA 91746-3434
(562)595-6463 or (888) 806-8942

You must include the following information with your notification: A copy of the Social Security Disability Award.

Note: Before applying for the disability extension, be sure to read the provisions of California COBRA Extension for Qualified Beneficiaries enrolled in insured medical plans in California below.

You should study the benefits available to you through Covered California (*https://www.****covered****ca.com****), the marketplace for medical benefits in California. Depending upon your income, you may be eligible for a federal subsidy that will pay for a portion of the insurance cost.***

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and Dependent children if the former Active Employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a Dependent child.

In all of these cases, you must make sure that the Fund Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:

I.A.T.S.E Local 504 Health and Welfare Trust Fund
c/o Benefit Programs Administration – COBRA
13191 Crossroads Pkwy N, Suite 205
City of Industry, CA 91746-3434
(562)595-6463 or (888) 806-8942

Depending upon the type of qualifying event, you will be required to provide: a copy of your divorce decree or legal separation; a certified copy of the death certificate; or a child no longer satisfying the eligibility rules for Dependents.

California COBRA Extension – Medical Benefits

If you have a Qualifying Event, California law requires insured plans to provide up to 36 months (combined federal and state COBRA extensions) of continued medical coverage. California COBRA legislation does not apply to dental coverage. The California COBRA extension will affect you if you have an 18-month or 29-month COBRA Qualifying Event.

In order to be eligible for the California COBRA extension, you must have exhausted your federal COBRA coverage**.** You will be charged premiums that are consistent with the California law (generally 110% of the cost of coverage).

Conversion Option

When your coverage ends, you have the option of converting your group coverage to an individual plan if conversion is available. You must have exhausted all earned coverage and extensions available under COBRA You have 63 days to convert your coverage. You should contact your insurance carrier for information on conversion plans and their costs prior to the date of your loss of coverage. Conversion plans do not provide the same level of coverage as the plan for Active Employees and Dependents, and they generally cost more.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact:

I.A.T.S.E Local 504 Health and Welfare Trust Fund
c/o Benefit Programs Administration – COBRA
13191 Crossroads Pkwy N, Suite 205
City of Industry, CA 91746-3434
(562)595-6463 or (888) 806-8942

Or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

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

LIFE INSURANCE
(EMPLOYEE ONLY)

Life Insurance is provided by the Fund for you through Union Labor Life Insurance Company in the amount of $5,000. This coverage does not apply to Dependents. When proof of your death is received, the amount of Life Insurance is paid to your named beneficiary.

Life Insurance benefits terminate at retirement and during periods of COBRA continuation coverage.

Beneficiary for Life Insurance

You may name or change any beneficiary at any time by filing a written change in the Administrative Office. The change will take effect after it is received, provided benefits have not been paid before it was received.

If you name more than one beneficiary but do not state amounts or order of payment, benefits will be equally divided.

If you name more than one beneficiary and one dies before you, his or her share will go equally to the surviving beneficiaries.

If you have not named a beneficiary at the time of your death, benefits will be paid to the Eligible Individuals of the first surviving class as follows:

1. Your Spouse or Domestic Partner
2. Your Children
3. Your Parents
4. Your Brothers and Sisters
5. Your Executor or Administrator
6. Your Estate

Up to $1,000 of the benefits may be paid to anyone who pays expenses for your final illness or burial. Any payment made in good faith under these provisions will discharge the liability of Union Labor Life Insurance Company to the extent of the payment.

Claim Provisions

If a covered loss occurs, notice of claim must be given to the Fund. Notice must be received by the Fund within 90 days after loss occurs, or as soon as reasonably possible. The notice must identify the Employee and must be given to the Administrative Office. The notice of claim will be sent to Union Labor Life Insurance Company for processing and your beneficiary will be sent a claim form

for completion. Union Labor Life Insurance Company will pay benefits upon receipt of due proof of loss, but may at its own cost, require an autopsy where legal.

ACCIDENTAL DEATH AND DISELIGIBLE INDIVIDUALMENT BENEFITS (EMPLOYEE ONLY)

Accidental Death and Dismemberment Insurance is provided by the Fund for you through Union Labor Life Insurance Company in the amount of $5,000. This coverage does not apply to Dependents. When proof of your death is received, the amount of Accidental Death and Dismemberment insurance is paid to your named beneficiary. You may name or change your beneficiary at any time by filing a written change form in the Administrative Office. If you have not named a beneficiary at the time of your death, benefits will be paid in the order shown under Life Insurance (page 19).

Dismemberment benefits terminate at retirement and during periods of COBRA continuation coverage.

When, within 90 days after and as a direct result of an accidental injury, you sustain one of the losses listed below, a dismemberment benefit will be paid to you and the accidental death benefit, if applicable, will be paid to your beneficiary**.**

For the loss of the following a $5,000 benefit will be paid:

1. Life
2. Both hands or both feet
3. Sight of both eyes
4. One hand and one foot
5. One hand and sight of one eye
6. One foot and sight of one eye

For the loss of the following a $2,500 will be paid:

1. One hand or one foot
2. Sight of one eye

Only one benefit is payable as a result of all losses sustained in any one accident, that is one for which the greatest benefit is payable and will not exceed the amount shown in the schedule above.

Loss means, with respect to hands and feet, the actual severance at or above the wrist or ankle joints, with respect to eyes, the entire and irrecoverable loss of sight.

EXCLUSIONS

Benefits will **NOT** be paid for any loss caused directly or indirectly by:

1. Sickness, bodily or mental infirmity, or treatment thereof;

2. Ptomaines or any infection, other than a pyogenic infection occurring through, and at the time of, an accidental cut or wound;

3. Suicide or attempted suicide, while sane or insane;

4. Intentionally self-inflicted injury, while sane or insane;

5. Declared or undeclared war or act of war;

6. Committing an assault or felony;

7. Voluntary or involuntary:

   (a) taking of drugs, except drugs taken as prescribed by a licensed medical doctor (M.D.) or doctor of osteopathy (D.O.),

   (b) taking of poison, except for food poisoning;

   (c) Inhaling of gas.

8. Service in the armed forces of any country while such country is engaged in war; or

9. Police duty as a member of any military, naval or air organization.

Claim Provisions

If a covered loss occurs, notice of claim must be given to the Fund. Notice must be received by the Fund within 90 days after loss begins or occurs, or as soon as reasonably possible. The notice must identify the Employee and must be given to the Administrative Office. The notice of claim will be sent to Union Labor Life Insurance Company for processing and you or your beneficiary will be sent a claim form for completion. Union Labor Life Insurance Company may, at its own cost, require physical examinations of the Employee as often as reasonably necessary while a claim is pending. In case of death, Union Labor Life Insurance Company, at its own cost, may require an autopsy where legal.

MEDICAL BENEFITS AND OPEN ENROLLMENT

Upon qualifying for coverage you will be given the opportunity to elect for yourself and your Dependents, coverage for medical and dental plans offered by the I.A.T.S.E Local 504 Health and Welfare Trust Fund. You may choose one of two Health Maintenance Organizations (HMO):

1. Kaiser Foundation Health Plan (HMO); or

2. Health Net HMO; or

A summary of the plan coverage is contained at the back of this Summary Plan Description.

Only you can decide which of these plans will best serve the medical needs of you and your family. We suggest you thoroughly review the descriptions of the benefits under each plan, as well as your out-of-pocket costs.

The coverage you select will apply to all your Dependents. The Eligibility Rules established by the Board of Trustees shall prevail, regardless of coverage selected.

To enroll in the HMOs, you must live or work within 30 miles from of the Medical Group's facilities and you **must** receive services at facilities associated with that HMO. If you do not receive services at an authorized facility, you will be responsible for 100% of the charges (except in the case of an emergency, in which case the HMO will determine how much it will pay). The benefits actually provided are subject to the terms and conditions of an agreement between the HMO and the Fund.

Summary Plan Descriptions outlining the benefits, exclusions and limitations of the plans will be provided to you by the HMO or Administrative Office at your request free of charge. Whichever plan you choose, make sure you and your Dependents read the information carefully and are aware which services or materials will be covered or excluded by the plan.

The coverage shall remain continuous until the next "Open Enrollment" period. The term "Open Enrollment" shall mean that period of time, as determined by the Board of Trustees, during which you may change plans.

During subsequent "Open Enrollment" periods, if no election is made, you and your Dependents will remain in the Plan in which you are enrolled at the time of the "Open Enrollment" period.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an

individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

MOTHER'S AND NEWBORN CHILDREN'S RIGHTS

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.
If you would like more information on WHCRA benefits, call the Administrative Office.

