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

SUMMARY PLAN DESCRIPTION

PLAN DOCUMENT

AS OF SEPTEMBER 1, 2018

Si tiene alguna pregunta o si necesits ayuda comuniquese con la Oficina Administrativa en (888) 806-8942

INTRODUCTION

The I.A.T.S.E. Local 504 Health and Welfare Trust Fund ("Fund" or "Plan") 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 are not vested; they 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 provisions of the Evidences of Coverage (EOC) as provided by the HMOs, which provide your benefits. ***The SPD contains all Plan changes as of September1, 2018 and is the governing Plan Document of the Fund to the extent it discusses eligibility and termination of eligibility.***

Please review the EOCs of the appropriate HMO to see the benefits available to you from that HMO. The EOCs govern with respect to the benefits provided under the Fund.

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

1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA. 90017
Office: (562) 463-5000
Toll free: (888) 806-8942
Email: dora@bpabenefits.com

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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 Trust Agreement, this Summary Plan Description (SPD), 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 SPD, 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.

"**Benefit Quarter**." The three month period during which the Employee is eligible for coverage based on the hours accrued in the prior Eligibility Quarter.

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 or physical disability (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 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 old 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; provided such Employee satisfies the rules for eligibility for benefits established by the Board of Trustees.

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

"**Eligibility Quarter**" means the 3 month period during which an employee must accrue the minimum hours to gain coverage during the following Benefit Quarter.

"**Individual Employer.**" The term Individual Employer means any Individual Employer who is required by any of the Collective Bargaining Agreements to make contributions to this 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), or as 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 of "Board of Trustees" means any persons designated as Trustees 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 as an Employee on the first day of the month after you work 400 hours during six rolling months for any Individual Employers who are signed to an agreement with the Union and paid health and welfare contributions to this Fund. The initial hours accrued during the six months shall become the employee's reserve account (bank) out of which the first Benefit Quarter's eligibility hours of 300 hours will be deducted.

CONTINUING ELIGIBILITY

You will maintain eligibility for benefits provided the health and welfare contributions received for your work during an Eligibility Quarter total at least 300 hours (the cost for benefits in the following Benefit Quarter).

Buy Up Option Rule and Self-Payments to Continue Eligibility

You will maintain eligibility for benefits provided the health and welfare contributions received for your work during an Eligibility Quarter total at least 300 hours (the cost for benefits in the following Benefit Quarter).

If your hours contributions during an Eligibility Quarter total less than 300 hours, but are at least 150 hours, you may maintain your eligibility during the subsequent Benefit Quarter provided you pay the Fund the applicable rate per hour (currently $4.75) for the number of hours necessary to bring your Eligibility Quarter hours up to 300 hours for the following Benefit Quarter. You can continue coverage under this rule for only two consecutive Benefit Quarters.

For example, if you have 160 hours reported in an Eligibility Quarter, you would pay $4.75 times 140 hours or $665.00 for the Eligibility Quarter. All self-payments are due and payable upon receipt of 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 Bank Reserve Hours has fewer hours than the number required for coverage. After one year, residual hours will be cancelled and the money will revert to the Fund.

Eligibility Table for Continuing Eligibility

After Initial Eligibility If You Work 300 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 worked in excess of 300 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.

REHIRE RULE

The Trustees have adopted a new rehire rule that allows an Employee to requalify for eligibility sooner than as a new employee.

For Employees who became eligible, but subsequently lost eligibility, they may requalify within one year of losing such eligibility provided they exhaust their ability to buy up their Reserve Bank within the year and provided they work at least 300 hours within any Eligibility Quarter within the year to requalify for their benefits. If the employee is unable to work 300 hours within any Eligibility Quarter within the 12 month period, then they will need to requalify under the "Initial Eligibility For New Employees" rules above.

BENEFITS FOR EMPLOYEES

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

You may be able to continue your coverage if you are disabled or under COBRA continuation, FMLA or USERRA. See pages 12 through 17 for additional information.

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; thereafter they will be offered an extension of coverage under COBRA. See page 12.

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 you are unable to work at your normal job due to an injury or illness.

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.

   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's 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 that was in effect immediately before his military 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 COBRA section. 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. FMLA also permits 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.

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.

TERMINATION OF COVERAGE FOR EMPLOYEES

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 benefit period for which the last contribution was made on your behalf; or

3. The date your Individual Employer ceases contributing to the 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.

7. The date coverage under the Buy Up rules is exhausted.

8. The date coverage under the Disability Extension is exhausted.

COBRA coverage may be available if you have lost coverage.

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 they are then a dependent. 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(s) 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 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

The Fund recognizes Qualified Medical Child Support Orders (**"**QMCSOs**")**, and enrolls any child of an Employee 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 an Employee with child support or health benefits under the Trust; or

- enforces a state law relating to medical child support, 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 Employee 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.

Upon receipt of a Medical Child Support Order, the Fund will notify the Employee and each child of the receipt of the Order and the Trust's procedures for determining whether the Medical Child Support Order is qualified.

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 will make such a determination within a reasonable period, and notify the Employee and each child of the determination. If the Order is a qualified Order, the child will be enrolled in the Plan.

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, 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 day 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.

NOTE: Even if your child is born and the birth was paid for by the medical plan covering you and your spouse, you must enroll the child to be eligible for benefits. Failure to enroll the new born within 30 days may result in no coverage for the child.

