INTERNATIONAL ALLIANCE
OF
THEATRICAL STAGE EMPLOYEES
LOCAL 22 WELFARE FUND

FOR
LOCAL 22 AND LOCAL 772
PARTICIPANTS

PLAN DOCUMENT
and
SUMMARY PLAN DESCRIPTION

(Restated Effective January 1, 2022)

International Alliance of Theatrical Stage Employees
Local 22 Welfare Fund

For I.A.T.S.E. Local 22 Welfare Plan Participants

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Dear Participant:

We are pleased to provide you with this updated plan document which details your benefits under the IATSE 22 Welfare Fund for I.A.T.S.E. Local 22 and 772 Welfare Plan ("Plan") participants. Since the purpose of the Welfare Fund is to benefit you, we urge you to read this booklet carefully so that you will understand the complete plan of benefits, as well as the eligibility rules and the procedures for filing claims.

This Plan, along with many other union plans in the area, participates in the Health Care Cost Containment Corporation of the Mid-Atlantic Region, Incorporated (HCCCC). It is designed to benefit participating union funds by reducing health care costs for participants and their families. By bargaining, the HCCCC is able to achieve greater economies of scale and significant cost savings due to increased bargaining power in the medical treatment market place.

The Life and Accidental Death and Dismemberment (AD&D) benefits for active participants are provided through (and guaranteed by) insurance contracts with Voya Financial. All other benefits, including retiree death benefits, are self-insured. The Fund contracts with a Preferred Provider Organization (PPO) to obtain discounts on medical benefits. A higher level of benefits is available if PPO providers are used. The Fund also contracts with a Utilization Management (UM) company to pre-certify hospital admissions and review certain large claims (called case management). The Weekly Disability Income coverage is administered through the Claims Office. Your vision benefits are administered by Vision Service Plan (VSP) — which uses union shops for the production of frames.

The Plan provides two levels of benefits, depending on your earnings and the Plan's eligibility provisions. The primary plan, called Tier One, is available for members who have satisfied a higher earnings requirement. Tier Two benefits may be available for members who do not meet the earnings requirement for Tier One benefits. Please see Section II for eligibility guidelines and Section IV for a description of the benefits in each plan.

The Trustees strive to provide the most appropriate benefits that will contribute to the security, health and well-being of the participants. Changing economic conditions require a constant assessment of the benefit plan to maintain its financial stability.

All of us, as consumers, should be looking daily for alternatives to paying more for our personal health care by maintaining our health, avoiding unnecessary risks such as smoking, and having new appreciation for exercise, rest and good nutrition. This booklet can help you in that search as it focuses on medical decisions you must make.

When it comes to any important medical decision, our goal is simple. Talk to your doctor. Information is available. Choices are available. But you will have to ask. In the medical field, a poorly informed buyer may pay more than just money for a bad decision.

Please remember that you have the right to submit to the Trustees for their consideration any questions or disagreements you may have in connection with the operation or administration of the Plan.

Sincerely,
BOARD OF TRUSTEES

IMPORTANT INFORMATION

TRUSTEE DISCRETION TO INTERPRET THE PLAN

The Trustees shall, subject to the requirements of the law, be the sole judges of the standard and amount of proof required in any case as well as the application and interpretation of this Plan, and decisions of the Trustees shall be final and binding on all parties.

The Trustees shall have the exclusive right and discretionary authority to construe the terms of the Plan, to resolve any ambiguities, and to determine any questions which may arise in connection with the Plan's application or administration, including but not limited to a determination of eligibility for benefits.

Wherever in the Plan the Trustees are given discretionary powers, the Trustees shall exercise such powers in a uniform and nondiscriminatory manner.

YOU MUST NOTIFY THE PLAN OF LIFE CHANGES

You must notify the Fund Administrator if there are any changes to your Eligible Dependents, family status, marital status, etc. If you fail to notify the Fund Administrator, it may affect eligibility for benefits under the Plan. If the Plan provides benefits for family members or other persons who do not qualify as Dependents, the Plan has the right to terminate your Dependent coverage and seek reimbursement of any claims that were improperly paid.

Also, please notify the Plan if you or any Eligible Dependent becomes covered under another Health Plan.

NONDISCRIMINATION REQUIREMENTS UNDER THE ACA

The IATSE Local 22 Welfare Fund complies with the applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The IATSE Local 22 Welfare Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Medical Benefits provided under this Plan are afforded without regard to an individual's sex assigned at birth, gender identity, or gender.

When necessary, the IATSE Local 22 Welfare Fund will provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). The IATSE Local 22 Welfare Fund also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages upon request. If you need these services, contact Joseph Swann at: IATSE Local 22 Welfare Fund, 9411 Philadelphia Road, Suite S, Baltimore, MD 21237, 1-800-941-2752, JSwann@bacorporation.com.

If you believe that the IATSE Local 22 Welfare Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Joseph Swann, IATSE Local 22 Welfare Fund, 9411 Philadelphia Road, Suite S, Baltimore, MD 21237, 1-800-941-2752, JSwann@bacorporation.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Joseph Swann is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-941-2752.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-941-2752 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-941-2752.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-941-2752.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-941-2752.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-941-2752.

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 1-800-941-2752 - هاتف الصم والبكم:.

AKIYESI: Bi o ba nsọ èdè Yorùbú ọfé ni iranlọwọ lori èdè wa fun yin o. Ẹ pe ẹrọ-ibanisọrọ yi 1-800-941-2752.

Ntị: Ọ bụrụ na asụ Ibo, asụsụ aka ọasụ n'efu, defu, aka. Call 1-800-941-2752.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-941-2752.

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خبردار :اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-800-941-2752 کر.

توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 1-800-941-2752 فراهم می باشد. با تماس بگیرید.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-941-2752.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-941-2752.

RESOURCES FOR INFORMATION

Preferred Provider Organization (PPO) Network

CareFirst Blue Cross Blue Shield
Web address: www.carefirst.com
(To find a provider, look under the BlueCross BlueShield Preferred Network)
Phone Number: 1 (800) 235-5160

Virginia Health Network
(In-Network for Virginia Residents and Virginia Providers)
Web address: www.vhn.com
Phone Number: 1 (804) 320-3837

Pre-Hospitalization Certification/Case Management

American Health Holding
Phone Number: 1 (800) 641-5566

Information Concerning Medical Claims and Coverage

IATSE Local 22/772 Claims Office
(Benefits Administration Corp.)
Phone Number: 1 (800) 941-2752

Vision Services

Vision Service Plan
Phone Number: 1 (800) 225-5877
Web address: www.vsp.com

Prescription Drugs and All Other Questions About Your Coverage

I.A.T.S.E. Local 22 Fund Office
Phone Number: (301) 593-1265

Death and Accidental Death & Dismemberment

Voya Financial
(Relastar Life Insurance)
20 Washington Ave South
Minneapolis, MN 55401
(Contact the Fund Office for any questions about this coverage)

Dental Services

Delta Dental
Phone Number: 1 (800) 932-0783
Web address: www.deltadental.com

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Virtual Physicals	$100 limit per calendar year
Motorized Wheelchairs/Scooters	$500 lifetime maximum
Mastectomy Supplies	$750 limit per calendar year

PARTICIPANT COST SHARING PROVISIONS	IN THE PPO NETWORK	OUTSIDE THE PPO NETWORK
■ **Calendar Year Medical Deductible**		
Individual	$500	$500
Family (3 times Individual Maximum)	$1,500	$1,500
■ **Calendar Year Out-of-Pocket Maximum** (payments to meet the Medical Deductible count toward satisfying the Out-of-Pocket maximum)		
Individual	$1,500	$1,500
Family	$3,000	$3,000

MEDICAL BENEFITS (continued)

	WHAT THE PLAN PAYS	
	IN THE PPO NETWORK	**OUTSIDE THE PPO NETWORK**
OFFICE VISITS		
■ **Physician or Provider Home or Office Visits**	After you pay a $20 per visit copayment—plan pays 100% of Covered Charges	After you pay a $40 per visit copayment—plan pays 70% of Covered Charges (up to 70% of UCR)
HOSPITAL, HOME HEALTH AND OTHER SERVICES		
■ **Hospital Services on an Inpatient or Outpatient Surgery Basis** (including Physician Services)	80% of Covered Charges after you have met the deductible	70% of Covered Charges (up to 70% of UCR) after you have met the deductible
■ **Emergency Room Care Note: In order for emergency room care to be considered a covered expense, it must be for a Medical Emergency** (see definition on page 23)	80% of Covered Charges after you have met the deductible	70% of Covered Charges (up to 70% of UCR) after you have met the deductible
■ **Urgent Care Center**	After you pay a $50 per visit copayment—plan pays 100% of Covered Charges	70% of Covered Charges (up to 70% of UCR) after you have met the deductible
■ **Diagnostic X-ray & Laboratory Services**	80% of Covered Charges after you have met the deductible	70% of Covered Charges (up to 70% of UCR) after you have met the deductible
■ **Other Medical Benefits**	70% of Covered Charges after you have met the deductible	70% of Covered Charges (up to 70% of UCR) after you have met the deductible
■ **Home Health or Hospice Care**	70% of Covered Charges	70% of Covered Charges (up to 70% of UCR)

DENTAL BENEFITS (Administered by Delta Dental)

■ **Dental Deductible per Individual** You pay $50
(does not apply to diagnostic and preventive services)

■ **Coinsurance**	Plan pays 50% of Covered Charges (up to 50% UCR)
■ **Annual Maximum Benefit per Individual** (does not apply to pediatric dental benefits)	$2,000

PRESCRIPTION DRUG COVERAGE (Administered by Express Scripts)

■ **Calendar Year Prescription Drug Deductible**

Individual	You pay $50
Family (3 times Individual Maximum)	You pay $150

■ **Drug Card (Network Pharmacy) (45 day supply or less)**	Generic: $15 Formulary: $30 Non-Formulary: $50
■ **Drug Card (Network Pharmacy) (46-80 day supply)**	Generic: $30 Formulary: $60 Non-Formulary: $100
■ **Drug Card (Network Pharmacy) (81 day supply or more)**	Generic: $45 Formulary: $90 Non-Formulary: $150

If you receive a formulary or non-formulary when a generic is available, you also pay the difference between the formulary or non-formulary and generic, unless your doctor specifies brand name.
(Must first satisfy the Calendar Year Drug Deductible)

■ **Mail Order Service (90 day supply)**	Generic: $30 Formulary: $60 Non-Formulary: $100

If you receive a formulary or non-formulary when a generic is available, you also pay the difference between the formulary or non-formulary and generic, unless your doctor specifies brand name.
(Must first satisfy the Calendar Year Drug Deductible)

VISION BENEFITS	**IN VSP NETWORK**	**OUTSIDE VSP NETWORK**
■ **Copayment**	$10	$10
■ **Conventional Vision Exam** (once every 12 months)	Covered in Full	$35
■ **Conventional Lenses** (once every 12 months)		
Single vision	Covered in Full	$25
Bifocal	Covered in Full	$40
Trifocal	Covered in Full	$55
Lenticular	Covered in Full	$80
■ **Frames** (once every 24 months)	Covered in Full if from designated frames on display	$35

In lieu of all other Plan vision benefits:

■ **Contact Lenses used for elective or cosmetic reasons** (once every 12 months)		
Vision Exam	Covered in Full	$35
Contact Lenses (plus evaluation and fitting costs)	$105	$105
■ **Contact Lenses if medically necessary, with VSP authorization** (once every 12 months)		
Vision Exam	Covered in Full	$35
Contact Lenses (plus evaluation and fitting costs)	Covered in Full	$210

TIER TWO SCHEDULE OF BENEFITS
BENEFITS FOR ALL COVERED INDIVIDUALS WHO QUALIFY FOR TIER TWO COVERAGE

MEDICAL BENEFITS

PLAN MAXIMUMS – PER PERSON

Virtual Physicals	$100 limit per calendar year
Motorized Wheelchairs/Scooters	$500 lifetime maximum
Mastectomy Supplies	$750 limit per calendar year

PARTICIPANT COST SHARING PROVISIONS	IN THE PPO NETWORK	OUTSIDE THE PPO NETWORK
■ **Calendar Year Medical Deductible**		
Individual	$2,000	$2,000
Family (3 times Individual Maximum)	$6,000	$6,000
■ **Calendar Year Out-of-Pocket Maximum** (payments to meet the Medical Deductible count toward satisfying the Out-of-Pocket maximum)		
Individual	$3,000	$3,000
Family	$7,500	$7,500

MEDICAL BENEFITS (continued)

	WHAT THE PLAN PAYS	
	IN THE PPO NETWORK	**OUTSIDE THE PPO NETWORK**
OFFICE VISITS		
■ **Physician or Provider Home or Office Visits**	After you pay a $20 per visit copayment—plan pays 100% of Covered Charges	After you pay a $40 per visit copayment—plan pays 70% of Covered Charges (up to 70% of UCR)
HOSPITAL, HOME HEALTH AND OTHER SERVICES		
■ **Hospital Services on an Inpatient or Outpatient Surgery Basis** (including Physician Services)	80% of Covered Charges after you have met the deductible	70% of Covered Charges (up to 70% of UCR) after you have met the deductible
■ **Emergency Room Care Note: In order for emergency room care to be considered a covered expense, it must be for a Medical Emergency** (see definition on page 23)	80% of Covered Charges after you have met the deductible	70% of Covered Charges (up to 70% of UCR) after you have met the deductible
■ **Urgent Care Center**	After you pay a $50 per visit copayment—plan pays 100% of Covered Charges	70% of Covered Charges (up to 70% of UCR) after you have met the deductible
■ **Diagnostic X-ray & Laboratory Services**	80% of Covered Charges after you have met the deductible	70% of Covered Charges (up to 70% of UCR) after you have met the deductible
■ **Other Medical Benefits**	70% of Covered Charges after you have met the deductible	70% of Covered Charges (up to 70% of UCR) after you have met the deductible
■ **Home Health or Hospice Care**	70% of Covered Charges	70% of Covered Charges (up to 70% of UCR)

MEDICAL BENEFITS (continued)

	WHAT THE PLAN PAYS IN THE PPO NETWORK	OUTSIDE THE PPO NETWORK

PRESCRIPTION DRUG COVERAGE

- **Calendar Year Prescription Drug Deductible**

Individual	You Pay $50
Family (3 times Individual Maximum)	You Pay 150

- **Drug Card (Network Pharmacy) or Mail Order Service**

After you satisfy the Calendar Year Drug Deductible, your copayment is 50% of the cost of each eligible prescription.