CONVERSION OF MEDICAL BENEFITS

When group medical insurance coverage ends you and/or your Dependents may be entitled to enroll in an individual conversion plan offered by your medical plan. In order to qualify for a conversion plan, you must have exhausted all eligibility for Plan benefits, including COBRA. This coverage may cost more and/or provide fewer benefits than your group health coverage. You have 63 days after termination of your group coverage to apply and pay the required premium for such individual or family policy. Your right to conversion, if any, is discussed in the brochures provided to you by the medical plan you selected.

CLAIMS AND APPEALS UNDER THE KAISER PLAN AND THE HEALTH NET MEDICAL PLANS

In accordance with law, new requirements went into effect regarding the timing of claims submissions, claims appeals, and denial of benefits. Since your benefits are provided through insurance contracts, you will be receiving notice of the provisions that apply to the benefits available to you. The Board of Trustees wants to remind you that you must follow the procedures for claims that apply to the insurance carrier. If you have any questions about your rights, please contact the insurance carrier or the Administrative Office**.**

The Board of Trustees has no responsibility for the appeals process regarding claims. If you wish to appeal a claim for benefits that has been denied in whole or in part, you must follow the appeals procedures outlined in the Kaiser or Health Net Evidence of Coverage– whichever group is providing your coverage.

GENERAL INFORMATION ABOUT CLAIMS AND APPEALS PROCEDURES

The following provides you with general information about your right to appeal claims that are denied in whole or in part. However, any benefits provided through insured contracts require that you follow the claim procedures established by the carrier.

Claims Appeals and Arbitration Procedures

If an Eligible Individual has a dispute concerning the service and/or the benefit levels provided, or any other matter pertaining to one or more of the benefit Plans provided by the Trust Fund, the Eligible Individual has the right to file a written Appeal. For medical and dental benefits, the first level of Appeal is through the service provider with whom the Eligible Individual is enrolled. The Eligible Individual should contact his medical or dental provider through their customer service representative. A customer service number is provided in the provider benefit booklet or on the Fund's website: www.iatse504welfare.org. If an Eligible Individual has any questions, or requires assistance in accessing the grievance and Appeals procedures of one of the benefit providers he may contact the Fund Administrative office. In most cases, arbitration procedures may also be available under the medical Plan in which the Eligible Individual is enrolled. If the Eligible Individual is dissatisfied with the provider's response to his Claims Appeals, or if applicable the arbitration procedure affected the Eligible Individual adversely, he may still file a Claim with the Board of Trustees.

The dental plan has its own appeals and grievance procedures that are described in the benefit booklet of the Plan concerned. An Eligible Individual may implement the appeal and grievance procedure by contacting the customer service number listed in the benefit booklet, or by contacting the Fund Administrative Office or go to the Fund's website: www.iatse504welfare.org.

Appeals to the Board of Trustees

If an Eligible Individual is not satisfied with the manner in which his Claims and/or arbitration was processed, or with the decision rendered by any one of the medical or dental providers, the Eligible Individual may file an Appeal with the Board of Trustees of the I.A.T.S.E. Health and Welfare Trust Fund.

Claims Appeal Procedures

Claims Appeal procedures described in this section will be followed in the processing of Claims and any Appeals for benefits submitted to the Board of Trustees. These Claims Appeals procedures will also generally be followed by the carriers with whom the Trust has a contract to provide benefits to Eligible Individuals.

No Employee, Eligible Individual or beneficiary or other person shall have any right or Claim to benefits under the Plan, other than those benefits specified in the Plan. Benefits provided through

various medical and dental providers or any other contract provider are specifically limited to the benefits for which the Board of Trustees and the medical providers have contracted.

In accordance with regulations issued by the Department of Labor the Plan adopts the following procedures and time limits for notification of benefit determinations (the insurance carrier will have similar claims and appeals procedures):

Claims Procedure

1. **Filing of Claim Form**

An Employee or Dependent, or his or her duly authorized representative, individually or collectively referred to as "Claimant," may file a Claim for benefits. An Employee or Dependent may be required to verify in writing that an individual is an authorized representative. All Claims for benefits shall be filed on forms provided by the Plan, which will be available from the Fund Administrative Office and such other places as may from time to time be designated by the Board, or on such other forms as may be acceptable to the Plan. A Claim shall be considered to have been filed when it is received by the Fund Administrative Office or at such other location as may be indicated on the Claim form, regardless of whether it contains all the information necessary to render a decision. The Board may designate a Utilization Review Company, in appropriate circumstances, to perform Fund Administrator services in the Claims and Appeal process.

Telephonic or written requests for information about Plan benefits or eligibility are not considered Claims. Telephonic or written requests for prior approval are not considered Claims, unless prior approval is required by the Plan as a condition to receipt of full benefits and the request is submitted in the manner required by the Plan.

Claims must be filed with the Plan within one year from the date services are rendered. If a Claim is not filed within this time, the Claim will be denied.

2. **Urgent Care Claims**

An Urgent Care Claim may be filed by the Claimant, or by a Doctor or other health professional authorized to act on behalf of the Claimant, without completing an authorized representative form.

The Plan will determine whether the Claim is an Urgent Care Claim based upon the information provided by the Claimant or the Claimant's Doctor to establish an Urgent Care Claim by showing that the usual time for processing a Claim either (i) could seriously jeopardize the Claimant's life, health or ability to regain maximum function, as determined by the Fund Administrator, or Utilization Management Company, as appropriate, applying the judgment of a prudent layperson with an average knowledge of health and medicine, or (ii) in the opinion of a Doctor with knowledge of the Claimant's medical condition, it would subject the Claimant to severe pain that cannot be adequately managed without the care that

is the subject of the Claim. Within 72 hours of the submission of an Urgent Care Claim, the Fund Administrator or Utilization Management Company, as appropriate, will notify such Claimant whether or not the Claim is covered under the terms of the Plan. In the event additional supporting documentation is needed in order to make a determination of the Claim, the Fund Administrator or Utilization Management Company, as appropriate, shall notify the Claimant within 24 hours of receipt of the Urgent Care Claim of the specific information which is required, and the Claimant will have 48 hours within which to respond to the demand for information.

The Fund Administrator or Utilization Management Company, as appropriate, shall notify each Claimant of the Plan's determination within 48 hours after the Plan receives the additional information, or the end of the time given for response, whichever is earlier.

Any notice sent by the Fund Administrator or Utilization Management Company, as appropriate, in connection with an Urgent Care Claim may be communicated orally and confirmed in writing within three days of the oral communication, and will provide all the information required to be given by the Fund Administrator with any adverse benefit determination.

3. **Concurrent Care Claims**

In cases where the Plan has previously approved an ongoing course of treatment to be given over a period of time or number of treatments, any reduction in that course will be considered an adverse benefit determination. In the event of such an adverse benefit determination, the Plan will give each Claimant notice, sufficient time to appeal a determination and time to receive a decision of the Appeal before an interruption of care.

In cases where the Plan has approved an ongoing course of treatment and the Claimant seeks to extend the treatment beyond what has already been approved by the Plan, if the treatment requested is for Urgent Care the determination by the Plan will be made in accordance with the same expedited procedures for determination of Urgent Care Claims. If the request is made at least 24 hours before the end of the approved treatment, the Plan will notify the Claimant of the Plan's decision as soon as possible but no later than 24 hours after receipt of the Claim.

4. **Pre-Service Claims**

Claims for non-Urgent Care that require pre-authorization before care is obtained will be decided by the Plan, and notice will be sent to the Claimant, within 15 Days of receipt of a completed Claim by the Fund Administrator. The Plan will notify each Claimant within 5 Days of receipt of the Claim if the Claim cannot be processed because the communication does not follow the proper procedures for filing a Claim. If the Claim is properly filed and the Plan needs additional time to process the Claim due to matters beyond its control, the Plan may extend the time to respond for up to 15 Days, if necessary, if the Plan notifies the Claimant prior to the end of the initial 15 Day period of the circumstances requiring the

extension of time and the date by which the Plan expects to render a decision In the event the extension is due to the Claimant's failure to submit information necessary to make the benefit determination, the Plan will notify the Claimant in writing of the specific information which is required within the initial 15 Day period, and the Claimant will have 45 Days from the receipt of the Plan's request to provide the additional information. The period within which the Plan is waiting for additional information will not be counted toward the time within which the Plan is required to respond. A Claimant may voluntarily consent to a longer extension.