If your Dependent becomes eligible for Medicare and you remain actively at work, 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, be terminated.

TERMINATION OF COVERAGE FOR DEPENDENTS

Dependent coverage will cease upon the earliest of:

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

2. The last day 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 unless mandated by law; or

4. The date the Plan terminates; or

5. The date the Domestic Partnership ceases; or

6. The date a divorce becomes final; or

7. The date the coverage for your dependents ceases under the rules if the employee's coverage is being extended as a result of disability.

When coverage ends, you may qualify for continued coverage under COBRA (see below). 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**)

CONTINUATION COVERAGE RIGHTS UNDER COBRA

COBRA continuation coverage is a temporary extension of coverage under the Plan. 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
1200 Wilshire Blvd, Fifth Floor
Los Angeles, CA 90017
(562) 463-5000
(888) 806-8492

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, Employees, their spouses and the dependent children of 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 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 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 Employee dies;

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

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

(4) The parent 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

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund 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 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 in writing 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
1200 Wilshire Blvd, Fifth Floor
Los Angeles, CA 90017
(562) 463-5000
(888) 806-8492

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's Notification Requirements

Once the Fund 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 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 (see below).

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 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 written notice should be sent to:

I.A.T.S.E Local 504 Health and Welfare Trust Fund
c/o Benefit Programs Administration – COBRA
1200 Wilshire Blvd, Fifth Floor
Los Angeles, CA 90017
(562) 463-5000
(888) 806-8492

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.coveredca.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 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 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
1200 Wilshire Blvd, Fifth Floor
Los Angeles, CA 90017
(562) 463-5000
(888) 806-8492

Depending upon the type of qualifying event, you will be required to provide: a copy of your divorce decree or legal separation or a certified copy of the death certificate You must also provide notice of 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 or vision 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
1200 Wilshire Blvd, Fifth Floor
Los Angeles, CA 90017
(562) 463-5000
(888) 806-8492

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 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.

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.

LIFE INSURANCE
(EMPLOYEE ONLY)

Life Insurance is provided by the Fund for you through The Union Labor Life Insurance Company (Union Labor Life) 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 are not covered under 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 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 for processing and your beneficiary will be sent a claim form for completion. Union Labor Life will pay benefits upon receipt of due proof of loss, but may at its own cost, require an autopsy where legal.

For a complete copy of the policy, setting out the terms and provisions of your life insurance with Union Labor Life, you may download a copy from the Fund's website: www.iatse504welfare.org or request a copy from the Administrative Office.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (EMPLOYEE ONLY)

Accidental Death and Dismemberment Insurance is provided by the Fund for you through Union Labor Life 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 18).

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. any attempt at suicide or intentionally self-inflicted injury, while sane or insane;
2. war or any act of war;
3. active participation in a riot, insurrection, or terror activity;
4. committing or attempting to commit a felony;

5. the Person's voluntary intake of any drug unless prescribed by a physician and taken in accordance with the physician's instructions or any poison, gas, or fumes unless they are the direct result of an occupational accident;
6. being intoxicated as defined by the jurisdiction where the loss occurred;
7. being engaged in an illegal occupation; or
8. engaging in aviation other than as a fare-paying passenger.

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 for processing and you or your beneficiary will be sent a claim form for completion. Union Labor Life 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, at its own cost, may require an autopsy where legal.

MEDICAL BENEFITS OPEN ENROLLMENT

AND

DENTAL ENROLLMENT REQUIREMENT

Medical Plan Choices and Enrollment
(Summary medical schedules are included at the end of this SPD)

IF YOU DO NOT ENROLL IN A MEDICAL PLAN OPTION, YOU WILL NOT BE COVERED FOR MEDICAL. You must enroll yourself and your dependents in the medical plan you choose in order to be covered.

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

1. Kaiser Foundation Health Plan (HMO); or

2. Health Net (HMO)

The Fund covers the cost for the medical plan regardless of which provider you select, provided you timely submit a completed enrollment form.

Dental Enrollment Requirement

(A Sample of Copayments under the Prepaid Dental Plan is included at the end of this SPD)

IF YOU DO NOT ENROLL IN THE DENTAL PLAN YOU WILL NOT BE COVERED FOR DENTAL. You must enroll yourself and your dependents in the dental plan in order to be covered.

1. **Currently the Fund contracts with Delta Dental for prepaid dental coverage (DHMO).** You are not required to make a self-payment for dental coverage under the prepaid plan but you must enroll and elect coverage from one of the providers for services. This dental plan includes orthodontia benefits.

   You must receive all of your dental care from the provider you select otherwise you must pay for all of your dental work.

Important Information for Medical and Dental Coverage

Only you can decide which of the medical 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 you and all of your Dependents. The Eligibility Rules established by the Board of Trustees shall prevail, regardless of coverage selected.

To enroll in the medical HMOs you must live or work within 30 miles from of the Dental or Medical Group's facilities and you **must** receive all services at facilities associated with that Medical 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. **.**

Schedules of benefits 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. You can also request a copy of the Evidence of Coverage from the HMO to review the complete document, setting out the benefits, exclusions and limitations of the applicable plan of benefits. Whichever plans 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 (GINA)

The Genetic Information Nondiscrimination Act (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 (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 (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.