OTHER SCHEDULE OF BENEFITS

BENEFITS FOR COVERED EMPLOYEES AND RETIREES ONLY WHO QUALIFY FOR TIER ONE COVERAGE

- **Life and Accidental Death or Dismemberment Insurance for Covered Employees**

-	Under Age 70	$25,000
-	Age 70 to age 75	$16,250
-	Over age 75	$12,500

- **Death Benefit for Covered Retirees** $5,000

- **Weekly Income Benefits** 66 2/3% of highest gross compensation for the three calendar years immediately preceding year in which disability occurred divided by 52 weeks (not to exceed $300 per week). Excludes injuries sustained while unable to work due to work-related injuries.

- **Additional Weekly Income** $200 per week for first 2 weeks of disability if unable to work and Hospitalized for non-mental health or non-substance abuse related illness. Excludes injuries sustained while unable to work due to work-related injuries.

- **Work-Related Injury** No benefits payable.

I. DEFINITION OF TERMS

Allowable Expense
A health care service or expense, including Deductibles, Coinsurance or Copayments, that is covered in full or in part by this Plan or any other plan in which the person making the claim participates, except as otherwise provided by the terms of this Plan. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense.

Behavioral Health Disorders
Disorders, conditions and diseases as defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD-9-CM) manual, which includes, among other things, autism, depression, schizophrenia, and Substance Abuse.

Approved Clinical Trial
The term Approved Clinical Trial has the same meaning as that term is defined under Section 2709 of the Public Health Services Act (PHSA) and, generally, means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition and meets additional criteria set forth in Section 2709 of the PHSA including, but not limited to, that the clinical trial be a study or investigation:

1. that is either approved or funded by the National Institutes of Health ("NIH"), the Centers for Disease Control and Prevention ("CDC"), the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid Services ("CMS"), certain groups in cooperation with these agencies (or the Department of Defense ("DoD") or Department of Veterans Affairs ("VA")), identified research entities receiving grants from the NIH, and, under certain circumstances, the VA, DoD, or Department of Energy; or

2. conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

3. a drug trial that is exempt from having such an investigational new drug application.

The Plan Administrator or its designee intends to interpret this term consistent with the definition under Section 2709 of the PHSA.

Behavioral Health Practitioners
A Physician, psychologist, certified mental health counselor, or social worker who:

1. is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and

2. acts within the scope of his or her license; and

3. is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Behavioral Health Treatment Facility
A public or private facility, licensed and operated according to law, that provides a program for diagnosis, evaluation, and effective treatment of Behavioral Health Disorders.

The facility must:

1. have at least one Physician on staff or on call; and

2. provide skilled nursing care by licensed Nurses under the direction of a full-time Registered Nurse (RN); and

3. prepare and maintain a written plan of treatment for each patient, which plan must be based on the medical, psychological and social needs of the patient.

Benefit, Benefit Payment, Plan Benefit
The amount of money payable for a claim, based on the Usual and Customary Charge, after calculation of all Deductibles, Coinsurance and Copayments, and after determination of the Plan's exclusions, limitations and maximums.

Calendar Year
The 12-month period beginning January 1 and ending December 31. All annual Deductibles and Annual Out-of-Pocket Maximum Plan Benefits are determined during the Calendar Year, except as provided under the carryover provisions described on page 45.

Claims Administrator
A person or company retained by the Plan Administrator to administer the claim payment responsibilities of the Plan as well as related day-to-day administrative duties. The Plan Administrator has retained Benefits Administration Corp. as the Claims Administrator.

Coinsurance
The Coinsurance percentage is the percentage of Covered Charges that the Plan pays after you have met your annual Medical Deductible and/or your applicable Copayment amount.

Collective Bargaining Agreement
The contract(s) or labor agreement(s), as amended, between the International Alliance of Theatrical Stage Employees Local 22 or Local 772 and any Contributing Employer.

Contributing Employer
"Contributing Employer" or "Employer" means an employer signatory to a Collective Bargaining Agreement with the Union requiring contributions to this Fund and an employer signatory to any other agreement requiring contributions to this Fund. It shall also include the International Alliance of Theatrical Stage Employees Local 22 Pension Fund, the International Alliance of Theatrical Stage Employees Local 22 Welfare Fund, the International Alliance of Theatrical Stage Employees Local 22 Training Fund, and the Union. An employer shall not be deemed a Contributing Employer simply because it is part of a controlled group of corporations (as defined in Section 414(b) of the Internal Revenue Code of 1986, as amended) or of a trade or business under common control (as defined in Section 414(c) of the Internal Revenue Code of 1986, as amended), some other part of which is a Contributing Employer.

Coordination of Benefits (COB)
The rules and procedures applicable to determine how Plan Benefits are payable when a person is covered by two or more health care plans. **See the Plan section on Coordination of Benefits and Medicare**, which sets forth the Plan's COB rules and procedures.

Copayment, Copay
The set dollar amount you are responsible for paying when you incur an Eligible Expense for certain services.

Cosmetic Surgery or Treatment
Surgery or medical treatment to improve or preserve physical appearance, but not physical function, as distinguished from Surgery or medical treatment to correct defects resulting from trauma, infection, or other diseases or the consequences of treatment of trauma, infection, or other diseases, or to correct a congenital disease or anomaly of a covered Dependent Child that causes a functional defect.

Covered Charge
Expenses or charges for services or supplies, but only to the extent that:

1. they are Medically Necessary, as defined in this Definitions section; and

2. the charges for them are Usual and Customary, as defined in this Definitions section; and

3. coverage for the services or supplies is not excluded, as provided in the Exclusions section of this document, or in any other Plan provision; and

4. the Lifetime Maximum and any specific coverage limitations to Plan Benefits for those services or supplies has not been reached.

Covered Employee
An employee who: (1) is covered by a Collective Bargaining Agreement or any written agreement requiring Employer contributions on his or her behalf, and (2) satisfies the Eligibility requirements outlined in Section II of this Plan, and (3) is not a Covered Retiree. If the International Alliance of Theatrical Stage Employees Local 22 Pension Fund, the International Alliance of Theatrical Stage Employees Local 22 Welfare Fund, the International Alliance of Theatrical Stage Employees Local 22 Training Fund, or the Union is a Contributing Employer, the employees with respect to whom such Employer participates in this Plan are also to be deemed Covered Employees.

Covered Individual
Any individual who is eligible for coverage under the Plan and is actually covered by the Plan.

Covered Retiree
A Covered Individual to whom a pension is being paid (or to whom a pension would be paid but for administrative processing time) from the International Alliance of Theatrical Stage Employees Local 22 Pension Fund, except that a retiree whose benefits have been suspended pursuant to Section 6.07(b) of the International Alliance of Theatrical Stage Employees Local 22 Pension Plan is considered a Covered Employee, not a Covered Retiree, under this Plan.

Deductible
The amount of Eligible Expenses you are responsible for paying before the Plan begins to pay Benefits.

1. **Individual Deductible:** The amount one covered person must pay before the Plan begins to pay Benefits for that person.

2. **Family Deductible:** The amount that all covered family members must pay before the Plan begins to pay Benefits for the family members.

Dental
Dental services and supplies are **not** covered under the medical expense coverage of the Plan unless the Plan specifically indicates otherwise. As used in this Plan, Dental refers to any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics, but not including prescription drugs, prescribed by a Dentist, even if the services or supplies are necessary because of symptoms, illness or injury affecting another part of the body. Dental services include treatment to alter, correct, fix, improve, replace, reposition, restore or treat:

- teeth;
- the gums and tissues around the teeth;
- the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges);
- the jaw, any jaw implant, or the joint of the jaw;
- bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or
- teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection.

See the Dental Section for applicable limitations to the Dental services covered by this Plan.

Dental Care Provider
A Dentist, or Dental Hygienist or other Health Care Practitioner or Nurse as those terms are specifically defined in this section, who is legally licensed and who:

1. is a Dentist or performs services under the direction of a licensed Dentist; and

2. acts within the scope of his or her license; and

3. is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Hygienist
A person who is trained and legally licensed and authorized to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed Dentist, and who:

1. acts within the scope of his or her license; and

2. is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Treatment Plan
An attending Dentist's written report of recommended treatment for a period of dental treatment, on a form satisfactory to the Plan Administrator or its designee, which does the following:

1. itemizes the dental procedures required for the necessary care of the individual; and

2. shows the charges for each procedure; and

3. is accompanied by any appropriate diagnostic materials (such as x-ray) as may be required by the Plan

Dentist
A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who:

1. is legally licensed and authorized to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered; and

2. acts within the scope of his or her license; and

3. is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dependent Child(ren)
For the purposes of this Plan, a Dependent Child is any of your children, including any stepchild, foster child, child placed for adoption or legally adopted child who lives with you, or any such child for whom you are legally obligated to provide support, provided the child has not reached his or her 26th birthday.

Coverage of a Dependent Child may continue beyond age 26 for any unmarried child who is mentally or physically Handicapped and is:

1. incapable of self-sustaining employment as a result of that handicap; and

2. dependent chiefly on you and/or your spouse for support and maintenance.

A grandchild of a participant who meets the following conditions shall also be considered an Eligible Dependent:

1. the grandchild is unmarried; and

2. the grandchild is in court-ordered custody of and residing with the Covered Individual; and

3. the grandchild is the dependent of the Covered Employee or Covered Retiree; and

4. the grandchild must not have reached aged 24 unless he or she is incapable of self support because of a Handicap which occurred prior to reaching age 24.

Coverage of a Dependent Child ends at the end of the month in which that child becomes eligible under this Plan as a Covered Employee.

Eligible Dependent
Your Spouse (unless you are legally separated) and your Dependent Child(ren).

Eligible Expense
Eligible Expense has the same meaning as Covered Charges.

Experimental and/or Investigational
Except as provided by another term or provision of the Plan, the Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational.

A. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service or supply was performed, or provided, or considered for Precertification, **any** of the following conditions are present:

1. The service or supply is described as an alternative to more conventional therapies in the protocols or consent document of the Health Care Practitioner that prescribes or renders the service or supply;

2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;

3. There is a preponderance of authoritative medical, dental or scientific literature:

   - published in the United States; **and**
   - written by experts in the field;

   that shows that recognized medical, dental or scientific experts:

   - classify the service or supply as experimental and/or investigational; **or**
   - indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;

4. Food and Drug Administration (FDA) approval:

   - is required in order for the service and supply to be lawfully marketed; **and**
   - has not been granted at the time the service or supply is prescribed or provided.

5. The prescribed service or supply is available to the covered person only through:

   - participation in FDA Phase I or Phase II clinical trials; **or**
   - FDA Phase III experimental or research clinical trials or corresponding trials sponsored by the National Cancer Institute or National Institutes of Health.

6. A current investigational new drug or new device application has been submitted and filed with the FDA.

7. As a whole, the service or supply would not be classified as Experimental and/or Investigational given the above six criteria, but one or more essential provisions of the service or supply **are** Experimental and/or Investigational based on the above criteria.

B. However, a drug will **not** be considered Experimental and/or Investigational if it is:

1. approved by the FDA as an "investigational new drug for treatment use"; **or**

2. classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; **or**

3. approved by the FDA for the treatment of cancer;

   - and has been prescribed for the treatment of a type of cancer for which the drug was **not** approved for general use; **and**

   - the FDA has **not** determined that such drug should not be prescribed for a given type of cancer.

C. The Plan Administrator or its designee will monitor the status of an Experimental and/or Investigational service or supply and may decide, using the criteria set forth above, that a service or supply which at one time was deemed to be Experimental and/or Investigational may be covered as of some later point in time.

Fund Administrator and Plan Administrator
The Plan Administrator is the person or legal entity designated by the terms of the Plan and its Trust Agreement as the party who has the fiduciary responsibility for the overall administration of the Plan. The Plan Administrator is the Board of Trustees of the Plan. Certain day-to-day administrative duties may be delegated by the Board to a person or entity referred to as the Fund Administrator. At this time, the Plan Administrator is also the Fund Administrator.

Handicap or Handicapped (Physically or Mentally)
The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise Totally Disabled, provided the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition.

Health Care Practitioner
A Physician, Behavioral Health Practitioner, Chiropractor, Dental Hygienist, Dentist, Nurse, Optometrist, Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, as those terms are defined in this section, or any other health care provider, who:

1. is legally licensed, certified and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered; and

2. acts within the scope of his or her license, certification and/or scope of practice; and

3. is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Health Care Provider
A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility, Behavioral Health Treatment Facility, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility, as those terms are defined in this Definitions section, and any other health care provider who is acting within the scope of that provider's license or certification under applicable State law.

Home Health Aide
An individual, other than a Registered Nurse, who provides medical or therapeutic care under the supervision of a Home Health Care Agency.

Home Health Care
Intermittent Skilled Nursing Care services provided by a licensed Home Health Care Agency as defined below.

Home Health Care Agency
An agency licensed or certified and operating according to law that meets all of the following requirements:

1. It primarily provides skilled nursing and other therapeutic services under the supervision of Physicians or Registered Nurses; and

2. It is run according to rules established by a group of professional medical providers including Physicians and Registered Nurses; and

3. It maintains clinical records on all patients; and

4. It is licensed by the jurisdiction where it is located if licensure is required, and operates according to the laws of the jurisdiction pertaining to agencies providing Home Health Care; and

5. It is certified by Medicare.

Home Health Care Plan
A program for care and treatment that is required as a result of Illness or Injury and is approved in writing by the patient's attending Physician. The attending Physician must certify that Home Health Care is a replacement for Hospital or Skilled Nursing Facility confinement.

Hospice
A facility or organization licensed and operating according to law and certified by Medicare that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home or in a home-like setting. The emphasis shifts from curing to keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family.

Hospital
A public or private facility or institution, other than one owned by the U.S. Government, licensed and operating according to law, that is accredited by the Joint Commission on Accreditation of Hospitals and Healthcare Organizations (JCAHHO) and that provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises. A Hospital may include facilities for mental, nervous and/or substance abuse treatment that are licensed and operated according to law. Any portion of a Hospital used as a Subacute Care Facility, Skilled Nursing Facility, or residential treatment facility or place for rest, custodial care of the aged shall not be regarded as a Hospital for any purpose related to this Plan.

Illness
Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. Pregnancy will be considered to be an Illness for the purpose of coverage under this Plan. Infertility is not an Illness for the purpose of coverage under this Plan.