5. **Post-Service Claims**

Post-service Claims will be determined and notice of denial will be sent to the Claimant, within 30 Days from receipt of a completed Claim by the Fund Administrator. The Plan will notify each Claimant within 5 Days of receipt of the Claim if the Claim cannot be processed because the communication does not follow the proper procedures for filing a Claim. If the Claim is properly filed and the Plan needs additional time to process the Claim due to matters beyond its control, the Plan may extend the time to respond for up to 15 Days, if necessary, if the Plan notifies the Claimant prior to the end of the initial 30 Day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. In the event the extension is due to the Claimant's failure to submit information necessary to make the benefit determination, the Plan will notify the Claimant in writing of the specific information which is required within the initial 30 Days, and the Claimant will have 45 Days from the receipt of the Plan's request to provide the additional information. The period within which the Plan is waiting for additional information will not be counted toward the time within which the Plan is required to respond. A Claimant may voluntarily consent to a longer extension.

6. **Non-Medical Claims (Death and Accidental Death and Dismemberment Claims)**

The notice of denial of a Non-medical Claim shall be given within 45 Days after a Non-medical Claim is filed, unless special circumstances require an extension of time for processing the Claim. If such an extension is required, written notice shall be furnished to the Claimant within 30 Days of the time the Non-medical Claim is filed, stating the special circumstances requiring an extension of time and the date by which a decision on the Claim can be expected, which shall not be more than 180 Days from the date the Claim was filed. A Claimant may voluntarily consent to a longer extension.

7. **Notice of Denial of Claim**

If a Claim under the terms of the Plan is denied, in whole or in part, the Fund Administrator shall send a written notice to Claimant. Any notice of an adverse benefit determination sent in connection with Urgent Care, Pre-service Claims, Concurrent Care, Or Post-service Claims will:

a. Specify the reasons for the adverse determination;

b. Provide a reference to the specific Plan provision being relied on;

c. Identify any information the Claimant needs to provide to complete the Claim and provide an explanation as to why the information is required;

d. Provide a description of the Plan's review procedures and the time limits applicable to such procedures (the denial notice for an Urgent Care Claim must contain a description of the expedited review process available for such Claims);

e. Advise the Claimant that the Claimant is entitled to file suit in the federal court after exhausting the internal review process.

8. If any internal rule, guideline or Plan procedure was relied upon in making the adverse benefit determination, the rule or guideline will be provided or a statement will include the specific rule that was relied on, and is available to the Claimant free of charge upon the Claimant's request.

9. If the adverse benefit decision was based upon lack of medical necessity or experimental or similar exclusion, the Plan will provide an explanation of the scientific or clinical judgment made, and will apply it to the terms of the Plan and the Claimant's specific medical condition, or will notify the Claimant that the information is available free of charge upon request.

Appeal of Adverse Benefit Determination

Any Claimant who has received an adverse benefit determination will have 180 Days for a Claim and 60 Days for a Non-medical Claim from the date of the denial of the Claim to file a written Appeal with the Fund Administrative Office requesting a review by the Board of Trustees. The Appeal must contain a written explanation of the basis for the Appeal, and may include written comments, documents, records and other information relating to the Claim. An Appeal is filed when it is received by the Plan, regardless of whether it contains all the information necessary to render a decision. A request for review which is not timely filed shall constitute a waiver of the Claimant's right to reconsideration of the denial and need not be considered by the Board of Trustees absent extraordinary circumstances. This shall not, however, preclude the Claimant from establishing entitlement at a later date based on additional information and evidence which was not available to him within either such 60-Day or 180-Day period from the date of the denial.

A Claimant may request that the Plan provide access to, and copies of, all documents, records, and other information relevant to the Claim free of charge. The Board of Trustees will review and consider all comments, documents, records and other information submitted by the Claimant, whether or not such information was submitted in connection with the initial determination of the Claim. The review by the Board of Trustees will consider all information and documents submitted by the Claimant and will not afford deference to the initial review in deciding the Appeal. The Board

shall exercise its reasoned discretion in making, interpreting and applying Plan rules, and resolving any Appeals.

When the initial decision is based on medical judgment, the Board of Trustees will consult with an expert in the relevant field with appropriate training and experience who did not participate in the original determination. If requested by the Claimant, the Board of Trustees will disclose the identity of each expert consulted by the Plan, whether such expert was relied upon or not in making the final decision on Appeal.

At the time of filing the written Appeal, the Claimant may request a formal hearing before the Board of Trustees. The Claimant shall have no right to appear personally before the Board of Trustees unless the Board of Trustees concludes that such an appearance would be of value in enabling it to perform its obligations hereunder.

Expedited Appeal Procedure for Urgent Care Claims

Appeals of adverse benefit determinations involving "Urgent Care" Claims may be submitted orally or in writing by the Eligible Individual or authorized representative by telephone, facsimile or any other expeditious manner, so long as all information necessary to review the Appeal is provided.

Notification of Appeals Determinations

1. **Urgent Care Claim Appeals**

   The Board of Trustees will review the Appeal of an "Urgent Care" Claim and will notify the Claimant of the Board's decision with 72 hours of the Appeal, unless medical exigencies require that the Appeal be determined sooner.

2. **Pre-Service Claim Appeals**

   In the event that a Claimant appeals an adverse benefit determination for a Pre-service Claim, the Board of Trustees will review the Appeal of a Pre-service Claim and notify the Claimant within 30 Days of the determination by the Plan

3. **Post-Service Claim Appeals**

   Each Appeal of an adverse benefit determination of a Post-service Claim will be considered at the next regularly scheduled meeting of the Board of Trustees following the receipt of the written Appeal. However, if the Appeal arrives within 30 Days of the Board meeting, it may be reviewed and decided at the following meeting of the Board. If special circumstances require an extension of time for processing the Appeal, the Claimant will be given a notice in writing by the Fund Administrative Manager prior to beginning of the extension period, explaining the special circumstances requiring an extension of time and indicating the date by which the Trustees expect to render a final decision on the Appeal, which will be no later than the third meeting of the Board after the Appeal is filed.

a. **Extension Due to Claimant's Failure to Submit Information**

If the extension is due to the Claimant's failure to submit information necessary to decide the Appeal of a Claim, and the extension notice specifically describes the required information, the Claimant will have at least 45 Days from receipt of the extension notice within which to provide such information. The time period for making the decision will be suspended from the date on which the extension notice is sent to the Claimant to the earlier of (i) the date on which the Claimant's response is received by the Plan, or (ii) the due date established by the Plan for the furnishing of the requested information.

b. **Extension Due to Claimant's Failure to Submit Information (Non-Medical)**

If the extension is due to the Claimant's failure to submit the information necessary to decide the Appeal of a Non-medical Claim, and the extension notice specifically describes the required information, the decision on review will be made by the first regular meeting that is at least 30 Days after the Claimant responds. If, after a reasonable period of time, but not less than 90 Days, the Claimant has not responded to a request for additional information, the Board may decide the Appeal, provided the Claimant is notified in writing at least 60 Days before the decision on review is made, that such decision will be made, regardless of whether the Claimant responds.

4. The Fund Administrative Office will notify the Claimant or their authorized representative of the Board of Trustees' decision in writing not later than 5 Days after the determination is made.

Notice Upon Denial of Appeal

If the Appeal is denied in whole or in part by the Board of Trustees, the Fund Administrative Office shall advise the Claimant in writing of the specific reason or reasons for the denial, including any specific Plan provision upon which the denial is based. The notice will include a statement that the Claimant is allowed to have, free of charge, all documents, records and other information relevant to the Claimant's Claim for benefits; and a statement describing the voluntary Appeals procedures of the Plan, along with the information required in connection with the voluntary Appeal procedure. If applicable, the notice will also include the specific rule, guideline, or protocol relied on by the Board of Trustees in making the decision, and will either include a copy of the document or will advise the Claimant that a copy is available free of charge. If the decision is based either in whole or in part on a medical judgment, the notice will explain the basis for the judgment or will contain a statement that the explanation is available free of charge to the Claimant.

The Board of Trustees shall have full discretion and authority to determine questions concerning the interpretation or administration of this Plan, including without limitation, all questions relating to eligibility for Plan benefits, and the determinations of the Board shall be conclusive and binding as to

all persons and for all purposes. The Board of Trustees shall administer the terms and provisions of the Plan in full accordance with any and all laws applicable to the Plan.

In the event an Appeal is denied by the Board of Trustees, the person filing the Appeal will be entitled to review all relevant information relied upon by the Board of Trustees in deciding the Appeal, as well as any document, record, or other information which was submitted, considered, or generated in the course of making the benefit determination, whether or not it was relied upon in deciding the Appeal.