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

Since your benefits are provided through Health Maintenance Organizations (HMOs) as set out in the Evidences of Coverage (EOCs), you will receive notice of the benefits available to you from the HMO. The Board of Trustees wants to remind you that you must follow the procedures for claims that apply to the HMO. If you have any questions about your rights, please contact the HMO 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 HMO is providing your coverage.

DENTAL BENEFITS

Dental benefits are provided by the Fund for you and your Dependents through Delta Dental of California. ***Enrollment in a dental plan is required if you want coverage for yourself and your dependents.***

The Prepaid Dental Plan (DeltaCare) DHMO

- The prepaid DHMO dental benefits require you to enroll for coverage, select a dental provider and receive all of your dental care from the dentist you have selected.
- The prepaid dental plan has no deductible or annual maximum and it does have an orthodontia benefit.
- Most procedure require you to pay a flat amount for the services (see samples in th schedule at the end of this booklet)

At the end of this SPD, a table summarizes copays for dental benefits under the prepaid dental plan.
A Schedule of benefits, detailing the benefits, exclusions and limitations will be provided to you by Delta Dental of California, and is available on the IATSE Local 504 web site or can be obtained from the Administrative Office. There is no charge for the information. Make sure you and your Dependents read the Schedule of benefits 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 the Fund's 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 its contract with EyeMed Vision Care but you can also get a vision exam under the Health Net medical plan at the regular office visit copay (currently $20).

However, if you are using the EyeMed vision plan for your eye exam (rather than the Health Net medical plan), your copay is only $10 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:

Health Net (Eye Med Vision Care)

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

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.

Act of Third Parties - Third Party Liability

When you or your covered Dependent are injured or become ill because of the actions or inactions of a third party, the Trust will cover your health care expenses. However, you must notify the Fund or the HMO that your illness or injury was caused by a third party and must follow the rules of the Fund or HMO. Each has their own rules which set out the conditions under which benefits will be provided to you and your obligations to repay either the Fund or the HMO from any recovery you receive as a result of the third party injury. Please note, in the event the amount of benefits expended on your behalf is not repaid from your recovery from a third party, the Trust or the HMO may have the right to recover the amount paid and to recoup any unpaid amount by withholding payment, if necessary, of future benefits until the amount is recovered from you. If you have any questions regarding your obligations please contact the Administrative Office at (888) 806 8942- or your HMO whose name and address is listed on the next page.

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
Appeals & Grievance
PO Box 10348
Van Nus, CA 91410
Telephone: (800) 522-0088

Health Net Claims
PO Box 14702
Lexington, KY 40512
800 522-0088

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

Kaiser Foundation Health Plan
Member Service Contact Center
PO Box 7012
Downey, California 90242-7004
(800) 464-4000

For the Dental Plan, you may contact:

Delta Dental of California
DeltaCare USA/Claims Department
P.O. Box 1810 Alpharetta, GA 30023
Telephone: (800) 422-4234

Email: Cs-deltacare@delta.org
Web site: www.deltadentalins.com

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

The Union Labor Life Insurance Company
8403 Colesville Road
Silver Spring, MD 20910
Telephone (800) 431-5425

All claims for benefits must be submitted to 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

Generally, claims for medical benefits under the Plan will be processed by the HMO, 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 medical claims that your HMO may review under this Plan. A general description of these claims and the benefit determination time period are described below, but you must review the EOC of your HMO to insure you are following the HMO's claims and procedures to grieve your disputes:

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.

Benefits Unpaid at Death – Incompetency

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.

Eligibility and Life and AD&D Claims

For all eligibility claims and claims for life insurance and accidental death and dismemberment benefits, a written appeal may be filed within 60 days of notice of a claim denial.

Your appeal regarding eligibility will be decided by the next regularly-scheduled meeting of the Board of Trustees scheduled at least 30 days after your written appeal is received. If special circumstances require additional time to process your appeal, you will be notified of those circumstances, and a decision will be made no later than the third meeting following receipt of your written appeal.

If your appeal is denied, you will receive written (or electronic as permitted by law) notice, including the specific reasons, reference to the specific plan provisions, and you may have access to all records that were used in reaching the decision.

Appeals

1. **General Appeal Procedures** - The following appeals procedures generally apply to all claims for benefits through your HMO:

    a. You have 180 days to appeal a claim denial after your initial claim is denied.

    b. No deference will be given to the initial claim denial. Your appeal will be decided by individuals who did not take part in the claim denial and who are not subordinates of such persons.

    c. If your claim involves a medical judgment, a health care professional trained in the relevant field will be consulted. That professional will be one who did not take part in your claim denial and who is not a subordinate of such a person. You may also request the names of medical professionals who gave advice on your claim denial.

    d. Note that if you appeal a denial of a claim for, the HMO hears your appeal. However you

may seek the assistance of the Board in dealing with the HMO. Your appeal will be decided by the next regularly-scheduled meeting of the Board of Trustees scheduled at least 30 days after your written appeal is received. However, the Plan may extend this schedule if special circumstances require. In that case, you will be notified in writing of the extension, the reasons for it, and the date of the Board meeting. Your appeal may be may be held up to three regularly scheduled Board meetings following receipt of your appeal. The Administrator will inform you of the Board's decision within the five days that follow it.

e. You will be informed of an interim decision and have an opportunity to respond before the determination is final.