In-Network Services
Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network Services that are provided by a Health Care Provider that is not a member of the PPO.

Injury
Any damage to a body part resulting from trauma from an external source.

Inpatient Services
Services provided in a Hospital or other Specialized Health Care Facility during the period when charges are made for room and board.

Medical Emergency
A condition that requires treatment without delay and is evidenced by sudden and unexpected symptoms of a sickness or by an injury; and either is, or reasonably appears to be, life threatening; or would reasonably appear to preclude a complete recovery if not treated without delay. It does not include less acute medical conditions which can be treated by a physician during regular office hours.

Medically Necessary
A service or supply will be determined to be "Medically Necessary" by the Plan Administrator or its designee if it:

1. is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it; and

2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted medical standards; and

3. is determined by the Plan Administrator or its designee to meet all of the following requirements:

   - It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and

   - It is not provided solely for the convenience of the patient, Physician, Hospital, Health Care Provider, or Health Care Facility; and

   - It is an appropriate service or supply given the patient's circumstances and condition; and

   - It is a cost-effective supply or level of service that can be safely provided to the patient; and

   - It is safe and effective for the illness or injury for which it is used.

A service or supply will be considered to be appropriate if:

1. It is a diagnostic procedure that is called for by the health status of the patient, and is:

   - as likely to result in information that could affect the course of treatment as; and

   - no more likely to produce a negative outcome than

   any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

2. It is care or treatment that is:

   - as likely to produce a significant positive outcome as; and
   - no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

A service or supply will be considered to be cost-effective if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the coverage provided by the Plan.

A Hospitalization or confinement to a Specialized Health Care Facility will not be considered to be Medically Necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

A service or supply that can safely and appropriately be furnished in a Physician's or Dentist's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital or Specialized Health Care Facility or other more costly facility.

The non-availability of a bed in another Specialized Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a Hospital or other Specialized Health Care Facility is Medically Necessary.

A service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Health Care Practitioner, or any Hospital or Specialized Health Care Facility.

A service or supply will not be considered to be Medically Necessary if it is considered to be in conflict with accepted medical standards.

Medicare
The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Non-Participating Provider
A Health Care Provider who does not participate in the Plan's Preferred Provider Organization (PPO).

Nurse
A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed Midwife, Nurse Practitioner, Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who:

1. acts within the scope of his or her license; and

2. is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Out-of-Network Services
Services provided by a Health Care Provider that is not a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network Services that are provided by a Health Care Provider that is a member of the PPO.

Out-of-Pocket Maximum
The maximum amount of Coinsurance each covered person or family is responsible for paying during a Calendar Year before the Coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of any additional Covered Expenses for the remainder of the Calendar Year. The Plan's payments, any expenses for medical services or supplies that are not covered by the Plan, any penalties or disallowed charges incurred as a result of noncompliance with the Plan's managed care requirements, and all charges in excess of the Usual and Customary Charges as determined by the Plan Administrator or its designee do not count toward the Out-of-Pocket Maximum.

Outpatient Services
Services provided either outside of a Hospital or Specialized Health Care Facility setting or at a Hospital or Specialized Health Care Facility when room and board charges are not incurred.

Participating Provider
A Health Care Provider who participates in the Plan's Preferred Provider Organization (PPO). You may contact the Plan Administrator to obtain a list of Participating Providers (at no charge to you). The most current and complete list of providers, however, can be found on the PPO's web site, or by calling the PPO's toll free number. Information on the web site name and the PPO phone number are also available from the Plan Administrator.

Period of Dental Treatment
All treatment performed in the oral cavity during one or more sessions as the result of the same initial diagnosis, and shall include any complications arising during such treatment.

Physician
A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who:

1. acts within the scope of his or her license; and

2. is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Plan, this Plan
The program, benefits and provisions described in this document.

Plan Participant
The Covered Employee or individual who is eligible for coverage under the Plan. As used in this document, this term does not include the Spouse or Dependent Child(ren) of the Plan Participant.

Pre-Admission Testing
Laboratory tests and x-rays and other Medically Necessary tests performed on an out-patient basis prior to a scheduled Hospital admission or out-patient Surgery.

Precertification
A managed care program designed to assure that Hospital and Specialized Health Care Facility admissions and lengths of stay, Surgery and other health care services are Medically Necessary by having the Utilization Management (UM) Company determine the Medical Necessity before the services are provided. You, a family member or your Physician must call the UM Program before any and all planned Hospital stays. For emergencies, the call must be made within 2 working days after you are admitted to the Hospital.

Preferred Provider Organization (PPO)
A group or network of Health Care Providers under contract with the Plan to provide health care services and supplies at agreed-upon discounted rates as payment in full, except with respect to a defined Copayment for which the Plan Participant or Eligible Dependent is responsible, and to handle the paperwork required for submission of claims.

Preventive Services
Evidence-based items or services that have, in effect, a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved; immunizations for routine use in children, adolescents, and adults that have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and with respect to women, to the extent not described above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, when services are obtained through a preferred provider (or pharmacy benefit manager, as appropriate). Any change to a recommendation or guideline that occurs after September 23, 2009 will be covered as a preventive service as of the first day of the first plan year beginning on or after the date that is one year after the new recommendation or guideline went into effect.

Qualified Medical Child Support Order (QMCSO)
A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a Dependent Child, and requiring that Benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child.

Skilled Nursing Care
Services performed by a licensed Nurse if the services:

1. Are ordered by and provided under the direction of a Physician; and

2. Are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and

3. Require the skills of a Nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a Nurse.

Routine Patient Costs
The term Routine Patient Costs has the same meaning as that term is defined under Section 2709 of the Public Health Services Act (PHSA) and includes items or services that are otherwise covered under the terms of the Plan, but generally does not include (i) the investigational item, device, or service being studied in the Approved Clinical Trial; (ii) items and/or services that are provided solely to satisfy the Approved Clinical Trial's data collection and analysis needs; or (iii) a service clearly inconsistent with widely accepted and established standards of care for a particular

diagnosis. The Plan Administrator or its designee intend to interpret this term consistent with the definition under Section 2709 of the PHSA.

Skilled Nursing Facility
A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets all of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Hospitals and Healthcare Organizations (JCAHHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and

2. It maintains on its premises all facilities necessary for medical care and treatment; and

3. It provides services under the supervision of Physicians; and

4. It provides nursing services by or under the supervision of a licensed Registered Nurse, with one licensed Registered Nurse on duty at all times; and

5. It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicted, mentally deficient, or suffering from tuberculosis; and

6. It is not a hotel or motel.

Specialized Health Care Facilities
For the purposes of this Plan, Specialized Health Care Facilities include Ambulatory Surgical Facilities, Behavioral Health Treatment Facilities, Birthing Centers, Hospices, Skilled Nursing Facilities, and Subacute Care Facilities, as those terms are defined in this Definitions section.

Spouse
The Covered Employee's or Covered Retiree's lawful spouse.

Subacute Care Facility
A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility, licensed and operated according to law and authorized to provide Subacute Care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, generally not to exceed 60 days, to the patient's home or to a suitable Skilled Nursing Facility, and that meets all of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Hospitals and Healthcare Organizations (JCAHHO) as a Subacute Care Facility or is recognized by Medicare as a Sub-Acute Care Facility; and

2. It maintains on its premises all facilities necessary for medical care and treatment; and

3. It provides services under the supervision of Physicians; and

4. It provides nursing services by or under the supervision of a licensed Registered Nurse; and

5. It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicted, mentally deficient, or suffering from tuberculosis; and

6. It is not a hotel or motel.

Surgery
Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan Benefits.

When the procedures will be considered to be separate procedures the following percentages of the Usual and Customary Charge will be allowed as the Plan's Benefit:

1. Allowances for multiple Surgeries through the same incision or operational field:

Primary procedure	100% of Usual and Customary Charge
Secondary procedure	50% of Usual and Customary Charge
Additional procedures	25% of Usual and Customary Charge per procedure

2. Allowances for multiple Surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of Usual and Customary Charge
First site secondary procedure	50% of Usual and Customary Charge
First site additional procedures	25% of Usual and Customary Charge per procedure
Second site primary procedures	50% of Usual and Customary Charge
Second site additional procedures	25% of Usual and Customary Charge per procedure

Total Disability, Totally Disabled
The inability of a Covered Employee to perform all the duties of his or her occupation as a result of a non-occupational illness or injury, or the inability of a covered Dependent to perform the normal activities or duties of a person of the same age or sex.

Trust Agreement
The Agreement and Declaration of Trust establishing the International Alliance of Theatrical Stage Employees Local 22 Welfare Fund and any modifications, amendments, extensions or renewals thereof.

Union
The International Alliance of Theatrical Stage Employees Local 22 and Local 772.

Urgent Care Facility
A public or private free-standing facility, not located on the premises of or operating in conjunction with a Hospital, that is licensed or legally operating, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Registered Nurses and x-ray technicians are in attendance at all times the facility is open, and that includes x-ray and laboratory equipment and a life support system.

Usual and Customary Charge
The charge for Medically Necessary services or supplies will be determined by the Plan Administrator or its designee to be the lowest of:

1. The usual charge by the Health Care Provider for the same or similar service or supply; or

2. No more than the Prevailing Charge of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply; or

3. The Health Care Provider's actual charge.

The "Prevailing Charge" of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply shall be determined by the Claims Administrator who shall use proprietary data that is updated no less frequently than annually, and provided by a reputable company or entity.

The Plan will not always pay benefits equal to or based on the Health Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the Usual and Customary charge for health care services or supplies. **Any amount in excess of the Usual and Customary Charge does not count toward the Plan's annual Out-of-Pocket Maximums.**

With respect to a PPO Health Care Provider, the Usual and Customary Charge means the charges set forth in the agreement between the PPO Health Care Provider and the PPO.

The Usual and Customary Charge is sometimes referred to as the U & C Charge, and may sometimes be called the reasonable and customary charge, the R & C charge, the usual, customary and reasonable charge, or the UCR charge.

You, Your
When used in this document, these words refer to the Employee or Retiree who is covered by the Plan. They do not refer to any Dependent of the Employee or Retiree.

II. ELIGIBILITY RULES

SUMMARY OF ELIGIBILITY RULES

■ **Initial Eligibility -**	Must meet one of the following requirements: Minimum Earnings Requirement during 2020 Calendar Year (for 2021 coverage); or Minimum Monthly Earnings Requirement during a Work Month; or Two to Six Times the Minimum Monthly Earnings Requirement during two to six consecutive Work Months.
■ **Continued Eligibility -** Earnings	Full Coverage for 2021 if you meet Minimum Requirement in 2020 Calendar Year Coverage for one Benefit Coverage Month if you earn at least the Minimum Monthly Earnings during a Work Month (or 2 to 6 times the Minimum Monthly Earnings during 2 to 6 consecutive Work Months)
■ **Self-Pay -**	Continued coverage and eligibility in 2021 if you meet at least 50% of Minimum Earnings Requirement in 2020 and self-pay for each 1/12 of Minimum Earnings Requirement not met; or Continued coverage and eligibility for up to three Work Months if you had coverage but do not meet "Continued Eligibility" requirements for a Benefit Coverage Month.
■ **Continued Coverage - (No Self-Pay)**	One month's coverage in 2021 for each 1/12 of Minimum Earnings Requirement earned in 2020 if you do not meet 50% of Minimum Earnings (then coverage will be based on meeting the Minimum Monthly Earnings Requirement)

INITIAL ELIGIBILITY FOR COVERAGE

This Plan covers all employees who (i) satisfy either the Minimum Earnings Requirement (for 2021 Coverage only) or the Minimum Monthly Earnings Requirement, who (ii) are in Covered Employment under Collective Bargaining Agreements of the Union and (iii) on whose behalf contributions are required to be paid to the Fund.

Minimum Earnings Requirement (2021 Coverage Only)

As in prior years, you may establish eligibility for benefits for the 2021 Plan Year (January 1 through December 31) by meeting the Minimum Earnings Requirement in Covered Employment during the **2020** calendar year. The Minimum Earnings Requirement is determined annually by the Trustees.

You must earn at least the following amount in 2020 to be eligible for Tier One benefits in 2021:

- $45,500 - Local 22 Participants ($33,000 if age 60 or over)
- $22,750 - Local 772 Participants

Example: You began working in covered employment for Local 22 in 2020, and earned $45,500 or more in 2020. You would be eligible for one full year of Tier One coverage in 2021.

NOTE: The Minimum Earnings Requirement for Tier One benefits generally increases by $1,000 in each successive calendar year unless the Trustees vote otherwise.

You must earn at least the following amount in 2020 to be eligible for Tier Two benefits in 2021:

- $31,750 (but less than $43,500) - Local 22 Participants
- $19,500 (but less than $21,750) - Local 772 Participants

Example: You began working in covered employment for Local 772 in 2020, and earned at least $19,500 (but less than $22,750) in 2020. You would be eligible for one full year of Tier Two coverage in 2021.

Minimum Monthly Earnings Initial Eligibility

Beginning in the 2021 Plan Year and all future years, you establish initial eligibility for benefits by meeting the Minimum Monthly Earnings Requirement during a Work Month (defined below). If you do not meet the Minimum Monthly Earnings Requirement, you may also establish initial eligibility for benefits by meeting between two and six times the Minimum Monthly Earnings Requirement during a period of between two and six consecutive Work Months.

Minimum Monthly Earnings

The Minimum Monthly Earnings Requirement is approximately $^{1}/_{12}$ of the Minimum Earnings Requirement earned in Covered Employment under Collective Bargaining Agreements of the Union for which contributions are received by the Fund during a Work Month.

You must earn at least the following amount in one Work Month to be eligible for Tier One benefits in one Benefit Coverage Month:

- $3,791.67 - Local 22 Participants ($2,750 if age 60 or over)
- $1,895.83 - Local 772 Participants

You must earn at least the following amount in one Work Month to be eligible for Tier Two benefits in a Benefit Coverage Month:

- $2,645.83 (but less than $3,791.67) - Local 22 Participants
- $1,625 (but less than $1,895.83) - Local 772 Participants

Once you meet the Minimum Monthly Earnings Requirement in one Work Month, your benefit coverage commences on the first day of the following Benefit Coverage Month, as defined below.

Work Month	**Benefit Coverage Month**
October	January
November	February
December	March
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December

[Please note there is a two-month interval between the end of the Work Month and the start of the Benefit Coverage Month. This is to allow time for the required employer contributions to be invoiced, paid and reconciled by the Fund.]