Voluntary Request for Reconsideration

In the event an Appeal is denied, the person filing the Appeal may request reconsideration by the Board of Trustees of its decision. A request for reconsideration is voluntary. A request for reconsideration must be in writing, and must state in clear and concise terms the reason or reasons for disagreement with the decision of the Board of Trustees. Any such request for reconsideration must also indicate whether or not the person filing such request requests a formal hearing before the Board of Trustees. The Claimant shall have no right to appear personally before the Board unless the Board concludes that such an appearance would be of value in enabling it to perform its obligations hereunder. A request for reconsideration must be filed or received by the Fund Administrative Office within 60 Days after the date of receipt of the notice from the Fund Administrative Office of the Board of Trustees' determination of the Claims Appeal.

No person shall be required to file a request for reconsideration, and shall be deemed to have exhausted all Fund Administrative remedies under the Plan after the initial determination by the Board of Trustees. In the event a request for reconsideration is filed, the time period within which a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") must be filed will not begin to run until the Board of Trustees notifies the Claimant in writing that the request for reconsideration has been denied.

Upon good cause shown, the Board of Trustees may permit the petition for reconsideration to be amended or supplemented. The failure to file a petition for reconsideration within such sixty (60) Day period shall constitute a waiver of the person's right to reconsideration of the decision on the basis of the information and evidence submitted to the Board of Trustees prior to the decision by the Board of Trustees.

Right to Bring a Civil Action

If a Claimant is dissatisfied with the final decision of the Board of Trustees either after written notice of the Board of Trustees' initial denial of their Claims Appeal, or after its reconsideration, if any, of the Appeal, the Claimant has a right to bring a civil action under section 502(a) of ERISA in either state or federal court.

No action may be filed by any person against the Plan, the Trustees, or any of the Trustees' agents more than 180 Days after a Claimant is given written notice of the denial of an Appeal by the Board of Trustees, or denial of the request for reconsideration, whichever is later. Unless a Claimant is

otherwise expressly advised in writing, the 180-Day period shall not be extended even if the Board of Trustees again considers the Appeal after the initial denial. This 180-Day limitation period shall apply to all legal and equitable actions arising out of, or relating to, a Claim for benefits including, but not limited to, any legal or equitable action under ERISA to the extent the Claim relates to the provision of benefits or rights under the Plan.

If any person has a dispute with the Board of Trustees as to eligibility, type, amount or duration of such benefits, the dispute shall be resolved by the Board of Trustees under and pursuant to the Plan and this Claims procedure. The decision of the Board of Trustees shall be final and binding upon all parties thereto.

Claims Appeals to the Board of Trustees must be filed with the Fund Administrative Office at:

I.A.T.S.E Local 504 Health and Welfare Trust Fund
c/o Benefit Programs Administration
13191 Crossroads Pkwy N, Suite 205
City of Industry, CA 91746-3434
(562)595-6463 or (888) 806-8942

DENTAL BENEFITS

Dental benefits are provided by the Fund for you and your Dependents through Delta Dental of California. The following table ***briefly summarizes*** some of the dental plan provisions:

Benefit	Copayments
Deductible	None
Calendar Year Maximum	None for general services
Orthodontics	24-month treatment plan; $25 up to $1,900
Diagnostic	None for general services
Preventive	No copay up to $45
Restorative	No copay up to $195
Endodontic	No copay up to $220
Periodontic and Prosthodontic	No copay up to $195
Oral and Maxillofacial surgery	No copay up to $90
Adjunctive general services	No copay up to $165
Emergency out-of-area	$100 plan benefit

A SPD detailing the benefits, exclusions and limitations will be provided to you by Delta Dental of California, or the Administrative Office, at your request without charge. A list of Preferred Providers will also be provided to you. Make sure you and your Dependents read the SPD carefully and are aware which services or materials will be covered or excluded by the plan.

You must be enrolled in this Dental Plan to obtain benefits. Enrollment forms are available from the Administrative Office or o the Funds website: www.iatse504welfare.org

VISION BENEFITS

Vision benefits are provided by the Fund for you and your Dependents under the two HMO medical plans.

If you are enrolled in the Kaiser Permanente medical plan, you and your Dependents are eligible for vision exams once each year and an allowance of $175 for the purchase of lenses and frames from Kaiser once every 24-months.

If you are enrolled in the Health Net Plan, you are eligible for vision benefits through their contract with EyeMed Vision Care. The EyeMed Care plan has an extensive network of independent opticians from which you can choose, or you may use any provider and receive reimbursement of a portion of your expenses. The following table briefly summarizes the EyeMed network benefits and the out-of-network allowances:

Benefit Description	Member Cost	Out-of-Network Allowance
Exam with Dilation as Necessary	$10 copayment	Up to $40
Exam Options (fit and follow-up):		
Standard contact lenses	Up to $55	n/a
Premium contact lenses	10% off retail	n/a
Standard Plastic Lenses	$25 copayment	Up to $40
Single vision		
Lined bifocal	$25 copayment	Up to $60
Lined trifocal	$25 copayment	Up to $80
Lenticular lenses	$25 copayment	Up to $80
Standard progressive lenses	$90	$60
Premium progressive lenses	$90, plus 80% of change less $120 allowance	$60
Frames		
Any frame available at a provider location	$0 copayment, $100 retail allowance for any frame plus 20% off balance over allowance	Up to $45
Any frame available at a provider location	$0 copayment, $100 retail allowance for any frame plus 20% off balance over allowance	

GENERAL PROVISIONS

The benefits provided by this Fund are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

COORDINATION OF BENEFITS

All medical and dental benefits are subject to coordination. If you or your Dependents are entitled to benefits under any other plan which will pay part or all of the expense incurred for treatment of sickness or injury, the benefits payable under this Plan and any other plans will be coordinated so that the aggregate amount paid will not exceed 100% of the allowed expense incurred. In no event will the amount of benefits paid under this Plan exceed the amount which would have been paid if there were no other plan involved.

Benefits under this Plan will be coordinated with any group plan providing benefits or services for hospital or medical treatment that is: (a) group insurance coverage, (b) blanket insurance coverage which does not contain a non-duplication of benefits or excess policy provision, (c) group Blue Cross, Blue Shield, group practice and other prepayment coverage provided on a group basis, (d) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or any other arrangement of benefits provided on a group basis; (e) any group coverage under governmental programs, and any group coverage required or provided by any statute, and (f) no-fault auto insurance.

Which Plan Pays First?

If both plans have a coordination of benefits provision, the plan that insures you as an active employee pays first. If you receive benefits as an active employee under one plan and as a retiree under another, the plan you have as an active employee pays first. If you are insured as an employee under two plans, the plan which has insured you longer is primary. If one plan does not have a coordination of benefits provision, that plan is always primary. An Eligible Individual or qualified beneficiary is subject to this Plan's rules even if the Plan is a secondary carrier. If a Dependent child is covered under two plans, the plan of the parent whose birthday (month and day) is earlier in the year will pay its benefits first. If the parents of a Dependent child are divorced or legally separated, the plan of the parent with custody of the child pays its benefits first. If the parent with custody remarries, the order of payment is as follows:

1. Natural parent with whom the child resides;

2. Stepparent with whom the child resides;

3. Natural parent not having custody of the child.

This order of payment can change if a court order *specifically* and *unambiguously* requires one of the parents to be financially responsible for the child's medical expenses.

COORDINATION OF BENEFITS AND MEDICARE

Medicare Benefits at Age 65

If you are entitled to benefits under Medicare because you are age 65 or older, this Plan will be the primary plan to Medicare for you if you are:

1. An active Employee; or
2. A Dependent of an active Employee.

To determine the amount of reduction for purposes of COB, the Plan will include all benefits for which you are eligible under Medicare Parts A and B. Such benefits will be considered payable under Medicare, whether or not you have registered for Part A benefits, or enrolled for Part B benefits.

Medicare Benefits Due to Total Disability

You may become entitled to Medicare benefits prior to age 65 if you are totally disabled or have end stage renal disease. The following rules apply with respect to COB with Medicare due to total disability or end stage renal disease prior to age 65. Upon attainment of age 65, the rules for COB with Medicare, as specified under "M**edicare Benefits at Age 65"**, will apply, if applicable.

During Medicare Waiting Period

This Plan will be a primary plan to Medicare during any waiting period for Medicare benefits due to total disability or end stage renal disease.