2. **Urgent Care Appeals** - For urgent care claims, you may make a request for an expedited appeal, orally or in writing, and all necessary information may be exchanged by telephone, facsimile or other expeditious method. Appeals for urgent care claims will be decided as soon as possible, but not later than 72 hours after receipt of the appeal.

3. **Pre-service Appeals** - Appeals of claims made before treatment will be decided within a reasonable period of time, but not later than 30 days.

4. **Contents of Appeals Denials** - If your appeal is denied, you will receive written (or electronic as permitted by law) notice, including the specific reasons, reference to the specific plan provisions, and you may have access to all records that were used in reaching the decision.

   If any internal rule, guideline, protocol or other similar criterion was used in the appeal denial, you will be told about it and may have a copy of it.

   You will receive a reminder that the Plan will provide you, upon request, with free copies of all documents, records, or other information relevant to your claim and appeal.

   If the denial is based on medical necessity or experimental treatment or the like, you may have a copy of whatever scientific or clinical explanation was used in the determination.

   The appeal denial will also provide the following disclosure, as required by law: "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."

5. **Limitation Period in which to File a Lawsuit** - If you are not satisfied with the decision made on your appeal, you may file a lawsuit in federal court against the Plan. However, you must complete the appeals process to the Trustees and receive a final written denial notice of your appeal before you file a lawsuit. You will waive your rights to file a lawsuit against the Trust, unless you do so **within 24 months** after you complete the appeals process and the Fund denies your claim.

Reviewing a Denied Claim Externally

1. **In General** - You may have the right to appeal any adverse claim decision to an independent third party after completing an "internal" appeal, as described above. An "external" review is handled by an independent review organization (IRO), which is independent from the Plan and is not bound to the Plan's findings, as described in this section.

   External review is only available for: (a) claims that involve medical judgment (including the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or the Plan's determination that a treatment is experimental or investigational); and (b) rescissions of coverage.

   Generally, you must exhaust the internal claims and appeals procedure before an external review is available to you. However, in the event that completing an internal appeal would jeopardize your life, health, or ability to regain maximum function, you are entitled to apply for expedited external review.

   If the IRO reverses the Plan's benefit denial, the Plan must immediately provide coverage and payment for the reversed claim(s).

   There are two types of external review: standard and expedited.

2. **Standard External Review Procedures**

   a. **Dates to Request** - You may request external review within four months of receiving notice that your claim has been denied. In the event that there is no corresponding date four months after the date of such receipt (for example, Feb. 30th), you must file by the first day of the fifth month following receipt of your claim denial.

   b. **Initial Determination** - Within five days of receipt of the request, the Plan will make an initial determination whether you are eligible for Plan participation and have provided all the requisite paperwork for the appeal. Within one day after completing the initial determination, the Administrator will notify you of the results. If your request is incomplete, the notice will state why it is incomplete and allow you to correct it within 48 hours or by the end of the four month request period, whichever is later. If you are ineligible for Plan participation, the notice will state the reasons why you are ineligible and provide you contact information for the government agency that regulates plans like this one.

   c. **Referral** - If your request is complete, it will be forwarded to an IRO. To combat any bias, the IRO will be one of at least three that the Plan rotates external review requests between, none of which are eligible for any financial incentives from the Plan to support a denial of benefits to you.

   d. **Review by IRO** – The Plan's contract with the IROs that it refers requests for external review will provide that:

      i. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
      ii. The IRO will notify you of the request's eligibility and acceptance for review. That

notice will inform you that you may submit additional information that the IRO must consider for the review within 10 days of receiving the notice; after 10 days, the IRO is allowed, but not required, to review the information you send it.

iii. The Plan will send the IRO all the documents and other information it considered for your claim within five days of referring it the IRO. If the Plan fails to provide this information timely, the IRO may reverse the claim denial. If that happens, it will notify you within one day.

vi. The IRO will consider the documentation and provide a written notice of its determination to you and the Plan within 45 of receiving the referral.

e. **Notice from IRO** – The IRO's notice will contain:

i. A general description of the request for review and information sufficient to identify the claim (including dates of service, names of healthcare providers, the claim amount (if applicable), diagnosis codes and their corresponding meanings, treatment codes and their corresponding meanings, and the reason for the previous denial),

ii. The date the IRO received the request for external review and the date of the IRO's decision,

iii. Reference to specific evidence or documentation considered in reaching its conclusion,

iv. A discussion of the reason(s) for its decision,

v. Notification that the determination is binding, except that other remedies may be available to you or the Plan in court, and

vi. Contact information for the government agency that regulates plans like this one.

3. **Expedited External Review Procedures**

a. **Availability** - The Plan must provide for an expedited review if: (1) the time for a regular external review would seriously jeopardize your life or health or your ability to regain maximum function and you file a request for an expedited review, or (2) your claim involves an admission, availability of care, continued stay or healthcare service for which you received emergency services but have not been discharged from a facility.

b. **Initial Determination** – Immediately after receiving the request, the Plan will make an initial determination whether you are eligible for Plan participation and have provided all the requisite paperwork for the appeal. The Plan must then immediately notify you of the results. If your request is incomplete, the notice will state why it is incomplete and allow you to correct it within 48 hours or by the end of the four month request period, whichever is later. If you are ineligible for Plan participation, the notice will state the reasons why you are ineligible and provide you contact information for the government agency that regulates plans like this one.

c. **Referral** - If your request is complete, it will be expeditiously forwarded to an IRO, along with any documentation regarding your claim.

d. **Review by IRO** – Expedited review by the IRO has the same requirements as standard review, except that it must complete the review and provide its decision as expeditiously as possible, considering your medical needs. The process may not exceed 72 hours for notice in writing, or 48 hours if the notice is not in writing.

e. **Notice from IRO** – The content of the IRO notice must meet the same requirements as those for standard review.