Example #1: You worked in Covered Employment for Local 22 beginning in October. During the October Work Month, you earn a total of $4,000 in Covered Employment for which contributions are received by the Fund. Your Tier One coverage under the Plan begins January 1 (the first day of the next Benefit Coverage Month).

Example #2: Same facts as Example #1, but instead during the January Work Month you earn $3,000.00 in Covered Employment for which contributions are

received by the Fund. Your Tier Two coverage under the Plan begins April 1 (the first day of the next Benefit Coverage Month).

If you do not meet the Minimum Monthly Earnings Requirement in one Work Month, you can still commence benefit coverage in a Benefit Coverage Month if, over a period of between two and six consecutive Work Months you earn a total of between two and six times the Minimum Monthly Earnings Requirement. (In other words, you can commence benefit coverage in a Work Month if you earn at least two times the Minimum Monthly Earnings over a period of two consecutive Work Months, or if you earn at least three times the Minimum Monthly Earnings Requirement over a period of three consecutive Work Months, and so forth, up to six times the Minimum Monthly Earnings Requirement over a period of six consecutive Work Months.)

> **Example #3:** You work in Covered Employment for Local 772. During the November Work Month, you earn $1,000 in Covered Employment, which is less than the Minimum Monthly Earnings Requirement ($1,895.83 for Local 772 Tier One Coverage). However, during the September, October, and November Work Months, you earn a total of $6,000 in Covered Employment for which contributions are received by the Fund. Since you earned more than three times the Minimum Monthly Earnings Requirement ($1,895.83 x 3 = $5,687.49), your Tier One coverage under the Plan begins February 1 (the next Benefit Coverage Month).

COVERAGE FOR ELIGIBLE DEPENDENTS

For Local 22 participants, your Eligible Dependents are covered under this Plan on the date you are eligible or on the date you acquire an Eligible Dependent, whichever is later.

For Local 772 participants, you may choose to self-pay for Eligible Dependents at a cost to be determined by the Trustees from time to time. The self-pay amount must be paid monthly by the 15th of the month preceding the month of coverage. If payment is not made by the 15th of the month, your dependent coverage will cease. The payment of the required amount will be considered timely if it is made within 30 days of the due date.

If your Eligible Dependent is continuing to satisfy the definition of Eligible Dependent due to a disability or Handicap, you must submit to the Board of Trustees proof of your child's incapacity at least 31 days prior to the date that such Dependent coverage would otherwise terminate. The Board of Trustees has the right to require that any Eligible Dependent covered under this provision, be examined by a Physician whom they may designate as often as reasonable but not more than once each year. In addition, proof of continued incapacity must be provided to the Board of Trustees as often as reasonably required but not more than once each year. All rights under this provision shall automatically and immediately cease on the earliest of the following dates:

- the date the Eligible Dependent's incapacity as described herein no longer exists; or
- the date the Eligible Dependent fails to submit to any required medical examination; or
- the date the Plan Participant or Eligible Dependent fails to submit any required proof of the uninterrupted existence of such incapacity of the Dependent.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

If the Plan receives a Medical Child Support Order (MCSO) issued by a court of competent jurisdiction with respect to the provision of health care coverage for any of the Plan Participant's Dependent Children, the Plan Administrator or its designee will determine if the court order is a

Qualified Medical Child Support Order (QMCSO) as defined by federal law, and that determination will be binding on the Plan Participant.

A "qualified" medical child support order (QMCSO) is an order that (A) either creates or recognizes the right of an "alternate recipient" (a Plan Participant's child who is recognized under a MCSO as having a right to be enrolled under the plan) or assigns to the alternate recipient the right to receive benefits for which a participant or other beneficiary is entitled under the plan, and (B) includes (i) the name and last known mailing address of the participant and the name and address of each alternate recipient, (ii) a reasonable description of the type of coverage to be provided by the group health plan or the manner in which such coverage is to be determined, (iii) the period for which coverage must be provided, and (iv) each plan to which the order applies, and (C) does not require the plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan or it requires the Plan to provide coverage for a Dependent Child of a Plan Participant who is not covered by the Plan (except to the extent necessary to meet requirements of Medicaid laws).

If an order is determined to be a QMCSO, and if the Plan Participant is covered by the Plan, the Plan Administrator or its designee will so notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the Dependent Child(ren). However, no coverage will be provided for any Dependent Child under a QMCSO unless all of the Plan's requirements for coverage of that Dependent Child have been satisfied.

Once the Plan Administrator or its designee has determined that a MCSO is or is not "qualified," the Plan will pay benefits to the Plan Participant and to each alternate recipient child in line with the determination. Alternate recipients are considered "plan beneficiaries" for all purposes under ERISA and are considered "plan participants" with respect to reporting and disclosure requirements under ERISA. Any payment for benefits made by the plan under a QMCSO to reimburse the child's out-of-pocket medical expenses paid by the child, by his custodial parent, or his legal guardian shall be made to the child, custodial parent or legal guardian.

RETIREE COVERAGE

If you meet the eligibility rules for retiree coverage and satisfy any self-pay requirements which may apply (specified below and in the Continuation of Eligibility section of this document), you and your Spouse and Eligible Dependents will continue to be covered by the Plan. Eligible Dependents will be covered as long as they continue to meet the definition of an Eligible Dependent.

To be eligible for any retiree coverage, you must be covered under this Plan as a Participant at the time you retire and you must retire under the International Alliance of Theatrical Stage Employees Local 22 Pension Plan (hereinafter the "Local 22 Pension Plan") prior to the expiration of your coverage under this Plan.

A retiree who has coverage based on work in Covered employment prior to retirement will have benefits extended until the earned coverage terminates (see page 33, Special Note on Medicare Enrollment and Limited Reimbursement of Medicare Part B).

As with all provisions of this Plan, the Board of Trustees reserves the right to amend these retiree provisions at any time.

Retiree Coverage Prior to Medicare Eligibility

If a Participant, who is not also entitled to benefits as a dependent under the Plan, retires under the Early Retirement Pension provisions of the Local 22 Pension Plan, such retiree may self-pay to

continue coverage under this Plan. Such Covered Retiree who wishes to continue coverage under this Plan must authorize deduction of the cost of the self-pay amount, as determined by the Trustees, from his or her pension.

Retiree Coverage when Medicare Eligible

If a Covered Retiree, who is Medicare eligible, has been covered by this Plan at any time during the 60 month period preceding his or her retirement date under the Local 22 Pension Plan, the Covered Retiree and his or her Eligible Dependents, may continue coverage under this Plan. Such Covered Retiree who wishes to continue coverage under this Plan must authorize deduction of the cost of the self-pay amount, as determined by the Trustees, from his or her pension.

When a Covered Retiree becomes eligible to enroll in Medicare, benefits under the Plan will be coordinated with Medicare (see Section XV for details regarding how this Plan coordinates its benefits with Medicare).

If a Covered Retiree works 40 or fewer hours in Covered employment, as follows:

- at the trade after Normal Retirement Age, (age 65), or,
- for the Union or its Funds prior to Normal Retirement Age (under age 65);

and earns at least 50% of the Tier One Minimum Earnings Requirement, the Covered Retiree may bridge coverage in accordance with the self-pay rules in the next section, Continuation of Eligibility. If the Covered Retiree continues to work and eventually earns at least 20 Pension Credits under the Local 22 Pension Plan, the Covered Retiree and his or her Eligible Dependents will be eligible for coverage under this Plan with self-payments required as determined by the Trustees.

Special Note on Medicare Enrollment and Limited Reimbursement of Medicare Part B

When you are retired and have reached age 65, this Plan will pay benefits as though you are covered by Medicare (whether or not you have enrolled in Medicare). This is true if you are self-paying for coverage or if you have a period of continued eligibility remaining because of your service as an active employee. Section XV of the Plan explains in detail how this Plan coordinates with Medicare.

If you are, or become a Covered Retiree who still has extended eligibility for Plan benefits as result of having met the Minimum Earnings Requirement as a Covered Employee in the previous calendar year, you are eligible, for a limited period, for reimbursement of the Part B premium you pay to Medicare. The Fund will reimburse to a Covered Retiree the monthly Medicare Part B premium for the Covered Retiree and, if applicable, his or her Spouse, for those months of eligibility under this Plan that were earned solely as a result of such individual's having met the Minimum Earnings Requirement as a Covered Employee. When such eligibility expires, the Covered Retiree's eligibility for Part B premium reimbursement under this provision will cease. The Covered Retiree must submit documentation to the Fund demonstrating enrollment in Medicare Part B and payment of premium in order to be eligible to receive such reimbursement. The Fund will make reimbursement once each calendar year.

CONTINUATION OF ELIGIBILITY

Changing Tiers and Open Enrollment

Changing Tiers

This Plan has two benefit schedules with different eligibility requirements and benefits: Tier One and Tier Two. Once you become covered by Tier One benefits, you cannot become eligible again for Tier Two benefits (at the reduced earnings requirement). Participants cannot switch from Tier One to Tier Two during the Plan Year.

However, as explained below, the Plan has established a process through which you can choose not to advance from Tier Two to Tier One benefits during a Plan Year.

Open Enrollment

The Plan has established an annual Open Enrollment period that will usually take place in the month of November. During this period, you will be given the opportunity to make an election applicable to the upcoming Plan Year beginning on January 1st. You can elect to remain covered by the Plan's Tier Two benefit schedule for the entire Plan Year, so long as you meet the eligibility requirements, **even if you would otherwise be eligible to advance to Tier One benefits.** In other words, so long as you meet the Plan's eligibility requirements, you can choose to receive Tier Two benefits during the Plan Year even if your wages would otherwise move you up to Tier One benefits under the terms Plan.

This election is completely voluntary and cannot be revoked after the close of the Open Enrollment period. If the Fund does not receive a completed Open Enrollment election form from you by the deadline set by the Fund and communicated to you, you will be treated as having not elected to remain covered by the Plan's Tier Two benefit schedule for the Plan Year. **In this case, you will be subject to the Plan's standard eligibility rules (*i.e.*, can move from Tier Two to Tier One benefits) for the upcoming Plan Year.**

Continuation of Eligibility for 2021 Based on 2020 Earnings

After your initial year of Tier One coverage, the Plan has three levels at which you may continue your Tier One coverage for 2021 based upon the Minimum Earnings Requirement.

1. **Full level - If you satisfy 100% of the Minimum Earnings Requirement for Tier One eligibility in the prior 2020 calendar year, you will be covered by the Plan for Tier One Benefits for the full 2021 Plan Year.** You will not be required to self-pay for coverage.

   Example: You became initially eligible as a Local 22 participant for coverage in 2020, and earn $46,000 in 2020. You would be eligible for one full year of Tier One coverage in 2021 without any self-payments required for the coverage.

2. **Self-pay -** If you do not meet the Minimum Earnings Requirement needed to maintain Tier One coverage for all of the 2021 Plan Year, but you earn **at least 50% of the Tier One Minimum Earnings Requirement** in 2020, you may continue Tier One coverage and bridge your eligibility through self-payments. The following rules apply for self-pay coverage:

- **Number of Months of Self-Payment -** Each 1/12 of the Tier One Minimum Earnings Requirement will allow one month's coverage under the Plan.

- **Amount of Self-Payment** - The amount of each self-payment contribution will be determined annually by the Trustees based on the estimated cost to provide the coverage.

- **Timing and Due Date for Self-Payment -** You must pay the premium by the **15th of the preceding month** for which coverage is desired. If you fail to make your premium payment by the 15th of the preceding month, your coverage will be canceled at the end of the month for which your last payment was made. Self-payments must be made after your period of earned coverage ends.

  Example #1: If you earned 10/12 of the Minimum Tier One Earnings Requirement in 2020, you must pay for coverage for the last two months (that is, November and December) of 2021 to bridge your Tier One eligibility. For coverage during November, your self-payment is due on or before October 15th. You will be eligible for coverage for the first ten months, from January through October, 2021, without any self-payments required.

  Example #2: If you choose not to bridge your eligibility by making self-payments, you may obtain free coverage for the first 10 months (January through October) of 2021. Your coverage will terminate after 10 months and you will have to reestablish Tier One Benefits eligibility. **Once you have become eligible for Tier One Benefits, you may not in any future year, become eligible for Tier Two benefits (at the reduced earnings requirement).**

3. **Reestablish Initial Eligibility -** If you do not satisfy at least 50% of the Tier One Minimum Earnings Requirement needed to maintain coverage for the 2021 Plan Year, you will be awarded one month of coverage for each 1/12 of the Tier One Minimum Earnings Requirement you did meet. After your coverage terminates, you will have to establish eligibility based on the Minimum Monthly Earnings Requirement. **As noted above, once you have become eligible for Tier One Benefits, Tier Two Benefits are not available to you in future years**.

   Example: If you become initially eligible for Tier One coverage in 2020 and earn 2/12 of the Tier One Minimum Earnings Requirement in 2020 toward eligibility in 2021, you will be eligible for two months of Tier One coverage in 2021. For coverage after the first two months, you must satisfy the Minimum Monthly Earnings Requirement in order to reestablish Tier One coverage without required self-payments.

   If you fail to earn 50% of the Tier One Minimum Earnings Requirement for eligibility during the Plan Year you are allowed to make up to one year of self-payments and six months of "COBRA continuation coverage" after your coverage runs out.

Employees with Tier One Benefits are eligible to self-pay for either individual or family coverage for:

- Medical and prescription coverage; or

- Medical, prescription, dental, vision, death, and accidental death and dismemberment benefits coverage

Continuation of Eligibility Based on Minimum Monthly Earnings

Beginning in the 2021 Plan Year, you can maintain your coverage under the Plan for a Benefit Coverage Month if you meet the Minimum Monthly Earnings Requirement during a Work Month in Covered Employment under Collective Bargaining Agreements of the Union for which contributions are received by the Fund.

> **Example #1:** You work in covered employment for Local 772 and have coverage for the August Benefit Coverage Month. During the June Work Month, you earn $2,000 in Covered Employment and contributions are actually received by the Fund. You will maintain your coverage for the September Benefit Coverage Month.
>
> **Example #2:** You work in covered employment for Local 22 and have coverage for the November Benefit Coverage Month. During the September Work Month, you earn a total of $4,000 in Covered Employment. You qualify to continue your coverage for the December Benefit Coverage Month.