After Medicare Waiting Period

After the Medicare waiting period has been met and you are entitled to Medicare benefits, this Plan will be:

1. A primary plan to Medicare for you if you are an active Employee, or the Dependent of an active Employee, and entitled to Medicare benefits due to total disability other than End Stage Renal Disease; and

2. A secondary plan to Medicare for you if you are an active Employee, or the Dependent of an active Employee, who is entitled to Medicare benefits due to End Stage Renal Disease.

Electing Medicare as Primary Plan

You or your Dependent, who is entitled to Medicare benefits at age 65, or as a result of total disability, may elect to have Medicare as the primary plan by giving notice to your Employer. If you or your Dependent elects Medicare as the primary plan, health coverage under this Plan will cease.

RIGHT TO RECEIVE AND RELEASE INFORMATION

This Plan may, without the consent of or notice to any insured, release or obtain from any insurance company, organization, or person, any information it deems necessary to determine eligibility, and to process benefit claims provided such rights are not in conflict with federal privacy rules. Whenever payments which should have been made by this Plan have been made by any other plan, this Plan will have the right to repay the plan the amount it determines will satisfy the intent of the coordination of benefits provision. Whenever this Plan pays out more than necessary, it has the right to recover the excess payment from any person, to whom such payments were made, or any insurance company or other organization.

RIGHT OF RECOVERY

You or one of your Dependents may receive benefits from this Plan for expenses incurred due to an injury involving a third party. You also may receive payments from the third party resulting from a lawsuit, settlement or otherwise. If this occurs, the Plan shall have the right to reimbursement by you up to the amount of benefits which it paid for the same expenses.

A lien shall exist in favor of the Plan against all sums of money recovered by you or your Dependent in connection with such injuries to the extent of the benefit payments made by the Plan. Nothing is to be done to prejudice the Plan's rights under this provision without its consent. You or your Dependent shall do whatever the Plan may require to enforce this right.

CLAIMS AND APPEALS PROCEDURES

How to File Claims

Claims and claims appeals for different plans are handled as follows:

If you selected the Health Net HMO Plan, you may contact:

Health Net
PO Box 6006
Cypress, CA 90630
Telephone: (800) 624-8822

If you selected the Kaiser Foundation Health Plan, you may contact:

Kaiser Foundation Health Plan
Claims Administration Department
PO Box 7004
Downey, California 90242-7004
(800) 464-4000

For the Dental Plan, you may contact:

Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, California 90703
Telephone: (800) 422-4234

Email: cs-cerritos@delta.org
Web site: www.deltadentalins.com

For Life Insurance or Accidental Death & Dismemberment benefits, you may contact:

Union Labor Life Insurance Company
1625 Eye St. N.W.
Washington, D.C. 20006
Telephone (800) 431-5425

All claims for benefits must be filed on forms provided by the respective plan. The claims procedure outlined in the SPD provided by the respective plan should be followed as much as possible to assure prompt payment of the claim.

The plan selected may require additional evidence to establish whether or not any claim should be paid. Supplementary documentation or the results of a physical examination or laboratory tests may

be required in order to adjudicate a medical claim. If the patient fails to cooperate with such requests, the claim may be denied.

Claims Appeal Procedures

- If you are enrolled in the Health Net HMO plan or the Kaiser plan, please refer to the Evidence of Coverage (EOC) provided by your carrier for information on the carrier's claims and appeals procedures.

- For Life and AD&D claims and appeals, please refer to the Union Labor Life Insurance Company Certificate of Group Insurance.

- If you are enrolled in the DeltaCare USA Plan, you must follow the claims appeals procedures that apply under the plan that are detailed in their EOC.

The Plan's claims procedures include administrative safeguards and processes designed to ensure and to verify that benefit claims determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated individuals.

Benefit Determinations

Claims for benefits under the Plan will be processed, and benefit determinations will be made, within the time frames allowed under the regulations depending on the type of claim submitted. There are four types of claims that may be filed under this Plan. A description of these claims and the benefit determination time period are as follows:

1. **Urgent Care Claim** – any claim for medical care or treatment that must be determined promptly to avoid jeopardizing your life, health or ability to regain maximum function, or in the opinion of the attending physician could subject you to severe pain if care or treatment is not received.

   Any urgent care claim you submit will be processed as soon as possible and you will be informed of the benefit determination (whether adverse or not) not later than 72 hours after receipt of your claim by the Plan, unless you failed to follow the filing procedure or provide sufficient information to determine the claim. In the case of such a failure, you will be notified within 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You will be given 48 hours to provide the specified information.

   You will be notified by the Plan of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

   a. the Plan's receipt of the specified information; or

   b. the end of the period given to you to provide the specified additional information.

2. **Pre-Service Claim** – any claim for a benefit that requires you to obtain approval before you receive care or treatment. This includes any prior authorization before you see a specialist before any higher benefit payment for an item or service.

   You will be notified by the Plan of the benefit determination (whether adverse or not) not later than 15 days after receipt of your claim by the Plan.

3. **Post-Service Claim** – any claim for treatment that you have already received.

   You will be notified of an adverse benefit determination not later than 30 days after receipt of your claim by the Plan.

4. **Concurrent Care Claim** – any claim that results from the termination or reduction of previously granted benefits to be provided over a period of time. The Plan will notify you in advance of the termination or reduction to allow you time to appeal the decision and obtain a determination before the benefit is reduced or terminated.

   Also included under this category are requests to extend the course of treatment beyond the initial prescribed period of time or number of treatments for urgent cases. In these situations, the Plan will inform you of the decision within 24 hours after receipt of the claim by the Plan, provided the claim is made to the Plan at least 24 hours before the expiration of the initially approved treatment. If such a claim were denied, it would be appealable as an urgent care claim.

   Any request to extend a course of treatment that does not involve urgent care is a claim that is governed by the standards generally applicable to such claims.

To Whom Benefits Are Payable

Any benefits payable that have not been paid when you die may be paid either to your beneficiary or to your estate, at the option of the Fund Administrator. All other amounts will be paid to you.

Benefits Unpaid at Death – Incompetency

Benefits may be payable to any person or institution entitled to such payment, as much as $500 of any benefits, that:

- are to be paid at the time of your death; or
- are to be paid to a minor who is not able to execute a valid release, and for whom no guardian has been appointed.

To the extent of the payment, the Fund Administrator will have no more liability under the group Plan.

Physical Examination and Autopsy

The Administrator shall have the right and opportunity to order the examination of Eligible Individual by a Physician of its choice, to determine the extent of any sickness or injury for which a claim is made. This right may be used as often as it is reasonable to do so. If an Eligible Individual dies, an autopsy may be required (where the law does not forbid it). Such an examination or autopsy shall be made at the expense of the Administrator.

Extensions For Pre-Service And Post-Service Claims

The initial determination of benefits will be made as soon as possible, but not later than the period of time indicated above after the Plan receives your claim. The initial benefit determination period may be extended as follows:

1. Pre-Service Claim – The initial 15-day benefit determination period may be extended up to an additional 15 days if special circumstances beyond the control of the Plan require an extension of time to process the claim. If such an extension is required, you will be sent a written notice before the expiration of the initial 15 day period, stating the special circumstances requiring the extension and the date a decision on the claim can be expected.

2. Post-Service Claim – The initial 30-day benefit determination period may be extended up to an additional 15 days if special circumstances beyond the control of the Plan require an extension of time to process the claim. If such an extension is required, you will be sent a written notice before the expiration of the initial 30 day period, stating the special circumstances requiring the extension and the date a decision on the claim can be expected.

Incomplete Claims

If you fail to follow the filing procedures or do not provide sufficient information for a pre-service or post-service benefit determination, you will be given at least 45 days to perfect your claim or provide any requested information. The time period for making a decision will be suspended from the date of the notification to the earlier of: (1) the date on which a response is received by the Plan, or (2) the date established by the Plan for furnishing the requested information (at least 45 days).

Notice Of Claim Denial

If the Plan makes an adverse benefit determination, in whole or in part, you will be notified in writing of the determination and will be given the opportunity for a full and fair review of the benefit decision. The written notice of denial will include:

1. the specific reason or reasons for the denial;

2. reference to specific Plan provisions on which the denial is based;

3. a description of any additional material or information necessary for you to perfect your claim and an explanation of why that material is necessary;

4. a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim; these relevant documents include any information that was relied upon, submitted, considered or generated in the course of making the benefit decision;

5. if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, you will be provided with a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request;

6. if a medical necessity or experimental treatment or similar exclusion or limit was relied upon in making the adverse determination, you will be provided with a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided to you free of charge upon request; and

7. a description of the Plan's appeal procedures including a statement of your right to bring a civil action under section 502 (a) of ERISA following an adverse determination on review.