Other Provisions

1. **Exhaustion of Remedies** – You may not bring a lawsuit for benefits or to enforce any rights under this Plan until you complete all of the following steps in accordance with the foregoing claims and appeals procedures:

   a. Submit a written claim for benefits,
   b. Receive written notice that the claim is denied (or the claim is deemed denied),
   c. File a written appeal for review, and
   d. Receive notice in writing that the appeal has been denied (or the appeal is deemed denied on review).

   You will waive your rights to file a lawsuit against the Fund, unless you do so **within 24 months** after you complete this appeals process and the Fund denies your claim.

2. **Trustee Discretion** - The Trustees have the exclusive right, power and authority in their sole and absolute discretion, to administer, apply and interpret this Plan and all other documents that describe the Plan and Trust Fund. The Trustees have discretionary authority and power to decide all matters arising in connection with the operation or administration of the Plan, including but not limited to: making factual findings, fixing omissions, resolving ambiguities, construing the terms of the Plan, making eligibility determinations, and resolving other disputes under the Plan. Except as described in these procedures, all determinations made by the Trustees with respect to any matter arising with regard to Plan benefits will be final and binding on all concerned. Any judicial review of any Trustee decision must be done in deference to the Trustees decision.

3. **Copies of These Procedures** - These procedures will be mailed to all Plan beneficiaries at the same time as Summary Plan Descriptions are mailed. Also, any beneficiary may request a copy of these procedures from the Plan Administrator at no charge.

RIGHT TO BRING A CIVIL ACTION:

If you are not satisfied with the decision made on your appeal, you may file a lawsuit in federal court against the Plan. However, you must complete the appeals process to the Trustees and receive a final written denial notice of your appeal before you file a lawsuit. You will waive your rights to file a lawsuit against the Trust, unless you do so **within 24 months** after you complete the appeals process and the Fund denies your claim.

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, Telephone Numbers, and Website 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
1200 Wilshire Blvd, Fifth Floor
Los Angeles, CA 90017
(562) 463-5000
(888) 806-8492
www.iatse504welfare.org

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 third party administrator.

Name, Address and Telephone Number of the Plan Administrator

Benefit Programs Administration
1200 Wilshire Blvd, Fifth Floor
Los Angeles, CA 90017
(562) 463-5000
(888) 806-8942

Name and Address of Agent for Service of Legal Paper

Benefit Programs Administration
1200 Wilshire Blvd, Fifth Floor
Los Angeles, CA 90017
(562) 463-5000
(888) 806-8942

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

Names and Addresses for Trustees as of September 1, 2018 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

William Clark
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 4 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 4 through 17 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

The 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 (888) 426-0030

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

Kaiser Foundation Health Plan
Member Service Contact Center
P.O. Box 7012
Downey, California 90242
Telephone: (800) 464-4000

For Dental Benefits

DeltaCare USA
Prepaid Dental Benefits
P.O. Box 1810
Alpharetta, GA 30023
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 $110 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 but only after first exhausting the claims and appeals procedures herein or through your HMO, if your claim involves benefits. In addition, if you disagree with the Plan’s decision or lack thereof concerning a medical child support order, you may file suit in federal court but only after first exhausting the claims and appeals procedures herein. 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 Administrative Office. 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, 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.

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 and vision Plan and Kaiser HMO Deductible Plan Hospital-Medical-Surgical-Prescription Drug Plan and vision benefits.

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

NOTICE OF PRIVACY PRACTICES

General Information About This Notice

The Plan is committed to maintaining the confidentiality of your private medical information. This Notice describes our efforts to safeguard your health information from improper or unnecessary use or disclosure and your privacy rights. This Notice only applies to health-related information created or received by or on behalf of the Plan. We are providing this Notice to you because privacy regulations issued under federal law, the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164 ("HIPAA"), require us to provide you with a summary of the Plan's privacy practices and related legal duties, and your rights in connection with the use and disclosure of your Plan information. We must follow the privacy practices that are described in this Notice while it is in effect.

In this Notice, the terms "Plan," "we," "us," and "our" refer to the Plan and third parties to the extent they perform administrative services for the Plan. When third party service providers perform administrative functions for the Plan, we require them to appropriately safeguard the privacy of your information.

Please note:

- ***If you are enrolled in an HMO you will also receive a separate notice from your HMO provider that describes the HMO provider's specific use and disclosure of your health information. Your rights with respect to their use and disclosure of your health information are set forth in that separate notice.***

Our Legal Duties

Federal law requires the Plan to have a special policy for safeguarding a category of medical information called "protected health information," or "PHI," received or created in the course of administering the Plan. PHI is health information that can be used to identify you and that relates to:

- ***your physical or mental health condition,***
- ***the provision of health care to you, or***
- ***payment for your health care.***

Your medical and dental records, your claims for medical and dental benefits, and the explanation of benefits ("EOBs") sent in connection with payment of your claims are all examples of PHI.