If you do not meet the Minimum Monthly Earnings Requirement in a Work Month, you can still maintain your eligibility for a Benefit Coverage Month if, over a period of between two and six consecutive Work Months, you earn between two and six times the Minimum Monthly Earnings Requirement. (In other words, you can continue benefit coverage for a Work Month if you earn at least two times the Minimum Monthly Earnings Requirement over a period of two consecutive Work Months, or if you earn at least three times the Minimum Monthly Earnings Requirement over a period of three consecutive Work Months, and so forth, up to six times the Minimum Monthly Earnings Requirement over a period of six consecutive Work Months.)

> **Example #3:** You worked in Covered Employment for Local 22 and have coverage for the January Benefit Coverage Month. During the November Work Month, you earn $3,000 in Covered Employment, which is less than the Minimum Monthly Earnings Requirement ($3,791.67). <u>However</u>, during the October Work Month and November Work Month, you earn a total of $8,000 in Covered Employment for which contributions are received by the Fund. Because you earned more than twice the Minimum Monthly Earnings Requirement ($3,791.67 x 2 = $7,583.34), your Tier One benefits under the Plan continue for the February Benefit Coverage Month.

Self-Payment

If you do not qualify for continued coverage based on Minimum Monthly Earnings, as discussed above, you have the right to self-pay for up to three consecutive Benefit Coverage Months. The amount you must self-pay is equal to thirteen percent (13%) of the difference between the amount you earned in the most recent month (i.e., the month before you start self-payments) and the Minimum Monthly Earnings amount.

Example: You worked in Covered Employment for Local 22 and had coverage for the January Benefit Coverage Month. In November, you earn $2,000 in Covered Employment, which is less than the Minimum Monthly Earnings Requirement ($3,791.67). The Fund has looked back two to six months, and you do not meet two to six times the Minimum Monthly Earnings Requirement during that time. Therefore, although your coverage will otherwise end, you can start three months of self-pay coverage in February. Based on these facts, your required self-pay amount is $232.92 per month ($3,791.67 - $2,000 = $1,791.67 * 13% = $232.92).

Self-payments are due on the 15th of the month in which coverage is provided. Self-payment is only available **if the premium is paid timely and if you have no break in coverage** (example: if you have coverage in January, but would lose coverage for February, you must start paying the self-payment premium for February's coverage; you could not skip February and then start self-payments in March).

If you experience a break in coverage, self-payment is unavailable (example: if you begin self-payment coverage in February but do not pay the premium for March, you cannot resume self-payment coverage in April).

Self-payment may be paid through ACH (Automated Clearing House), check, or other methods as the Fund Office may implement from time to time.

For Employees who have qualified for Tier Two (but not Tier One) Benefits

Continuation of Eligibility for 2021 Based on 2020 Earnings
After your initial year of Tier Two coverage, the Plan has three levels at which you may continue your Tier Two coverage in the 2021 calendar year based upon your earnings in covered employment during the 2020 calendar year. **Note also that you may qualify for Tier One Benefits in a subsequent period if you are able to meet the Tier One Earnings Requirement or Hours Requirement.**

1. **Full level - If you satisfy 100% of the Minimum Earnings Requirement for Tier Two eligibility in the 2020 calendar year, you will be covered by the Plan for Tier Two Benefits for the full 2021 Plan Year.** You will not be required to self-pay for coverage.

   Example: You became initially eligible for coverage as a Local 772 participant in 2020, and earn $19,500 in 2020. You would be eligible for one full year of Tier Two coverage in 2021 without any self-payments required for the coverage.

2. **Self-pay -** If you do not meet the Minimum Earnings Requirement needed to maintain Tier Two coverage for the full 2021 Plan Year, but you earn **at least 50% of the Tier Two Minimum Earnings Requirement** in the 2020 calendar year, you may continue Tier Two coverage and bridge your eligibility through self-payments. The following rules apply for self-pay coverage:

   - **Number of Months of Self-Payment -** Each 1/12 of the Tier Two Minimum Earnings Requirement will allow one month's coverage under the Plan.

   - **Amount of Self-Payment** - The amount of each self-payment contribution will be determined annually by the Trustees based on the estimated cost to provide the coverage.

   - **Timing and Due Date for Self-Payment -** You must pay the premium by the **15th of the preceding month** for which coverage is desired. If you fail to make your premium payment by the 15th of the preceding month, your coverage will be canceled at the end of the month for which your last payment was made. Self-payments must be made after your period of earned coverage ends.

     Example #1: If you earned 10/12 of the Minimum Tier Two Earnings Requirement in 2020, you must pay for coverage for the last two months (that is, November and December) of 2021 to bridge your eligibility. For coverage during November, your self-payment is due on or before October 15th. You will be eligible for coverage for the first ten months, from January through October 2021, without any self-payments required.

     Example #2: If you choose not to bridge your eligibility by making self-payments, you may obtain free coverage for the first 10 months (January through October) of 2021. Your coverage will terminate after 10 months and you will you must satisfy

the Minimum Monthly Earnings Requirement in order to reestablish or continue Tier Two Plan eligibility.

3. **Reestablish Initial Eligibility -** If you do not satisfy at least 50% of the Tier Two Minimum Earnings Requirement needed to maintain coverage for the 2021 Plan Year, you will be awarded one month of Tier Two coverage for each 1/12 of the Tier Two Minimum Earnings Requirement you did meet. After your coverage ends, you will have to establish eligibility based on the Minimum Monthly Earnings Requirement.

   Example: If you become initially eligible for Tier Two coverage in 2020 and earn 2/12 of the Minimum Tier Two Earnings Requirement in 2020 toward eligibility in 2021, you will be eligible for two months of Tier Two coverage in 2021. For coverage after the first two months, you may self-pay; however, you must satisfy the Minimum Monthly Earnings Requirement in order to reestablish or continue Tier Two coverage without required self-payments.

   If you fail to earn 50% of the Tier Two Minimum Earnings Requirement for eligibility during the Plan Year you are allowed to make up to one year of self-payments and six months of "COBRA continuation coverage" after your coverage runs out.

Employees with Tier Two Benefits are eligible to self-pay for either individual or family coverage for medical and prescription coverage only.

Continuation of Eligibility Based on Minimum Monthly Earnings Requirement

Beginning in the 2021 Plan Year, you can maintain your coverage under the Plan for a Benefit Coverage Month if you meet the Minimum Monthly Earnings Requirement in Covered Employment under Collective Bargaining Agreements of the Union for which contributions are received by the Fund in the prior Work Month. If you have been covered under Tier Two, these examples apply to you.

Example #1: You work in covered employment for Local 772 and have coverage for the August Benefit Coverage Month. During the June Work Month, you earn $1,700 in Covered Employment and contributions are actually received by the Fund. You will maintain your Tier Two coverage for the September Benefit Coverage Month.

Example #2: You work in covered employment for Local 22 and have coverage for the November 2021 Benefit Coverage Month. During the September 2021 Work Month, you earn a total of $3,000 in Covered Employment. You qualify to continue your Tier Two coverage for the December 2021 Benefit Coverage Month.

If you do not meet the Minimum Monthly Earnings Requirement in a Work Month, you can still maintain your eligibility for a Benefit Coverage Month if, over a period of between two and six consecutive Work Months, you earn between two and six times the Minimum Monthly Earnings Requirement. (In other words, you can continue benefit coverage for a Work Month if you earn at least two times the Minimum Monthly Earnings Requirement over a period of two consecutive Work Months, or if you earn at least three times the Minimum Monthly Earnings Requirement over a period of three consecutive Work Months, and so forth, up to six times the Minimum Monthly Earnings Requirement over a period of six consecutive Work Months.)

Example #3: You worked in Covered Employment for Local 22 and have coverage for the January Benefit Coverage Month. During the November Work Month, you earn $2,500 in Covered Employment for which contributions are received by the Fund, which is less than the Minimum Monthly Earnings Requirement ($2,645.83). However, during the October Work Month and November Work Month, you earn a total of $6,000 in Covered

Employment for which contributions are received by the Fund. Since you earned more than twice the Minimum Monthly Earnings Requirement ($2,645.83 x 2 = $5,291.66), your Tier Two benefits under the Plan continues for the February Benefit Coverage Month.

Self-Payment

If you do not qualify for continued coverage based on Minimum Monthly Earnings, as discussed above, you have the right to self-pay for up to three consecutive Benefit Coverage Months. The amount you must self-pay is equal to thirteen percent (13%) of the difference between the amount you earned in the most recent month (i.e., the month before you start self-payments) and the Minimum Monthly Earnings amount.

> **Example:** You worked in Covered Employment for Local 22 and had coverage for the January Benefit Coverage Month. In November, you earn $2,000 in Covered Employment, which is less than the Minimum Monthly Earnings Requirement ($2,645.83). The Fund has looked back two to six months, and you do not meet two to six times the Minimum Monthly Earnings Requirement during that time. Therefore, although your coverage will otherwise end, you can start three months of self-pay coverage in February. Based on these facts, your required self-pay amount is $83.96 per month ($2,645.83 - $2,000 = $645.83 * 13% = $83.96).

Self-payments are due on the 15th of the month in which coverage is provided. Self-payment is only available **if the premium is paid timely and if you have no break in coverage** (example: if you have coverage in January, but would lose coverage for February, you must start paying the self-payment premium for February's coverage; you could not skip February and then start self-payments in March).

If you experience a break in coverage, self-payment is unavailable (example: if you begin self-payment coverage in February but do not pay the premium for March, you cannot resume self-payment coverage in April).

Self-payment may be paid through ACH (Automated Clearing House), check, or other methods as the Fund Office may implement from time to time.

Continuation Of Surviving Spouse Coverage

After your death your surviving spouse may continue his or her coverage until remarriage. If you die after retiring, while covered by the Plan, your surviving spouse's coverage will continue with self-payment required as determined by the Trustees. If you die without having retired under the Local 22 Pension Plan, your spouse's coverage can be continued by self-paying the required premium until her or she remarries, subject to continued coverage under COBRA regulations (see page 38). If your surviving spouse's coverage lapses because he or she elects not to self-pay, no further coverage will be provided.

Continuation Of Eligibility During Period Of Disability

If you are disabled and are receiving Weekly Income Benefits from this Plan or from Worker's Compensation benefits, you will receive credit for the period of your disability, to a maximum of 26 weeks, to determine your continued future eligibility. Credit will be granted so that you will be considered to have earned 1/12 of the Minimum Earnings Requirement in employment covered

by this Plan for each full month in the calendar year that you receive Weekly Income benefits or benefits through Workers' Compensation.

Notification Of New Eligible Dependent

You must notify the Fund Administrator within 30 days of the birth of a newborn, adoption or placement of a child for adoption or your marriage if you want to add your new spouse or child as an Eligible Dependent.

Family And/or Medical Leave

If you are entitled to Family or Medical Leave, you can keep your coverage in effect if you have earned enough to have coverage for the entire leave period. Otherwise, you may self-pay to continue your coverage for any period of Family or Medical Leave for which you have insufficient earnings.

Questions regarding entitlement to benefits during Family and Medical Leave should be referred to the Fund Administrator.

Military Leave

If you go into active military service for up to 31 days, you can continue your coverage during that leave period at no cost to you.

If you go into active military service for more than 31 days, you may be able to continue your medical and dental coverage up to 18 months if you have enough credits to cover the entire leave period. Otherwise, you may self-pay to continue coverage for any part of the period of leave (up to 18 months) for which you have insufficient earnings credit. You may also choose to elect COBRA Continuation Coverage.

Questions regarding entitlement to benefits during Military Leave should be referred to the Fund Administrator.

SPECIAL RULES FOR THE UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994.

Special rules exist under the Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA) for a Participant who is on military leave. The Plan incorporates these rules by reference.

A Participant who qualifies for these special rules is permitted to continue his medical, dental and vision benefits for the lesser of

- 24 months from the start of the employee's absence due to performing uniformed service as that term is defined by USERRA; or
- when the service period is less than 24 months, the period ending on the date the employee fails to return from service or to apply for reimbursement.

A person who elects to continue coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

The USERRA continuation period runs concurrently with the COBRA continuation period.

TERMINATION OF COVERAGE

If your coverage terminates for any reason, you must again fulfill the initial Minimum Earnings Requirement (for coverage in 2021) or the Minimum Monthly Earnings Requirement. Coverage will be reinstated on the January 1 of the Plan Year following the year you fulfill that requirement (for coverage in 2021) or on the first day of the Benefit Coverage Month following the Work Month in which you satisfy the Minimum Monthly Earnings Requirement.

For Coverage Based on Minimum Earnings Requirement

Your coverage ends on the last day of the month in which any of the following occurs:

1. You fail to meet the Minimum Earnings Requirement for coverage under the Plan and you fail to make timely self-payment contributions to the Fund;

2. The end of the period for which you paid COBRA continuation premiums, if you do not make a required premium contribution when due;

3. The end of the COBRA continuation period;

4. The date you are inducted into active service in the Armed Forces[1]; or

5. The Plan terminates.

For Coverage Based on Minimum Monthly Earnings Requirement

Your coverage ends on the last day of the month in which any of the following occurs:

1. You fail to meet the Minimum Monthly Earnings Requirement for coverage under the Plan for the following Eligibility Quarter and you fail to make timely self-payment contributions to the Fund;

2. The end of the period for which you paid COBRA continuation premiums, if you do not make a required premium contribution when due;

3. The end of the COBRA continuation period;

[1] If your coverage terminates because you are inducted into the Armed Forces, your coverage will be reinstated on the date of reemployment with a contributing employer, if such date is within 90 days after discharge from the Service or from a hospital, if hospitalized at the time of separation from the Service, if the period of service was more than 180 days, or within 14 days of discharge, if the period of service was 31 days or more but less than 180 days, or 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 31 days.

4. The date you are inducted into active service in the Armed Forces[2]; or

5. The Plan terminates.

COBRA CONTINUATION COVERAGE

If you or your Eligible Dependents lose eligibility under certain circumstances, you have the right to continue benefits by paying the full cost of coverage to the Plan plus an administrative charge. This extended coverage is called "COBRA continuation coverage", named after the Federal law which requires health plans to offer such coverage.

COBRA Benefits Available

The health care coverage you are entitled to elect under COBRA is identical to the health care coverage provided under the Plan to similarly situated employees and their dependents. The COBRA continuation coverage includes all benefits provided under the Plan except the Death Benefits, the Weekly Income Coverage, and Accidental Death and Dismemberment Coverage. The benefits available to you are divided into "core" and "non-core" benefits. Local 22 Plan Participants and their Eligible Dependents may select "core benefits" which include only the Medical and Prescription Drug benefits; or "core" plus "non-core" coverage which includes Medical, Prescription Drug, Dental, and Vision Care. Once you have made an election for "core" only or "core" plus "non-core" benefits, your coverage will remain at that benefit level. Note that participants who prior to the loss of coverage were covered under Tier Two benefits may only elect the "core" benefits under COBRA.