In the Case of an Adverse Benefit Determination on a Claim Involving Urgent Care

The information described above and a description of the expedited review process for urgent care claims may be provided to you orally within 72 hours after receipt of your claim by the Plan. The written notice will be furnished to you not later than 3 days after the oral notification.

Expedited Review Process for Urgent Care Claims

A request for an expedited appeal for an adverse benefit determination may be submitted orally or in writing by you and all necessary information, including the Plan's benefit determination, will be transmitted to you by telephone, facsimile, or other available expeditious methods.

Appeals Procedures

If you apply for benefits and your claim is denied, or if you believe you did not receive the full amount of benefits to which you are entitled, you have the right to petition the Plan for a review of the denial of your claim.

The petition must be in writing, state the reason or reasons for disputing the denial and must be accompanied by any pertinent material not already furnished to the Plan. You or your authorized representative must file the appeal with the Plan within 180 days after you receive the notice of claim denial.

The Plan will review all submitted comments, documents, records and other information related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination. The Plan will not give deference to the initial adverse benefit determination.

If the adverse benefit determination is based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate), the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment. The health care professional will be an individual who is neither the individual consulted in connection with the initial benefit determination nor the subordinate of such individual. The Plan will provide you with the identification of any medical or vocational expert whose advice was obtained in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Appeals Determination Time Period

The time period for a benefit determination on review will begin at the time an appeal is filed under the Plan as instructed above, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. You must, therefore, make sure that your claims appeal is complete and any documentation or evidence is included with your claims when you file your appeal. You will be notified of the decision of the Plan in writing as follows:

1. **Urgent Care Claim** – You will be notified of the benefit determination not later than 72 hours after receipt by the Plan of your request for review of an adverse benefit determination.

2. **Pre-Service Claim** – You will be notified of the benefit determination not later than 30 days after receipt by the Plan of your request for review of an adverse benefit determination.

3. **Post-Service Claim*** – A properly filed appeal will be reviewed by the Appeals Committee for the Board of Trustees at its next regularly scheduled meeting. However, if the appeal is received within 30 days prior to the meeting, the appeal may be reviewed at the second meeting following receipt of your appeal.

   If special circumstances beyond the control of the Plan (such as the need to hold a hearing) that require an extension of time, the Board of Trustees will render a decision at the next scheduled Board meeting following receipt of the appeal. The Plan will provide you, prior to the start of the extension, with a written notice of the extension describing the special circumstances and the date that the Appeals Committee will make its decision. A written notice of the decision on an appeal will be provided to you within 5 calendar days following the Board of Trustees meeting.

a. In the event that you want or need additional time to present evidence in support of your petition for review, you may request such additional time in writing. The Trustees will grant your written request for additional time necessary to perfect a petition for review, provided the written request is received before the Trustees issue their decision. Requests for additional time and requests to submit additional information received after the Trustees' decision has been rendered will be denied, unless the Trustees, in their sole discretion, determine that the information is material to the petition and could not have been provided earlier.

b. You will receive a response within 45 days from the date the appeal is received. This period may be extended for up to an additional 45 days if additional information is required and you will be notified for the special circumstances and the date that the Plan expects to render the benefit determination.

In the case of an adverse benefit determination on the appeal, the written denial will indicate:

1. the specific reasons for the denial;

2. reference to the pertinent Plan provisions on which the denial is based;

3. a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;

4. a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;

5. a statement of your right to bring a civil action under section 502 (a) of ERISA;

6. if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, you will be provided with a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request;

7. if a medical necessity or experimental treatment or similar exclusion or limit was relied upon in making the adverse determination, you will be provided with a statement that the explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided free of charge upon request; and

8. a statement that you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

The failure to file an appeal within the 180-day period from the initial denial of your claim will constitute a waiver of your right to a review of the denial of your claim.

"Relevant," as used in this section, is defined as a document, record, or other information that (i) was relied upon in making the benefit determination; (ii) was submitted, considered, generated, or relied upon in the course of making the determination, without regard to whether such document, record, or other information was relied upon in making the determination; (iii) demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or (iv) constitutes a statement of Plan or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination."

Special Notes

Claims and Appeals Procedures for HMO Plans and the Dental and Life, and AD&D Benefits

If the benefits involved are provided by an insurance company, insurance service, health maintenance organization, or other similar organization, that organization may be entitled to conduct the review and make the decision. Disputes concerning benefits provided by one of the HMOs, Dental or the Life and AD&D Benefits, generally must be resolved using the appeal procedures established by that organization. See the applicable SPD or Evidence of Coverage (EOC) for details of the organization's claims and appeals procedures.

Authorizing a Representative

The claims and appeals procedures outlined above do not preclude your authorized representative from acting on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination. In order to determine if an individual or firm has been duly designated by you, a form authorizing such entity to act as your representative must be completed and received by the Plan. However, if a claim involves urgent care, the Plan will permit a health care professional with knowledge of your medical condition (i.e., a treating Physician) to act as your authorized representative.

SUMMARY PLAN INFORMATION

Name of the Plan

The name of the Plan is the I.A.T.S.E. Local 504 Health and Welfare Trust Fund pursuant to the terms of a Trust Agreement.

Duration of the Plan

It is intended that the Plan will continue indefinitely, but the Board of Trustees reserves the right to change and/or discontinue the Plan at any time. In addition, this Plan may terminate by agreement of the participating employers and unions or by operation of the law. If the Plan is terminated, its remaining assets after payment of all expenses will be used to continue to provide benefits for as long as the Plan assets permit, or else the assets will be transferred to a successor plan providing health care benefits. In no event will termination of the Plan result in a reversion of any assets to the contributing employers.

Name, Address and Telephone Number of the Board of Trustees

Board of Trustees of the I.A.T.S.E. Local 504 Health and Welfare Trust Fund, c/o Benefit Programs Administration, 13191 Crossroads Pkwy N, Suite 205
City of Industry, CA 91746-3434
(562)595-6463 or (888)806-8942

Identification Number

The taxpayer identification number assigned to the Fund by the Internal Revenue Service is EIN 95-6100367. The plan number is 501.

Type of Plan

The plan provides Medical, Dental, Vision, Life Insurance, and Accidental Death and Dismemberment benefits to Eligible Individuals.

Type of Administration

The Plan is administered by the Board of Trustees with the assistance of Benefit Programs Administration, a contract administrative manager.

Name, Address and Telephone Number of the Plan Administrator

Benefit Programs Administration, 13191 Crossroads Pkwy N, Suite 205, City of Industry, CA 91746-3434, (562)595-6463 or (888)806-8942.

Name and Address of Agent for Service of Legal Paper

Benefit Programs Administration
13191 Crossroads Pkwy N, Suite 205
City of Industry, CA 91746-3434
(562)595-6463 or (888)806-8942

Legal papers may also be served on any Trustee or the Board of Trustees.

Names and Addresses for Trustees as of February 1, 2014 are:

Labor Trustees

Samuel Bowers
I.A.T.S.E. 504
671 South Manchester Ave
Anaheim, Ca 91802

Tom Lane
I.A.T.S.E. 504
671 South Manchester Ave
Anaheim, Ca 91802

Loren Thies
I.A.T.S.E. 504
671 South Manchester Ave
Anaheim, Ca 91802

Management Trustee

Matt Curto
c/o Benefit Programs Administration
13191 Crossroads Pkwy N, Suite 205
City of Industry, CA 91746-3434

Jim Spivey
Segerstrom Center for the Arts
600 Town Center Drive
Costa Mesa, CA 92626

Description of Collective Bargaining Agreements

The Plan is funded entirely from employer contributions except for voluntary self-payments. Employers make contributions for bargaining unit employees as required by the term of the Collective Bargaining Agreements.

All contributions are paid to the I.A.T.S.E Local 504 Health and Welfare Trust Fund.

Copies of the applicable Collective Bargaining Agreement under which the Eligible Individual is covered will be furnished by the Trustees, upon written request addressed to the Administrative Office. The Trustees may impose a reasonable charge for copying costs. Also, copies are available for examination at the Administrative Office or the Union Office.

Participation, Eligibility and Benefits

For a description of the Participation and Eligibility requirements, see pages 8 through 12 of this Summary Plan Description.

Circumstances Which May Result in Disqualification, Ineligibility, or Denial, Loss, Forfeiture, Suspension of Benefits

There are some circumstances under which an Eligible Individual can lose his eligibility for benefits. A summary of these circumstances is included on pages 8 through 12 of this Summary Plan Description.

Source of Contributions

Contributions are made by the Participating employers.