The remainder of this Notice generally describes our rules with respect to your PHI received or created by the Plan.

Uses and Disclosures of Your PHI

To protect the privacy of your PHI, the Plan not only guards the physical security of your PHI, but we also limit the way your PHI is used or disclosed to others. We may use or disclose your PHI in certain permissible ways described below. To the extent required under federal health information privacy law, we use the minimum amount of your PHI necessary to perform these tasks.

- ***To determine proper payment of your Health Plan benefit claims.*** The Plan uses and discloses your PHI to reimburse you or your doctors or health care providers for covered treatments and services. For example, your diagnosis information may be used to determine whether a specific procedure is medically necessary or to reimburse your doctor for your medical care.

- ***For the administration and operation of the Plan.*** We may use and disclose your PHI for numerous administrative and quality control functions necessary for the Plan's proper operation. For example, we may use your claims information for fraud and abuse detection activities or to conduct data analyses for cost-control or planning-related purposes.

- ***To inform you or your health care provider about treatment alternatives or other health-related benefits that may be offered under the Plan.*** For example, we may use your claims data to alert you to an available case management program if you are diagnosed with certain diseases or illnesses, such as diabetes.

- ***To a health care provider if needed for your treatment.***

- ***To a health care provider or to another health plan to determine proper payment of your claim under the other plan.*** For example, we may exchange your PHI with your spouse's health plan for coordination of benefits purposes.

- ***To another health plan for certain administration and operations purposes.*** We may share your PHI with another health plan or health care provider who has a relationship with you for quality assessment and improvement activities, to review the qualifications of health care professionals who provide care to you, or for fraud and abuse detection and prevention purposes.

- ***To a family member, friend, or other person*** involved in your health care if you are present and you do not object to the sharing of your PHI, or it can reasonably be inferred that you do not object, or in the event of an emergency.

- ***For Plan design activities or to collect Plan contributions.*** The Plan may use summary or de-identified health information for Plan design activities such as underwriting. If we do use de-identified information for obtaining healthcare services bids or Plan design, we will not use any of your genetic information. In addition, the Plan may use information about your enrollment or disenrollment in a Plan in order to collect contributions that pay for your Plan participation.

- ***To the Plan Sponsor.*** The Plan may disclose PHI to the Plan sponsor, the Board of Trustees, to the extent provided by a rule of the Plan, provided that the sponsor protects the privacy of the PHI and it is only used for the permitted purposes described in this Notice.

- ***To Business Associates.*** The Plan may disclose PHI to other people or businesses that provide services to the Plan and which need the PHI to perform those services. These people or businesses are called business associates, and the Plan will have a written agreement with each of them requiring each of them to protect the privacy of your PHI. For example, the Plan may have hired a consultant to evaluate claims or suggest changes to the Plan, for which he needs to see PHI.

- ***Special Rule for Psychotherapy Notes.*** We will not disclose your psychotherapy notes without your written authorization, except to your psychotherapist for treatment, for our training programs, and to defend ourselves in legal actions brought by you.

- ***To comply with an applicable federal, state, or local law,*** including workers' compensation or similar programs.

- ***For public health reasons,*** including (1) to a public health authority for the prevention or control of disease, injury or disability; (2) to a proper government or health authority to report child abuse or neglect; (3) to report reactions to medications or problems with products regulated by the Food and Drug Administration; (4) to notify individuals of recalls of medication or products they may be using; or (5) to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition.

- ***To report a suspected case of abuse, neglect or domestic violence,*** as permitted or required by applicable law.

- ***To comply with health oversight activities,*** such as audits, investigations, inspections, licensure actions, and other government monitoring and activities related to health care provision or public benefits or services.

- ***To the U.S. Department of Health and Human Services*** to demonstrate our compliance with federal health information privacy law.

- ***To respond to an order of a court or administrative tribunal.***

- ***To respond to a subpoena, warrant, summons or other legal request*** if sufficient safeguards, such as a protective order, are in place to maintain your PHI privacy.

- ***To a law enforcement official for a law enforcement purpose.***

- ***For purposes of public safety or national security.***

- ***To allow a coroner or medical examiner to make an identification or determine cause of death or to allow a funeral director to carry out his or her duties.***

- ***To respond to a request by military command authorities*** if you are or were a member of the armed forces.

- ***For cadaveric organ, eye or tissue donation.*** The Plan may use and disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

- ***For research.*** The Plan may use and disclose protected health information to assist in research activities, regardless of the source of the funding for the research, where a privacy board or an Institutional Review Board has approved an alteration to or waived entirely the authorization requirements of the law and the Plan receives certain specific representations and documentation.

- ***To avert serious threat to health or safety.*** The Plan may use and disclose protected health information to prevent or lessen a serious threat to health or safety of any one person or the general public and the use or disclosure is (1) to a person or persons reasonably able to prevent or lessen the threat to health or safety or (2) necessary for law enforcement authorities to identify or apprehend an individual.

- ***Incident to a permitted use or disclosure.*** The Plan may use and disclose protected health information incident to any use or disclosure permitted or authorized by law.

- ***As part of a limited data set.*** The Plan may use and disclose a limited data set that meets the technical requirements of 45 Code of Federal Regulations, Section 164.514(e), if the Plan has entered into a data use agreement with the recipient of the limited data set.