QUALIFYING EVENTS AND QUALIFIED BENEFICIARY

For purposes of this Section, the term "Qualifying Event" means, with respect to any Participant (and his or her Dependents), any of the following events which, but for the Continuation Coverage hereunder, would result in loss of Medical Care coverage for a Qualified Beneficiary:

(A) The death of the Participant.

(B) The termination (other than by reason of a Participant's gross misconduct), or reduction of hours, of the Participant's employment. The term "gross misconduct" means conduct of a Participant which is (1) a deliberate a willful disregard of standards of behavior which the Employer has a right to expect, showing a gross indifference to the Employer's interest; or (2) a series of repeated violations of employment rules proving that the Participant has regularly and wantonly disregarded his or her obligations.

(C) The divorce or legal separation (if recognized by state law) of the Participant from the Participant's Spouse.

(D) The Participant becomes entitled to Medicare benefits under Title XVIII of the Social Security Act, as amended.

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[2] If your coverage terminates because you are inducted into the Armed Forces, your coverage will be reinstated on the date of reemployment with a contributing employer, if such date is within 90 days after discharge from the Service or from a hospital, if hospitalized at the time of separation from the Service, if the period of service was more than 180 days, or within 14 days of discharge, if the period of service was 31 days or more but less than 180 days, or 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 31 days.

(E) A Dependent child of a Participant ceases to be a Dependent Child under the specific terms of the Plan, as amended from time to time.

(F) An Employer's filing of Chapter 11 Bankruptcy.

For purposes of this Section, the term "Qualified Beneficiary" means:

(A) any Participant or Dependent who, on the day before the Qualifying Event is eligible for Benefits under the Plan on the basis of being either (i) the Participant, (ii) the Dependent Child of the Participant or (iii) the Spouse of the Participant. Except as set forth in (B), no Participant, Dependent Spouse or Dependent Child may be considered a Qualified Beneficiary if, on the date prior to the Qualifying Event, such individual was not already eligible for Benefits under the Plan.

(B) newborn infants and children placed for adoption who become Dependents during the period of time when a Participant is eligible for COBRA coverage but who were not covered under the Plan on the day before the Qualifying Event are still treated as "Qualified Beneficiaries"

(C) The term "Qualified Beneficiary" shall exclude nonresident aliens to the extent permitted by law.

COBRA Rules for Covered Employees

As a Covered Employee, you have the right to obtain COBRA continuation coverage for yourself and/or your Eligible Dependents. Coverage can be continued for up to 18 months if you lose eligibility as a result of one of the following qualifying events:

- you are terminated from employment in covered work;
- you retire prior to eligibility for Medicare; or
- you leave covered employment; or
- you reduce or have an insufficient number of hours that you work.

The period you can continue coverage through either COBRA continuation coverage or the Self-pay continuation, if available, run concurrently. This means that if you are eligible to elect one year of continued coverage under the self-pay provisions and up to 18 months under the COBRA coverage, you may elect to continue your coverage for the first 12 months under the self-pay provisions of the Plan and then continue for an additional 6 months under COBRA Continuation Coverage at the COBRA Coverage rate.

If you leave covered employment, take a new job, and join your new employer's group health plan but that group health plan does not cover or limits coverage for a preexisting medical condition which you or your dependent may have, you or your dependent may continue COBRA coverage under this Plan. The COBRA Coverage under this Plan will end on the earlier of the expiration of the COBRA Coverage period or such time as the new employer plan no longer imposes the pre-existing condition exclusion or limitation.

If you have a newborn child, adopt a child, or have a child placed with you for adoption (for whom you have financial responsibility) while your COBRA continuation coverage is in effect, you may add this child to your coverage. You must notify the Fund Office in writing of the birth or

placement within 31 days in order to add the child to your coverage. Of course, adding a child to your COBRA coverage may cause an increase in your COBRA premiums.

If you remarry while your COBRA continuation coverage is in effect, you may add your spouse and any children of this spouse. You must notify the Fund Office in writing of your remarriage within 31 days in order to add any new dependents to your coverage.

A child born, adopted or placed for adoption while you are on COBRA will have the same COBRA rights as your Eligible Dependents who were covered by the Plan before the event that triggered COBRA coverage. Like all qualified beneficiaries with COBRA coverage, their continued coverage depends on the timely and uninterrupted payment of premiums on their behalf.

COBRA Rules for Disabled Participants

If the Social Security Administration determines that you (or a member of your family who is eligible for COBRA continuation coverage) were totally and permanently disabled on the day you lost eligibility for health coverage under the Plan as a Covered Employee, or within 60 days after that, you or your disabled family member may elect to keep COBRA coverage for 29 months instead of the usual 18 months. In addition, other members of your family who have elected COBRA coverage can keep it for the extended period, if they choose. COBRA premiums may be higher for the extra 11 months of coverage.

You or your disabled family member must notify the Fund Office in writing of the Social Security disability determination within 60 days of the date it is issued, and before the end of the initial 18-month COBRA coverage period. You or your disabled family member must also notify the Fund Office within 30 days of the date of any final determination by the Social Security Administration that you or your family member is no longer disabled. As with all COBRA coverage, your and your family's eligibility for this extension depends on the timely and uninterrupted payment of all required premiums.

Continuation coverage ends if Medicare coverage begins before the 29-month period expires or upon recovery if you have already received 18 months of continuation coverage and were in the 11-month extension period.

COBRA Rules for Eligible Dependents

If you choose not to receive COBRA continuation coverage, your Eligible Dependents can separately purchase COBRA continuation coverage for themselves by making the election and the required premium payments.

The coverage can be continued for your Eligible Dependents up to 36 months if your Eligible Dependents' eligibility terminated as a result of any of the following qualifying events:

1. Your death, or;

2. Your divorce or legal separation, or;

3. Your becoming entitled to Medicare benefits; or;

4. In the case of your Dependent Child, the child no longer meets the Plan's definition of an "Eligible Dependent".

The 36-month maximum coverage period is not extendable, even if two or more of the "qualifying events" occur during that period.

COBRA Election Period

You or your Eligible Dependents must notify the Fund Office in writing of your divorce, your legal separation or change in Dependent status within 60 days from the date on which the event occurs. The Fund Office must also be notified of your death, termination of employment or reduction of your covered work hours also within 60 days of the occurrence. After the notification has been received in the Fund Office, you and your Eligible Dependents will receive information regarding COBRA continuation coverage rights and election procedures within 14 days of receipt of such notice or after your termination of employment or reduction in hours result in loss of your eligibility. The Fund Office will provide you with an election form which must be completed and returned within 60 days of the date on which your eligibility would have terminated or, if later, within 60 days immediately following your receipt of the COBRA Continuation Coverage notice from the Fund Office.

Payment for COBRA Coverage

You are responsible for paying the entire cost for COBRA Continuation Coverage in the form of monthly premiums. The initial premium is due within 45 days of the election of COBRA Continuation Coverage, and every 30 days after that. Payment of premiums must be made so that eligibility is continuous; there can be no gaps in eligibility. If you elect COBRA Continuation Coverage within the election period but after the date on which eligibility terminated, you must pay the required COBRA premiums retroactively to cover the elapsed period since the eligibility termination date, so that coverage will be continuous. The Fund Office will notify you of the "Core" and "Core Plus Non-Core" coverage rates at the time when you become entitled to COBRA Continuation Coverage and of the method for payment of monthly premiums.

Termination of COBRA Coverage

COBRA continuation coverage will terminate earlier than the maximum period if:

- All health care coverage offered by the Fund terminates;
- The required premium payments are not made on time;
- You become covered by another group health plan that does not exclude or limit coverage due to preexisting conditions or;
- You become entitled to benefits under Medicare. [If you become entitled to Medicare while under COBRA continuation coverage, your Eligible Dependents may continue their COBRA continuation coverage until 36 months after the date your COBRA coverage commenced.]

III. HOW YOUR HEALTH PLAN WORKS

YOUR HEALTH CARE PROVIDERS

This Plan provides medical benefits for Illnesses or Injuries which require Medically Necessary treatment by a Health Care Provider. Prescription drugs are also covered under this Plan by a self-insured contract with the Prescription Benefit Manager (PBM) chosen by the Plan Administrator.

Your benefits are provided by the IATSE Local 22 Welfare Fund for Plan Participants using a Preferred Provider Organization (PPO) Network. You have the option of obtaining medical treatment from any Physician you choose or from the lists of Physicians participating in the PPO. If you use Physicians in the PPO, you will pay significantly less for your visits, as shown on the benefit schedule. Contact the Fund Office for guidance on locating healthcare providers who are participating in the PPO Network.

The current PPO Network is the BlueCross BlueShield Preferred Network from Carefirst. In addition to calling the Fund Office, you can go online to www.carefirst.com/findadoc and select the BlueCross BlueShield Preferred PPO Plan to locate healthcare providers or call 1 (800) 235-5160.

In addition to BlueCross BlueShield Preferred Network, the Fund utilizes Virginia Health Network ("VHN") as a PPO Network that serves Plan Participants who are residents of Virginia and obtain medical treatment from a Virginia provider. In addition to calling the Fund Office, you can go online to http://www.vhn.com/body.cfm?id=61 and select Virginia Health Network PPO to locate healthcare providers or call 1 (804) 320-3837.

MANAGED CARE REQUIREMENTS - Utilization Management and Case Management

In order to ensure that you receive the best medical care possible at the least cost to you and the Fund, the Fund has adopted a Utilization Management Program (UM Program) which is administered by a company chosen by the Plan Administrator. There are several procedures that you must follow before undergoing surgery or staying in a Hospital. Specially trained staff will review your case and, if necessary, your medical records and history. The staff keeps all information **strictly confidential.** The Plan's UM Program consists of the following procedures. Others may be added or dropped in the future as the Fund continues to improve the administration of the Plan.

- **HOSPITAL ADMISSION AND SURGERY PRE-CERTIFICATION**

  This Plan requires Pre-certification of all Hospital admissions and some Surgeries. You, a family member or your Physician must call the UM Program before any and all planned Hospital stays. For emergencies, the call must be made within 2 working days after you are admitted to the Hospital.

- **PRE-ADMISSION TESTING**

  Many diagnostic tests required prior to Surgery can be performed simply and quickly before your Hospital stay. This can shorten your stay, keep you at home and on the job longer and save money.

If You Use Providers Inside or Outside Of The PPO Network

If you choose to use a Health Care Provider inside or outside of the PPO Network, you need to follow all the requirements of the UM Program for Hospital Pre-Certification. If these requirements are not followed, **your benefits for the Hospitalization related charges will be reduced by 25%, up to $2,000 per Calendar Year. The 25% reduction cannot be counted toward your Out-of-Pocket Maximum or your annual Medical Deductible.**

Your Plan identification card gives a telephone number to call for Hospital reviews.

PRE-ADMISSION CERTIFICATION
IS OBTAINED BY CALLING:
1-(800) 641-5566. (for any Utilization Management Services)

IV. MEDICAL BENEFITS

SUMMARY OF MEDICAL COVERAGE DEDUCTIBLES AND MAXIMUMS

- **Calendar Year Medical Deductible**

Tier One Benefits

Individual	$500
Family (3 times Individual)	$1,500

Tier Two Benefits

Individual	$2,000
Family (3 times Individual)	$6,000

- **Calendar Year Out-of-Pocket Maximum** (includes deductible)

Tier One Benefits

Individual	$1,500
Family	$3,000

Tier Two Benefits

Individual	$3,000
Family	$7,500

These Deductible and Maximum amounts are the same for inside and outside of the PPO Network

MEDICAL BENEFITS

Medical Benefits are payable for Covered Charges incurred by an individual for Medically Necessary treatment or services as a result of Injury or Illness. These benefits are payable in accordance with the Deductible, Copayment, Coinsurance, and Lifetime Maximum rules set forth below and in the Schedule of Benefits.

You should be familiar with the following terms under this Plan:

■ THE MEDICAL DEDUCTIBLE

In each Calendar Year you or your Eligible Dependents are covered under this Plan, you are responsible for paying an amount on a Calendar Year basis before the Plan will pay for covered medical services. That amount is the "Medical Deductible."

- For individuals, the annual Medical Deductible is $500 for Tier One and $2,000 for Tier Two.

- For families, the annual Medical Deductible is $500 per person up to a maximum of $1,500 for Tier One. For Tier Two, it's $2,000 per person up to a maximum of $6,000.

  Example:
  If you have 4 covered family members and you qualify for Tier One benefits, your Deductible is $1,500. Your Deductible is also $1,500 if you have 3 covered family members.

Carryover Deductible

Any expenses applied against the Medical Deductible for the last 3 months of a Calendar Year will also count toward the Medical Deductible for the next Calendar Year.

> **Example:** You had $100 worth of expenses which applied to your 2017 Medical Deductible between October 1, 2017 to December 31, 2017. The Plan will count the $100 toward satisfaction of your 2018 Medical Deductible and your 2018 Calendar Year Out-of-Pocket Maximum (see "Calendar Year Out-of-Pocket Maximum" on page 46).

Common Accident Deductible

Normally, the Medical Deductible is applied separately to each member of the family covered under the Plan. However, if two or more covered members of your family are injured in the same accident, the medical expenses which result from the accident will be combined and only one Deductible will be charged against all such expenses, regardless of the number of family members injured. In addition, in the following year, no Deductible will be applied for expenses resulting from the common accident.

■ PER-VISIT COPAYMENT

The per visit Copayment is the amount you pay for each physician home and office visit before the Plan pays. The per-visit Copayment is $20 in the PPO network and $40 outside of the PPO network.

The per-visit Copayment:

- will not be counted toward satisfaction of the Calendar Year Out-of-Pocket Maximum; and

- will not be counted toward satisfaction of your Calendar Year Medical Deductible; and

- will continue to apply after the Calendar Year Out-of-Pocket Maximum has been reached.

■ COINSURANCE

The Coinsurance percentage is the percentage of Covered Charges that the Plan pays for after you have met your annual Medical Deductible and/or paid your applicable Copayment amount.