Employer contributions are calculated on the basis of hours worked by employees under the Collective Bargaining Agreement.

Entities Used for Accumulation of Assets and Payment of Benefits

All employer contributions are received and collected by the Fund and deposited with Comerica Bank. The money is then used to pay premiums to the insurance carriers and providers of services, to pay the expenses of administration and to provide reserves. The Fund carriers and providers of services are as follows:

For Life Insurance and Accidental Death and Dismemberment

Union Labor Life Insurance Company
1625 Eye St. N.W.
Washington, D.C. 20006
Telephone (800) 431-5425

For Medical Benefits

Health Net –HMO/Vision Plan – Customer Service

HMO Customer Service – (800) 522-0088
Vision Member Service - (866)392-6058
Pharmacy Help Line - (800) 600-0180
Mental Health Member Service (800) 526-6657

Health Net – HMO Plan – Corporate Address
P.O. Box 9103
Van Nuys, CA 91409-9103

Kaiser Foundation Health Plan
Claims Administration Department
P.O. Box 7004
Downey, California 90242-7004
Telephone: (800) 464-4000

For Dental Benefits

DeltaCare USA
12898 Towne Center Dr
Cerritos, CA 90703-8579
Telephone: (800) 422-4234

Plan Year

The Plan has a fiscal year beginning July 1 and ending June 30.

This represents is a summary of benefits. The Plan's contracts with insurance providers, other health service providers providing benefits under the Plan, the Administrative Office, plan consultant, counsel, auditor and investment manager, the Trust Agreement, Collective Bargaining Agreements providing for contributions to the Plan, and all filings required by the state and federal governments are hereby incorporated by reference and are available for inspection by Plan Eligible Individuals and union or employer representatives at the Administrative Office upon reasonable notice.

A complete list of employers maintaining this Plan is available for examination at the Administrative Office or your local union office. A copy may be obtained upon written request to the Administrative Office. A charge may be made by the Administrative Office to provide you with this information.

No health care provider is an agent or representative of the Plan or of the Board of Trustees. The Plan does not control or direct the provision of health care services and/or supplies to Plan Eligible Individuals and beneficiaries by anyone. The Plan makes no representation or guarantee of any kind that any provider will furnish health care services or supplies that are malpractice-free.

The foregoing statement applies to any and all health care providers, including Health Maintenance Organizations, preferred and non-preferred providers under the terms of the Plan. The statement also applies to all entities (and their agents, employees and representatives) which contract with the Plan to offer Health Maintenance Organizations, preferred provider networks, or health-related services or supplies to Eligible Individuals and beneficiaries.

Nothing in this Plan affects the ability of a provider to disclose alternative treatment options to an Eligible Individual or beneficiary.

ERISA RIGHTS

As an Eligible Individual in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Eligible Individuals are entitled to examine, without charge, at the administrative office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions. Copies of these documents and other Plan information may also be obtained upon written request to the Administrative Office; a reasonable charge may be made for the copies. Plan Eligible Individuals also are entitled to receive a summary of the Plan's annual financial report. The joint Board is required by law to furnish each Eligible Individual with a copy of this summary annual report.

In addition to creating rights for Plan Eligible Individuals, ERISA imposes duties upon the people who are responsible for the operation of this 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 Eligible Individuals 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. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial, and you have the right to have the Plan review and reconsider your claim, as described previously in this Summary.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials as provided above and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and to pay up to $100 per day until you receive the materials, unless the materials were not sent because of reasons beyond the joint Board's control. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The Court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Fund Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), 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.

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Background. This Notice of Privacy Practices applies to participants of the I.A.T.S.E. Local 504 Health & Welfare Trust Fund as of September 23, 2013

A. Medical Plan for I.A.T.S.E. Local 504 Health & Welfare Trust Fund Active Participants – includes the following plans: Health Net HMO Hospital-Medical-Surgical-Prescription Drug Plan and Kaiser HMO Deductible Plan Hospital-Medical-Surgical-Prescription Drug Plan

B. Dental Plan for I.A.T.S.E. Local 504 Health & Welfare Trust Fund Active Participants – includes the following plan: Delta Care HMO Plan

C. Vision Plan for I.A.T.S.E. Local 504 Health & Welfare Trust Fund Active Participants – includes the following plans: Health Net Vision Plan PPO and Kaiser-Vision Essentials

Any reference in this notice to "the Plan" is to each of the foregoing health care plans under which you are covered. All of the health care plans are members of an organized health care arrangement ("OHCA"). All OHCA members will abide by the terms of this Notice.

The Notice describes how the Plan may use and disclose your protected health information. This Notice also sets out the Plan's legal obligations concerning your protected health information and describes your rights to control and access your health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act. This Notice has been drafted in accordance with the HIPAA Privacy Rule, contained in the Code of Federal Regulations at 45 CFR Parts 160 and 164. Terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule.

Questions and Further Information. If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact the Administrative Office using the Contact Information provided at the end of this Notice.

THE PLAN'S RESPONSIBILITIES

The Plan is required by law to maintain the privacy of your protected health information and provide you with certain rights with regard to your protected health information. It is obligated to provide you with a copy of this Notice setting forth the Plan's legal duties and its privacy practices with respect to your protected health information. The Plan must abide by the terms of this Notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following is a description of when the Fund is permitted or required to use or disclose your protected health information.

Payment and Health Care Operations. The Fund has the right to use and disclose your protected health information for all activities that are included within the definitions of "payment" and "health care operations" as defined in the HIPAA Privacy Rule.

Payment. The Fund will use or disclose your protected health information to fulfill its responsibilities for coverage and providing benefits as established under the Plan. For example, the Fund may disclose your protected health information when a provider requests information regarding your eligibility for benefits under the Plan or it may use your information to determine if a treatment that you received was medically necessary.

Health Care Operations. The Fund will use or disclose your protected health information to support the Fund's business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, business planning, and business development. For example, the Fund may use or disclose your protected health information: (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; (iii) in connection with fraud and abuse detection and compliance programs, or (iv) to survey you concerning how effectively the Fund is providing services, among other issues.

Business Associates. The Fund contracts with service providers – called business associates – to perform various functions on its behalf. For example, the Fund may contract with a service provider to perform the administrative functions necessary to pay your medical claims. To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after the Fund and the business associate agree in writing to contract terms requiring the business associate to appropriately safeguard your information.

Organized Health Care Arrangement. The OHCA members may share your protected health information with each other to carry out payment and health care activities.

Other Covered Entities. The Fund may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain health care operations. For example, the Fund may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and the Fund may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing, or credentialing. This also means that the Fund may disclose or share your protected health information with other health care programs or insurance carriers (such as Medicare, Health Net, Kaiser etc.) in order to coordinate benefits, if you or your family members have other health insurance or coverage.

Required by Law. The Fund may use or disclose your protected health information to the extent required by federal, state, or local law.

Public Health Activities. The Fund may use or disclose your protected health information for public health activities that are permitted or required by law. For example, it may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Fund also may disclose protected health information, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight Activities. The Fund may disclose your protected health information to a health oversight agency for activities authorized by law. For example: these oversight activities may include audits, investigations, inspections, licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and government agencies that ensure compliance with civil rights laws.

Lawsuits and Other Legal Proceedings. The Fund may disclose your protected health information in the course of any judicial or administrative proceeding or in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized). If certain conditions are met, the Fund may also disclose your protected health information in response to a subpoena, a discovery request, or other lawful process.

Abuse or Neglect. The Fund may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, if the Fund believes you have been a victim of abuse, neglect, or domestic violence, it may disclose your protected health information to a governmental entity authorized to receive such information.

Law Enforcement. Under certain conditions, the Fund also may disclose your protected health information to law enforcement officials for law enforcement purposes. These law enforcement purposes include, by way of example: (1) responding to a court order or similar process; (2) as necessary to locate or identify a suspect, fugitive, material witness, or missing person; or (3) as relating to the victim of a crime.

To Prevent a Serious Threat to Health or Safety. Consistent with applicable laws, the Fund may disclose your protected health information if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. It also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military. Under certain conditions, the Fund may disclose your protected health information if you are or were, Armed Forces personnel for activities deemed necessary by appropriate military

command authorities. If you are a member of foreign military service, the Fund may disclose, in certain circumstances, your information to the foreign military authority.

National Security and Protective Services. The Fund may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

Workers' Compensation. The Fund may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Disclosures to the Plan Sponsor. The Fund (or its health insurance issuers or HMOs) may disclose your protected health information to the Trustees of the I.A.T.S.E. Local 504 Health & Welfare Trust Fund and Benefit Programs Administration Personnel. The Plan Sponsor has amended the relevant Plan documents as required by the HIPAA Privacy Rule in order to receive your protected health information from the Plan.