- ***For fundraising.*** The Plan may use and disclose certain types of protected health information to a business or to an institutionally related foundation for the purpose of

raising funds. The types of information that may be disclosed under this exception to the authorization requirement are: (1) demographic information relating to an individual and (2) dates of health care provided to an individual. The fundraising materials must inform you of how you may elect to opt out of receiving further fundraising communications that are healthcare operations. The entity that sends you such communications must treat your request to opt out as a revocation of your authorization to receive any such communications.

Absent your written permission, the Plan will only use or disclose your PHI as described in this Notice. The Plan will not access your PHI for reasons unrelated to Plan administration without your express written authorization.

If an applicable state law provides greater health information privacy protections than the federal law, we will comply with the stricter state law.

Other Uses and Disclosures of Your PHI

Before we use or disclose your PHI for any purpose other than those listed above, we must obtain your written authorization. You may revoke your authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI except as described above (or as permitted by any other authorizations that have not been revoked). However, please understand that we cannot retrieve any PHI disclosed to a third party in reliance on your prior authorization.

Your Rights

Federal law provides you with certain rights regarding your PHI. Parents of minor children and other individuals with legal authority to make health decisions for a Plan participant may exercise these rights on behalf of the participant, consistent with state law.

Right to request restrictions: You have the right to request a restriction or limitation on the Plan's use or disclosure of your PHI. For example, you may ask us to limit the scope of your PHI disclosures to a case manager who is assigned to you for monitoring a chronic condition. Because we use your PHI to the extent necessary to pay Plan benefits, to administer the Plan, and to comply with the law, it may not be possible to agree to your request. *Except in the limited circumstances described below, the law does not require the Plan to agree to your request for restriction.* Except as otherwise required by law (and excluding disclosures for treatment purposes), the Plan is obligated, upon your request, to refrain from sharing your PHI with another health plan for purposes of payment or carrying out health care operations if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. The Plan will not agree to any restriction, which will cause it to violate or be noncompliant with any legal requirement. If we do agree to your requested restriction or limitation, we will honor the restriction until you agree to terminate the restriction or until we notify you that we are terminating the restriction with respect to PHI created or received by the Plan in the future.

You may make a request for restriction on the use and disclosure of your PHI by completing the appropriate request form available from the Plan.

Right to receive confidential communications: You have the right to request that the Plan communicate with you about your PHI at an alternative address or by alternative means if you believe that communication through normal business practices could endanger you. For example, you may request that the Plan contact you only at work and not at home.

You may request confidential communication of your PHI by completing an appropriate form available from the Plan. We will accommodate all reasonable requests if you clearly state that you are requesting the confidential communication because you feel that disclosure in another way could endanger your safety.

Right to inspect and obtain a copy of your PHI: You have the right to inspect and obtain a copy of your PHI that is contained in records that the Plan maintains for enrollment, payment, claims determination, or case or medical management activities. If the Plan uses or maintains an electronic health record with respect to your PHI, you may request such PHI in an electronic format of your choosing – provided we can practicably provide it in that format –, and direct that such PHI be sent to another person or entity.

However, this right does not extend to (1) psychotherapy notes, (2) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (3) any information, including PHI, as to which the law does not permit access. We will also deny your request to inspect and obtain a copy of your PHI if a licensed health care professional hired by the Plan has determined that giving you the requested access is reasonably likely to endanger the life or physical safety of you or another individual or to cause substantial harm to you or another individual, or that the record makes references to another person (other than a health care provider), and that the requested access would likely cause substantial harm to the other person.

If you request copies of your health information, we will process the request within 30 days or provide an explanation for why that timeframe is too narrow and a date when the request can be processed.

In the event that your request to inspect or obtain a copy of your PHI is denied, you may have that decision reviewed. A different licensed health care professional chosen by the Plan will review the request and denial, and we will comply with the health care professional's decision.

You may make a request to inspect or obtain a copy of your PHI by completing the appropriate form available from the Plan. We may charge you a fee to cover the costs of copying, mailing or other supplies directly associated with your request. You will be notified of any costs before you incur any expenses.

Right to amend your PHI: You have the right to request an amendment of your PHI if you believe the information the Plan has about you is incorrect or incomplete. You have this right as long as your PHI is maintained by the Plan in a designated record set. We will correct any mistakes if we created the PHI or if the person or entity that originally created the PHI is no longer available to make the amendment. However, we cannot amend PHI that we believe to be accurate and complete.

You may request amendments of your PHI by completing the appropriate form available from the Plan.

Right to receive an accounting of disclosures of PHI: You have the right to request a list of certain disclosures of your PHI by the Plan. The accounting will not include disclosures (1) to carry out treatment, payment and health care operations, (2) to you, (3) incident to a use or disclosure permitted or required by law, (4) pursuant to an authorization provided by you, (5) for directories or to people involved in your care or other notification purposes as permitted by law, (6) for national security or intelligence purposes, (7) to correctional institutions or law enforcement officials, (8) that are part of a limited data set, (9) that occurred more than six years before your request. Your first request for an accounting within a 12-month period will be free. We may charge you for costs associated with providing you additional accountings. We will notify you in advance of any costs, and you may choose to withdraw or modify your request before you incur any expenses.

You may make a request for an accounting by completing the appropriate request form available from the Plan.

Right to Receive Notice of Breach of Unsecured PHI: If the security of your unprotected PHI is breached, we will notify you about it.