After any applicable Copayment has been satisfied, the Plan pays 100% of the Covered Charges for Physician office visits if you use an In-Network PPO Physician and 70% of Covered Charges (up to 70% of the Usual & Customary charges) if the Physician does not participate in the PPO. The Plan pays 80% of Covered Charges for other services, including Hospital services provided on an Inpatient or Outpatient Surgery basis (including Physician services while in the Hospital) and Diagnostic X-Ray and Laboratory services if you use a PPO Physician and 70% of Covered Charges (up to 70% of the Usual & Customary charges) if the Physician does not participate in the PPO.

■ CALENDAR YEAR OUT-OF-POCKET MAXIMUM

The Calendar Year Out-of-Pocket Maximum is the total amount you or your family pay for medical expenses each year before the Plan starts paying 100% of your medical Covered Charges. Exceptions to this rule are that you will still be required to pay any expenses incurred for any per visit Copayment amounts, dental or vision expenses under the plan, and all other non-medical benefits under the Plan.

The Annual Out-of-Pocket Maximum is $1,500 for individuals and $3,000 for families with Tier One benefits. The Annual Out-of-Pocket Maximum is $3,000 for individuals and $7,500 for families with Tier Two benefits. Your payments to meet your Medical Deductible count toward your Out-of-Pocket Maximum. Expenses incurred during the last 3 months of a Calendar Year and applied to the following Calendar Year's Medical Deductible (see "Carryover Deductible" on page 45), will also be applied toward satisfying your Annual Out-of-Pocket Maximum for the same Calendar Year.

■ PREVENTIVE SERVICES

As required by federal law, Preventive Services (see Definitions, page 26) are covered by this Plan without the application of the Deductible and at 100% coverage. This level of coverage is available only to services provided by or obtained In-Network. Services provided by an Out-of-Network provider are subject to the Out-of-Network Deductible and Coinsurance without regard to whether the service would otherwise be considered a Preventive Service.

Regarding the coverage for the Office Visits associated with Preventive Services:

- if a Preventive Service is billed separately (or is tracked as individual encounter data separately) from an office visit, then this Plan will impose cost-sharing requirements with respect to the office visit,

- if a Preventive Service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is the delivery of the preventive item or service, then this Plan will not impose cost-sharing requirements with respect to the office visit and,

- if a Preventive Service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is not the delivery of the preventive item or service, then this plan will impose cost-sharing requirements with respect to the office visit.

Example:

Facts:

An individual covered by this Plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the Plan for an office visit.

Conclusion:

In this Example, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver preventive items or services. Therefore, the Plan will impose a cost-sharing requirement for the office visit charge.

The list below shows the Preventive Services subject to this no Deductible/100% In-Network coverage.

Covered Preventive Services for Adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adults
- Type 2 Diabetes screening for adults with high blood pressure

- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Immunization vaccines for adults – doses, recommended ages, and recommended populations vary:
  - ☐ Hepatitis A
  - ☐ Hepatitis B
  - ☐ Herpes Zoster
  - ☐ Human Papillomavirus
  - ☐ Influenza
  - ☐ Measles, Mumps, Rubella
  - ☐ Meningococcal
  - ☐ Pneumococcal
  - ☐ Tetanus, Diphtheria, Pertussis
  - ☐ Varicella
- Obesity screening and counseling for all adults
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users
- Syphilis screening for all adults at higher risk
- Annual lung cancer screening with low-dose computed tomography in adults ages 55-80 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.
- Hepatitis C screening for persons at high risk and persons born between 1945 and 1965.
- Hepatitis B screening for persons at high risk for infection.
- Use of low to moderate-dose statin for the prevention of cardiovascular disease for adults 40 to 75 years of age who have no history of cardiovascular disease but who have been diagnosed with one or more cardiovascular disease risk factors (i.e. dyslipidemia, diabetes, hypertension or smoking) and have a calculated 10-year risk of a cardiovascular event of 10% or greater. (Identification of dyslipidemia and calculation of the 10-year cardiovascular event risk requires universal lipids screening in adults aged 40 to 75 years.)
- Tuberculosis screening for latent tuberculosis infection in adults at increased risk of tuberculosis.

Covered Preventive Services for Women, Including Pregnant Women

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breast Feeding interventions to support and promote breast feeding
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- Domestic and interpersonal violence screening and counseling for all women
- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Sexually Transmitted Infections (STI) counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Well-woman visits to obtain recommended preventive services
- Low-dose aspirin for pregnant women who are at higher risk of an abrupt and dangerous increase in blood pressure known as preeclampsia.

Covered Preventive Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    - ☐ Diphtheria, Tetanus, Pertussis
    - ☐ Haemophilus influenzae type b
    - ☐ Hepatitis A
    - ☐ Hepatitis B
    - ☐ Human Papillomavirus
    - ☐ Inactivated Poliovirus
    - ☐ Influenza
    - ☐ Measles, Mumps, Rubella
    - ☐ Meningococcal
    - ☐ Pneumococcal

- ☐ Rotavirus
- ☐ Varicella

- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development
- Obesity screening and counseling
- Oral Health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children
- Tobacco use interventions to prevent initiation of tobacco use in school-aged children and adolescents.
- Hepatitis B screening for persons at high risk for infection.

Covered Preventive Services Related to COVID-19

- preventive services, including immunizations, intended to prevent or mitigate COVID-19
- The Plan covers these preventive services within 15 days of being recommended as such by the CDC or by the United States Prevent Services Task Force with a rating of "A" or "B".

■ EXPENSES NOT SUBJECT TO THE DEDUCTIBLE OR COPAYMENT

Please note that while the Deductible is not applied and there is no Copayment required for these services, if you receive services from an Out-of-Network Provider you will still be responsible for any required Coinsurance amount.

Mammography

Mammography benefits will be paid the same as for any other covered service, except that no Deductible or Copayment will be applied to such expenses. Coinsurance will apply if provided by a provider outside of the PPO network.

Colonoscopies

No Deductible or Copayment will be applied for colonoscopies. Coinsurance will apply if you use an Out-of-Network Provider.

Child Wellness Services

No Deductible or Copayment will be applied for certain child wellness services:

- all visits for and costs of childhood and adolescent immunizations recommended by the Center for Disease Control;
- one visit for a Phenylketonuria (PKU) test between two and four weeks of age;
- all visits and costs for screening tests as determined by the American Academy of Pediatrics for tuberculosis, anemia, lead toxicity, hearing and vision;
- a physical examination and a developmental assessment at each visit for the tests described; and,
- laboratory tests considered necessary by the physician for the child wellness services described herein.

Pediatric Vaccines administered to an Eligible Dependent from birth to 18 years old will be provided at 100% of Covered Charges and no Deductible or Copayment will be applied.

Acupuncture Services

No Deductible or Copayment will be applied for Medically Necessary acupuncture services. A physician referral is required. Office visits for acupuncture will be covered for up to 15 visits per Calendar Year, payable at 50% up to $30.00 per visit. If the acupuncturist is in the PPO Network then discounted rates will apply. Acupuncture benefits are not subject to the regular Copayment or Coinsurance provisions for office visits. In addition, acupuncture expenses will not count toward the satisfaction of your Calendar Year Out-of-Pocket Maximum or your Calendar Year Medical Deductible.

Chemotherapy and Radiation

No Deductible or Copayment will be applied for Medically Necessary chemotherapy or radiation therapy (x-ray, radium and radioactive isotope). Coinsurance will apply if you use an Out-of-Network Provider.

OTHER MAXIMUMS

▪ Virtual Physicals	$100 Limit Per Calendar Year
▪ Motorized Wheelchairs/Scooters	$500 Lifetime Maximum
▪ Mastectomy Supplies	$750 Limit Per Calendar Year

Coverage for COVID-19 Diagnostic Testing and Related Items and Services.

From March 18, 2020 through the duration of the COVID-19 public health emergency period as determined by the Secretary of Health and Human Services, the Plan fully covers the testing necessary to detect or diagnose SARS–CoV–2, the virus that causes COVID-19. This COVID-19 testing is covered by the Plan at 100% coverage, without application of the Deductible and coinsurance, when provided by both In-Network and Out-of-Network providers.

This COVID-19 testing benefit covers in vitro diagnostic products and the administration such products that are approved, cleared, or authorized by the FDA; authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or otherwise determined appropriate by the Secretary of Health and Human Services.

The Plan will pay for testing at the rate negotiated with a provider prior to the declaration of the COVID-19 public health emergency. Where the Plan does not have a negotiated rate with a provider in place, the Fund will pay the cash price that the provider is required to list on the provider's public website or a lesser rate negotiated by the Fund.

From March 18, 2020 through the duration of the COVID-19 public health emergency period as determined by the Secretary of Health and Human Services, the Plan fully covers items and services furnished to an individual that are related to the administration of the above COVID-19 testing products or are related to the evaluation of the need for such testing products. These items and services include those furnished to an individual during a visit to a health care provider, including in-person office visits and telehealth visits; an urgent care center; and an emergency room.

Coverage of Over-the Counter COVID-19 Diagnostic Testing

Effective for claims incurred on and after January 15, 2022 through the duration of the COVID-19 public health emergency period as determined by the Secretary of Health and Human Services, the Plan will fully cover over-the-counter (OTC) tests designed to detect or diagnose SARS-CoV-2, the virus that causes COVID-19, without an order or individualized clinical assessment by an attending health care provider. Such OTC COVID-19 tests are covered by the Plan at 100% coverage, without application of the Deductible and Coinsurance, at the reimbursement rates set forth below under "Reimbursement Rates."

Covered Testing Products

This subsection covers OTC COVID-19 tests that meet the statutory criteria under Section 6001(a)(1) of the Families First Coronavirus Response Act (FFCRA), as amended. Such criteria, in general, are in vitro diagnostic products which are: approved, cleared, or authorized by the Food and Drug Administration (FDA); awaiting FDA emergency use authorization and have not otherwise been denied such authorization; authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or otherwise determined appropriate by the Secretary of Health and Human Services. OTC COVID-19 tests that do not meet the statutory criteria under Section 6001(a)(1) of the FFCRA will not be covered. This subsection applies only to OTC COVID-19 tests that do not require a health care provider's order or involvement under the applicable FDA authorization, clearance, or approval.

Reimbursement Rates

The Fund may partner with its Pharmacy Benefit Manager (PBM) to reimburse preferred sellers of OTC COVID-19 tests for their full cost directly without requiring Participants to provide upfront payment and seek reimbursement. When such tests are furnished in this

fashion through both a retail pharmacy network and a direct-to-consumer shipping program, this is referred to as providing for "direct coverage" of OTC COVID-19 tests.

During periods in which the Fund provides for direct coverage in accordance with applicable federal government guidance, the Fund will reimburse Participants for OTC COVID-19 tests purchased from non-preferred pharmacies or other retailers (*i.e.*, sellers outside of the PBM's pharmacy network) the lesser of the actual price of each test or $12 per test.

During periods in which the Fund does not provide for direct coverage of OTC COVID-19 tests in accordance with applicable federal government guidance, the Plan will cover directly or reimburse Participants for the actual price of each test.

Requests for reimbursement under this subsection must be supported by reasonable documentation of proof of purchase as determined solely by the Fund. Examples of such documentation include the universal product code (UPC) for the OTC COVID-19 test to verify that the test is one for which coverage is required under the FFCRA as well as a receipt from the seller that documents the date of purchase and the price of the test.

When submitting a request for reimbursement or when obtaining a test from a retail pharmacy or other seller, Participants may be required to attest that the test was (A) purchased by the individual for personal use (not for employment purposes), (B) has not been (and will not be) reimbursed by another source, and (C) is not for resale.

Coverage Limit

Each Participant and Beneficiary is limited to coverage under this subsection for eight (8) OTC COVID-19 tests (obtained without an order or individualized clinical assessment by an attending health care provider) per 30-day period. In applying this limit, the Fund will count each test separately, even if multiple tests are sold in one package.

Exclusion from Coverage

This subsection covers only COVID-19 tests intended primarily for individualized diagnosis or treatment of COVID-19. This subsection does not cover COVID-19 tests that are required as a condition of employment (*e.g.*, testing conducted to screen for general workplace health and safety, such as testing conducted under employee "return to work" programs).

SUMMARY OF MEDICAL BENEFITS

If you use Physicians, Hospitals, and other Health Care Providers who are in the PPO Network, the per visit Copayments and Coinsurance percentages that you are responsible for paying will be lower for Physician home and office visits, as well as for Hospital services performed on an Inpatient or Outpatient basis.

MEDICAL BENEFITS	**WHAT THE PLAN PAYS**	
	IN THE PPO NETWORK	**OUTSIDE THE PPO NETWORK**
OFFICE VISITS		
■ **Physician or Provider Home or Office Visits**	After you pay a $20 per visit copayment—plan pays 100% of Covered Charges	After you pay a $40 per visit copayment—plan pays 70% of Covered Charges (up to 70% of UCR)
HOSPITAL, HOME HEALTH AND OTHER SERVICES		
■ **Hospital Services on an Inpatient or Outpatient Surgery Basis** (including Physician Services)	80% of Covered Charges after you have met the deductible	70% of Covered Charges (up to 70% of UCR) after you have met the deductible
■ **Diagnostic X-ray and Laboratory Services**	80% of Covered Charges after you have met the deductible	70% of Covered Charges (up to 70% of UCR) after you have met the deductible
■ **Other Services**	70% of Covered Charges after you have met the deductible	70% of Covered Charges (up to 70% of UCR) after you have met the deductible
■ **Home Health or Hospice Care**	70% of Covered Charges	70% of Covered Charges (up to 70% of UCR)
■ **Chemotherapy and Radiation Therapy**	100% of Covered Charges	70% of Covered Charges (up to 70% of UCR)

HOSPITALIZATION, EMERGENCY ROOM, AND DIAGNOSTIC SERVICES

After meeting the Calendar Year Medical Deductible, the Plan will pay 80% of the Covered Charges for the following services if provided in the PPO network and 70% of the Covered Charges (up to 70% of the Usual and Customary charges) if provided on an Out-of-Network basis.

Medically Necessary expenses which are covered by the Plan are as follows:

- Charges by a Hospital for room and board and other services required for purposes of treatment. (Maximum Covered Charge for an elective private room is the most frequent semi-private room rate being charged by the Hospital plus $6. Additional Covered Charges for the cost of a private room will be payable only if isolation is Medically Necessary for your health or the health of other patients.)

- Charges by a Hospital for room and board and other services in connection with childbirth for the mother or newborn child (if newborn child is a covered Eligible Dependent).