Others Involved in Your Health Care. The Fund may disclose your protected health information to a friend or family member that is involved in your health care. The Fund also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then, using professional judgment, the Fund may determine whether the disclosure is in your best interest.

Disclosures to the Secretary of the U.S. Department of Health and Human Services. The Fund is required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Fund's compliance with the HIPAA Privacy Rule.

Disclosures to You. The Fund is required to disclose to you or your personal representative most of your protected health information when you request access to this information. The Fund will disclose your protected health information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant law. Prior to such a disclosure, however, the Fund must be given written documentation that supports and establishes the basis for the personal representation. The Fund may elect not to treat the person as your personal representative if it has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person, treating such person as your personal representative could endanger you; or the Fund determines, in the exercise of its professional judgment, that it is not in your best interest to treat the person as your personal representative.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide the Fund with an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and

disclosures of protected health information. However, the revocation will not be effective for information that the Fund has used or disclosed in reliance on the authorization.

CONTACTING YOU

The Fund (or its health insurance issuers, HMOs, or third-party administrators) may contact you about treatment alternatives or other health benefits or services that might be of interest to you.

YOUR RIGHTS

The following is a description of your rights with respect to your protected health information:

Right to Request a Restriction. The HIPAA Privacy Rule provides that you may request a restriction on the protected health information the Fund uses or discloses about you for payment of health care operations. It also provides that you have a right to request a limit on disclosures of your protected health information to family members or friends who are involved in your care or the payment for your care. The Fund is not required to agree to any such restrictions that you request, and currently it is the policy of the Fund not to agree to any such restrictions.

Right to Request Confidential Communications. If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that the Fund communicate with you in an alternative manner or at an alternative location. For example: you may ask that all communications be sent to your work address. You may request a confidential communication using the Contact Information at the end of this Notice. Your request must specify the alternative means or location for communication with you. It also must state that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger. The Fund will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your protected health information could endanger you.

Right to Request Access. You have the right to inspect and copy protected health information that may be used to make decisions about your benefits. You must submit your request in writing. For your convenience, you may request a form using the Contact Information at the end of this Notice. If you request copies, the Fund may impose reasonable copy charges (which may include a labor charge), as well as postage if you request copies be mailed to you. Note that under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some, but not all, circumstances, you may have a right to have this decision reviewed.

Right to Request an Accounting. You have the right to request an accounting of certain disclosures the Fund has made of your protected health information. You may request an accounting using the Contact Information at the end of this Notice. You can request an accounting of disclosures made up to six years prior to the date of your request, except that the Fund is not required to account for

disclosures made prior to April 14, 2003. You are entitled to one accounting free of charge during a twelve-month period. There will be a charge to cover the Fund's costs for additional requests within that twelve-month period. The Fund will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

Right to be Notified of a Breach. You have the right to be notified in the event that the Fund (or a Business Associate of the Fund) discovers a breach of unsecured protected health information.

COMPLAINTS

If you believe the Fund has violated your privacy rights by, for example, denying your request to access or amend your protected health information, you may complain to the Fund or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the Fund using the Contact Information at the end of this Notice. The Fund will not penalize or in any other way retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE

The Fund reserves the right to change the provisions of this Notice and make the new provisions effective for all protected health information that it maintains. If the Fund makes a material change to this Notice, it will provide a revised Notice to you at the address that the Fund has on record for the participant enrolled in the Plan.

EFFECTIVE DATE

This Notice of Privacy Practices is effective September 23, 2013.

ADDRESS AND CONTACT FOR PRIVACY OFFICER

The Trustees of the I.A.T.S.E. Local 504 Welfare Trust Fund have appointed the following Privacy Officer:

Mr. Edward Simon, Vice President
c/o Benefit Programs Administration
13191 Crossroads Parkway North, Suite 205
City of Industry, CA 91746
(562) 595-6463

COMPARISON OF MEDICAL PLANS 2014

I.A.T.S.E. LOCAL 504 HEALTH & WELFARE TRUST FUND Open Enrollment – Medical Plan Options February 1, 2014		
	Health Net	**Kaiser**
Benefits	**HMO**	**HMO**
Allergy testing	$0 copay	$0 copay
Chiropractic care	Not covered	Not covered
Choice of providers	Health Net HMO only	Kaiser only
Deductibles – Calendar year	None	$1,000/CY, $2,000 family (applies to certain services)
Hospital/ambulatory surgical	$500/day, 4 days maximum deductible	20% coinsurance after CY deductible
Non-certification	Not applicable	Not applicable
Failure to obtain prior auth	Not applicable	Not applicable
Diagnostic X-ray/lab (MRI, CT, PET scans)	No charge preventive; MRI, CT, PET, MUGA, scans are $100 copay per procedure	No charge ispreventive$10/ encounter, no deductible. MRI, CT, PET scans are $50 per procedure with no deductible
Durable medical equipment	No Charge for diabetic supplies, nebulizers, facemasks and tubing for asthma; $5,000 max/CY; orthotics not covered	$20% with no deductible
Emergency room	$100 copay, waived if admitted	20% coinsurance after CY deductible
Hearing Aids	Not covered	Not covered
Home health services	No copay; $20/visit starting with the 31st calendar day after the 1st visit; 100 visit/CY	No copay, no deductible
Hospice	No copay	No copay and no deductible
Hospital	$500/day, 4 days maximum deductible	20% coinsurance after CY deductible
Lifetime maximum	Unlimited	Unlimited
Maternity care	$20/visit for elective abortion - $150; hospital same as other illnesses	same as any other illness
Mental health –	MHN for authorization	Prior author may be req'd
Inpatient	$500 copay	20% coinsurance after CY deductible
Outpatient	$20 copay	$20/visit – individual; $10

I.A.T.S.E. LOCAL 504 HEALTH & WELFARE TRUST FUND Open Enrollment – Medical Plan Options February 1, 2014		
	Health Net	**Kaiser**
Benefits	**HMO**	**HMO**
		group
Out-of-pocket maximum	$2,000/person, 3/family	$3,000/person; $6,000/family
Outpatient services – Chemotherapy	No copay	refer to EOC
Renal dialysis	No copay	refer to EOC
Outpatient surgery	$500 copay	20% coinsurance after CY deductible
Physician services – Hearing screenings	$20 copay	No copay, no deductible
Home visits	$40 copay/visit	refer to EOC
Hospital services	No copay	20% coinsurance after CY deductible
Office visits	$20 copay	$20 copay
Routine physicals	No copay	No copay, no deductible. Well child – No copay to age 24 months
Specialists	$20 copay	$20 copay, no deductible
Surgical services – outpatient	No copay	20% coinsurance after deductible
Physical and occupational therapy	$20 copay	$20 per visit with no deductible
Pre-existing condition	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions
Prescription drugs – Retail –	up to 30-day supply	30-day supply
Generic	$10 copay	$10 copay
Brand formulary	$25 copay	$30 copay
Non-formulary	$35 copay	$30 copay
Mail Order –	up to 90-day supply	100-day supply
Generic Brand formulary	$20 copay $50 copay	$20 copay $60 copay
Non-formulary	$70 copay	$60 copay
Skilled nursing facility	No copay through day 10, $25 copay per day for days 11 through 100	20% coinsurance
Maximum inpatient days	100 days/ CY	100 days/ benefit period
Speech therapy	$20 copay/ visit	$20/visit
Substance abuse – Rehab –		
Inpatient	$500 copay	20% coinsurance after CY deductible

I.A.T.S.E. LOCAL 504 HEALTH & WELFARE TRUST FUND Open Enrollment – Medical Plan Options February 1, 2014		
	Health Net	**Kaiser**
Benefits	**HMO**	**HMO**
Outpatient	$20 copay individual, $10 copay group	$20/visit
Detox –		
Inpatient	$500 copay	20% coinsurance after CY deductible
Outpatient	$20 copay individual, $10 copay group	$20/visit individual, $5 group
Transplant Services	$0 copay with prior authorization; see EOC for limitations	Refer to EOC
Urgent care	$20/visit; copay waived if admitted	$20/visit
Vision	$10 copay per exam; $25 copay for lenses/frames. $100 frame allowance; exam every 12 months and lenses/frames every 24 months	$20 per exam; $175 allowance for lens, frames and contacts every 24 months

Note: This is only a brief summary of your benefits. Refer to the carrier's EOC for details of the plans.