Right to file a complaint: If you believe your rights have been violated, you should let us know immediately. We will take steps to remedy any violations of the Plan's privacy policy or of this Notice.

You may file a formal complaint with our Privacy Officer and/or with the United States Department of Health and Human Services at the addresses below. You should attach any evidence or documents that support your belief that your privacy rights have been violated. We take your complaints very seriously. **The Plan prohibits retaliation against any person for filing such a complaint.**

Complaints should be sent to:

Benefit Programs Administration
Attn: Mr. Edward Simon, Vice President and Privacy Officer
1200 Wilshire Blvd, Fifth Floor Los Angeles, CA 90017
Phone: (888) 806-8942
Fax: (562) 463-5894

Region IX, Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: (415) 437-8310
FAX: (415) 437-8329
TDD: (415) 437-8311
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

COMPARISON OF MEDICAL PLANS 2018

I.A.T.S.E. LOCAL 504 HEALTH & WELFARE TRUST FUND Open Enrollment – Medical Plan Options as of September 1, 2018		
	Health Net	**Kaiser**
Benefits	**HMO**	**HMO**
Allergy testing	No copay	No copay
Chiropractic care	Not covered	Not covered
Choice of providers	Health Net HMO only	Kaiser only
Deductibles – Calendar year	None	None
Hospital inpatient	$500 copay per admission	$500 copay per admission
Diagnostic X-ray/lab (MRI, CT, PET scans)	No copay preventive; MRI, CT, PET, MUGA, scans are $100 copay per procedure	No copay
Durable medical equipment	No copay	No copay
Emergency room	$100 copay, waived if admitted	$100 copay; waived if admitted
Home health services	No copay; $20/visit starting with the 31st calendar day after the 1st visit; 100 visit/CY	No copay up to 3 visits/day; 100 visits/year
Hospice	No copay	No copay
Hospital	$500 per admission	$500 per admission
Lifetime maximum	Unlimited	Unlimited
Maternity care	$20 Prenatal/Postnatal visit; No copay for elective abortion; $500 per admission to hospital	No copay except $500 per admission to hospital
Mental health –	MHN for authorization	
Inpatient	$500 per admission	$500 per admission
Outpatient	$20 copay – individual; $10 copay - group	$20/visit – individual; $10 group
Out-of-pocket maximum	$2,000/person, $6,000/family; pharmacy - $2,000/person; $4,000/family	$1,500/person; $3,000/family

I.A.T.S.E. LOCAL 504 HEALTH & WELFARE TRUST FUND Open Enrollment – Medical Plan Options as of September 1, 2018		
Benefits	**Health Net HMO**	**Kaiser HMO**
Outpatient services –		
Chemotherapy	No copay	No copay
Renal dialysis	No copay	$20 copay
Outpatient surgery	$500 copay	$250 per procedure
Physician services –		
Hearing screenings	$20 copay	$20 copay
Home visits	$40 copay per visit	No copay up to 3 visits/day; 100 visits/year
Hospital services	No copay	No copay
Office visits	$20 copay	$20 copay
Routine physicals	No copay	No copay. Well child – No copay to age 24 months
Specialists	$20 copay	$20 copay
Surgical services – outpatient	No copay	No copay
Physical and occupational therapy	$20 copay	$20 copay per visit
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	$25 copay
Non-formulary	$35 copay	$25 copay
Specialty drugs	20% coinsurance up to $100 maximum for self-injectables; $35 copay for all others	20% coinsurance up to a maximum of $250 per prescription
Mail Order –	up to 90-day supply	100-day supply
Generic Brand formulary	$20 copay $50 copay	$20 copay $50 copay
Non-formulary	$70 copay	$50 copay
Skilled nursing facility	No copay through day 10, $25 copay per day for days 11 through 100; 100 days maximum/calendar year	No copay up to 100 days per benefit period

I.A.T.S.E. LOCAL 504 HEALTH & WELFARE TRUST FUND Open Enrollment – Medical Plan Options as of September 1, 2018		
	Health Net	**Kaiser**
Benefits	**HMO**	**HMO**
Speech therapy	$20 copay per visit	$20 copay per visit
Substance abuse – Rehab –		
Inpatient	$500 per admission	$500 per admission
Outpatient	$20 copay individual; $10 copay group	$20 copay individual; $5 copay group
Detox –		
Inpatient	$500 per admission	$500 per admission
Outpatient	$20 copay individual	$20 copay individual; $5 copay group
Transplant Services	$0 copay for physician services; $500 per admission; prior authorization; see EOC for limitations	$500 per admission
Urgent care	$20 per visit; copay waived if admitted	$20 copay per visit
Vision	$20 copay per exam if using the Health Net medical plan. $10 copay if using the Health Net Eye Med vision plan (see page 26 for EyeMed benefits)	No copay- 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.

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

SAMPLE OF DHMO DENTAL COPAYMENTS

Benefits	
Calendar Year Deductible	None
Diagnostic & Preventive	From no copay or up to $45 copay
Restorative	From no copay up to $195 copay
Endodontic	From no copay up to $220 copay
Periodontics	From no copay up to $195 copay
Prosthodontics	From no copay up to $195 copay
Oral and Maxillofacial surgery	From no copay up to $90 copay
Adjunctive general services	From no copay up to $125 copay
Emergency out-of-area	$100 plan benefit