- Note that this Plan does not, in accordance with 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 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, this Plan does not, under Federal law, require that a provider obtain authorization for the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

- Hospital services other than room and board, including nursing services, provided while receiving treatment in a Hospital on an Inpatient or Outpatient Surgery basis.

- Intensive Care Unit or Coronary Care Unit Services.

- Charges by a Physician for pathology or radiology services, or the administration of anesthesia while receiving treatment at a Hospital on an Inpatient or Outpatient Surgery basis.

- Surgical operative or cutting procedures and post-operative care.

- Facility and provider services in connection with reconstructive surgery after a mastectomy, including reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

- Diagnostic X-ray and laboratory services, radiation (x-ray, radium, and radioactive isotope) therapy and chemotherapy.

- The services of a licensed physical therapist, but only when such services are provided while receiving treatment in a Hospital on an Inpatient or Outpatient Surgery basis.

- Charges for blood and blood plasma when provided while the individual is receiving treatment in a Hospital on an Inpatient or Outpatient Surgery basis.

- Charges for the services of a Physician (including Surgery and Physician visits) while receiving treatment at a Hospital on an Inpatient or Outpatient Surgery basis.

- Services, drugs and medical supplies required to give an organ transplant to a Plan Participant or Eligible Dependent under this Plan. A living organ donor who is covered under another health plan may be covered under this Plan for Hospitalization charges associated with the organ donation that are not payable under the other plan up to this Plan's allowable charges. The Plan will pay up to $500,000 for all costs associated with an organ transplant. The $500,000 limit is per-transplant and applies to each Covered Individual. Human organ and tissue transplants that are not considered Experimental or Investigational under the Plan are covered.

- The services of a qualified social worker, but only when such services are provided while receiving treatment in a Hospital on an Inpatient or Outpatient basis.

- Charges for Emergency Care for a Medical Emergency provided in a Hospital-based emergency room Emergency Care for a Medical Emergency received from an Out-of-Network provider, (even if received within the Network area), will be payable at the In-Network level. If a member undergoes two or more Surgical procedures during any one time, Covered Charges for the services of the Physician for each procedure that is identified and defined as a separate procedure will be based on the schedule shown in the definition of Surgery.

- Charges for Urgent Care Centers. The Participant cost for care received from an In-Network Urgent Care Center will be a per-visit copayment of $50. Care received from an Out-of-Network Urgent Care Center will be covered at 70% of covered charges subject to the deductible.

- Charges for mental health and substance abuse. Such services will be covered on the same basis as if they were incurred for medical care. For example, a visit with a psychologist is treated as an office visit with a $20 co-payment if the provider is included in the PPO network.

PHYSICIAN OR PROVIDER HOME OR OFFICE VISITS AND OUTPATIENT SERVICES

Subject to the applicable Copayment, the Plan will pay 100% of Covered Charges for the following services provided in the PPO network and 70% of the Covered Charges (up to 70% of the Usual and Customary charges) provided on an Out-of-Network basis.

Expenses which are covered by the Plan are as follows:

- Charges for services furnished at the Physician's clinic or office or at the patient's home, including charges for surgical dressings, medical supplies and equipment; injections; anesthesia; take-home drugs; blood and blood plasma; prenatal and well baby care (not subject to the Medical Deductible); and routine physical examinations.

- The services of a licensed physiotherapist.

- Dental services to repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and if the charges for dental services are incurred within 12 months after the accident.

- Immunizations listed on the Center for Disease Control (CDC) Recommended Childhood Immunization Schedule, regardless of the age at which they are recommended.

- The services of a chiropractor.

- The services of a physical therapist.

- Renal Dialysis not covered by Medicare (see section on Coordination with Medicare).

OTHER SERVICES

After meeting the Calendar Year Medical Deductible; the Plan will pay 70% of Covered Charges (up to 70% of the Usual and Customary charges) for the following services provided in or outside the PPO network:

- Charges for transportation by ambulance provided by a Hospital or a licensed ambulance service to and from the nearest Hospital equipped and available to furnish needed treatment.

- Surgical dressings, casts, splints, braces, crutches, artificial limbs, and artificial eyes.

- Rental (or purchase if determined by Trustees to be more cost-effective than rental) of a wheelchair, hospital-type bed, or an artificial respirator.

- Oxygen (including rental or purchase, if determined by Trustees to be more cost-effective, of equipment for its administration).

EXCLUSIONS

The following medical expenses are <u>not covered</u> under this Plan:

- Any confinement, treatment or service due to sickness which is covered by a Workers' Compensation Act or other similar legislation, or due to Injury arising out of or in the course of any employment for wage or profit.

- Any confinement, treatment or service for which the person or Eligible Dependent has no financial liability or that would be provided at no charge in the absence of insurance (except Medicaid or other medical assistance plans for the needy or indigent).

- Any confinement, treatment or service which is compensated for or furnished by the United States Government or any Agency thereof (except as required under Federal law).

- Any confinement, treatment or service not Medically Necessary, or any part of a charge for confinement, treatment or service that exceeds Usual and Customary Charges; or the services of any person who is in the Plan Participant's or Eligible Dependent's immediate family.

- Any confinement, treatment or service not prescribed by a Physician.

- Charges for Emergency Care provided in a Hospital-based emergency room (or free-standing emergency room or urgent care center) if such charges are <u>not</u> for a Medical Emergency.

- Hearing aids (except in cases of cleft lip and cleft palate), vision materials (frames, lenses) or eye examinations for the correction of vision or fitting of glasses, except as provided in Section VIII of this Plan.

- Any confinement, treatment or service for Cosmetic Surgery unless such treatment or service is due directly to an accidental Injury and is commenced within 12 months from the date of the accident.

- Dental services, or materials, except as specifically provided in this section, and Section VII of this Plan.

- Drugs or medicines which do not require a Physician's prescription; vitamins, nutritional supplements, or special diets; or comfort or convenience services or supplies.

- Acupuncture or acupressure treatment, except as provided on page 52.

- Immunizations, other than as provided under the Physician or Provider Home or Office Visit and Outpatient Services.

- Any confinement, treatment or service for educational or training problems, learning disorders, marital counseling or social counseling (except as provided under Hospice Care, in Section IV).

- Any nursing or private duty nursing services (except as specifically described in the Plan).

- Any confinement, treatment or surgery, related to the restoration of fertility or the promotion of conception (including reversal of voluntary sterilization). No benefits are payable for in vitro fertilization procedures.

- Any confinement, treatment or service resulting from an act of war or from voluntary participation in a felony.

- Any Experimental or Investigational treatment, service or materials. This general exclusion for Experimental or Investigational treatment, service, or materials does not include Routine Patient Costs for items and services furnished in connection with participation in an Approved Clinical Trial if the costs would otherwise be covered by the Plan.

- Any expenses which are submitted to the Plan after one year from the date of service.

NOTICE OF COMPLIANCE UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 (the "1998 Law") requires the Trustees of this Plan to notify you, as a participant or beneficiary of the Plan, of your rights related to benefits provided through the Plan in connection with a mastectomy. You as a participant or beneficiary have rights to coverage to be provided in a manner determined in consultation with your attending physician 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; and

- prostheses and treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided under the "Basic Medical Benefits" portion of the Plan. These benefits will be subject to the applicable deductible and general copayment provisions which exist in the Plan.

In addition, benefits will be provided for breast form bras, equipment to maintain such bras, and wigs required as a result of hair loss due to cancer treatments, up to an annual limit of $750.

Keep this Notice for your records and call your Plan Administrator for more information.

NOTICE OF COMPLIANCE UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, the Plan generally may not 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 delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also under federal law, the Plan may not set the level of benefits or out-of-pocket coast so that any later portion of the 48-hour (or 96 hour) say is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre certification. For information on pre-certification, contact the Plan Administrator.

V. HOME HEALTH, HOSPICE AND EXTENDED CARE BENEFITS

PRIOR TO INCURRING EXPENSES UNDER THIS SECTION, PLEASE CONTACT THE PLAN'S UTILIZATION MANAGEMENT SERVICE:

1-(800) 641-5566

HOME HEALTH CARE BENEFITS

Home Health Care Benefits are payable to the extent provided below. The plan will pay 70% of Covered Charges for Home Health Care, after the Medical Deductible is met.

Home Health Care Covered Charges must be for supplies or services provided in accordance with a Home Health Care Plan. They include Covered Charges that do not exceed Usual and Customary Charges by a Home Health Care Agency for:

- Part-time or intermittent home nursing care by or under the supervision of a registered Nurse.
- Part-time or intermittent Home Health Aide.
- Physical, occupational or speech therapy provided by a licensed therapist.
- Medical supplies, drugs and medicines prescribed by the attending Physician but only to the extent that such supplies, drugs and medicine would have been Covered Charges if the individual remained Hospitalized.
- Laboratory services by or on behalf of the Hospital but only to the extent that such services would have Covered Charges if the individual had been Hospitalized.

EXCLUSIONS

The following expenses are <u>not covered</u> under this Plan:

- Any services or supplies not included in the Home Health Care Plan; or
- Any services of an individual who ordinarily resides in your home or is a member of your family; or
- Transportation services; or
- Custodial care (services or supplies provided to assist an individual in activities of daily living, e.g. meals, personal grooming); or

- More than 40 Home Health Care visits in a Calendar Year. For this purpose, up to four hours of Home Health Care service will be considered as one Home Health Care visit.

HOSPICE CARE BENEFITS

Medical Covered Charges will include charges for Hospice care services provided by a Hospice Facility, Hospice care team, Hospital-based Hospice program, Home Health Care Agency, or Skilled Nursing Facility for:

- Any sick or injured individual (Plan Participant or an Eligible Dependent) who, in the opinion of the attending Physician, has no reasonable prospect of cure and is expected to live no longer than six months.

- The family (Plan Participant or Dependents) of any such individual; but only to the extent that such Hospice care services are provided under the terms of the Hospice care program and are billed through the Hospice that manages that program.

HOSPICE BENEFITS

After the Medical Deductible has been satisfied, the Plan will pay 70% of Covered Charges for any episode of Hospice care for the following:

- Inpatient and Outpatient care, home care, nursing care, counseling, and other supportive services and supplies provided to meet the physical, psychological, spiritual, and social needs of the dying individual.

- Drugs and medicines (requiring a Physician's prescription) and other supplies prescribed for the dying individual by any Physician who is a part of the Hospice care team.

- Instructions for care of the patient, counseling, and other supportive services for the family of the dying individual.

EXCLUSIONS

Covered Charges <u>do not</u> include Hospice Care charges that:

- Are for Hospice care services not approved by the attending Physician.

- Are for transportation services.

- Are for services or supplies provided to assist a person in daily living (*e.g.*, meals and personal grooming), unless such services and supplies are provided under the terms of a Hospice care program, such as an Inpatient Hospice Facility.

- Are for Hospice care services provided at a time other than during an episode of Hospice care.

SKILLED NURSING CARE FACILITY BENEFITS

After the Medical Deductible has been satisfied, Covered Charges will include charges by a Skilled Nursing Facility for room, board, and other services required for treatment, provided the confinement:

- Is certified by a Physician as Medically Necessary for recovery from a sickness or Injury.
- Follows three or more consecutive days of Hospital confinement for which benefits were payable under this Plan.
- Results from the sickness or Injury that was the cause of the Hospital confinement.
- Begins no later than 14 days after the end of the Hospital confinement or not later than 14 days after the end of the prior Skilled Nursing Facility confinement for which benefits were payable under this Plan.

SKILLED NURSING FACILITY BENEFIT LIMITATIONS

Covered Charges for each day will not be more than 50% of:

- The actual room charge (if the Hospital confinement was in a semiprivate room); or
- The Hospital room maximum (if the Hospital confinement was in a private room) of the Hospital in which the Plan Participant or Eligible Dependent was confined before the Skilled Nursing Facility confinement.

Also, Covered Charges will not include charges for more than 120 days for all Skilled Nursing Facility confinements that result from the same or a related sickness or Injury. In addition, Covered Charges will not include any charges after the date the attending Physician stops treatment or withdraws certification.

VI. DENTAL CARE BENEFITS – TIER ONE ONLY

This Plan pays benefits for Covered Charges for Dental Care through Delta Dental, a dental benefits program under contract with the Plan as detailed in the Schedule below.

DENTAL BENEFITS	
■ **Dental Deductible - per Individual** (does not apply to Preventive and Diagnostic services)	You pay $50
■ **Coinsurance**	Plan pays 50% of Covered Charges (up to 50% of UCR)
■ **Annual Maximum Benefit per Individual** **The Annual Maximum Benefit does not apply to benefits considered to be pediatric dental services.**	$2,000

DENTAL BENEFITS

Dental services are payable based on the Usual and Customary Charges using zip codes in the Washington, D.C. area. Dental Covered Charges are payable at 50% of Covered Charges (up to 50% of UCR). The Dental Deductible does not apply to Preventive and Diagnostic services listed in this section or Preventive Services as discussed on page 46.

Total payment for all Covered Charges incurred by a Covered Individual in a Calendar Year shall not exceed the applicable Maximum Benefit per Individual.

DENTAL COVERED CHARGES

Dental Covered Charges shall include charges only for dental treatments or services which:

- Are performed by a Dentist or dental hygienist; and
- Are Medically Necessary for dental care and meet professionally recognized standards of quality; and
- Begin and are completed while the individual is covered by this Plan.

A treatment or service will be considered to begin on the date it is performed. However, for those procedures shown below, treatment or service will be considered to begin as follows:

- For root canal therapy, the date the pulp chamber is opened and the pulp canal is explored to the apex;
- For crowns, inlays and onlay restoration, the date the tooth or teeth are fully prepared.

A temporary dental treatment will be considered an integral part of the final treatment rather than a separate treatment.

ALTERNATE PROCEDURES
If alternate procedures, services or courses of treatment may be performed to correct a dental condition, the maximum covered charge which will be considered for payment will be for the least expensive procedure which will, as determined by Delta Dental, produce a professionally satisfactory result.

PRE-DETERMINATION OF BENEFITS
If total estimated charges for a period of dental treatment are greater than $200, you should submit a dental treatment plan prior to undergoing the dental treatment. The dental treatment plan should be submitted to Delta Dental on a dental form provided by the Delta Dental (or on an accepted standard dental form provided by your dentist) and will be returned to the attending dentist with a predetermination of the benefits provided for the procedures submitted. Charges incurred as a result of emergency treatment will not require the filing of a dental treatment plan.

COORDINATION OF DENTAL BENEFITS
The dental benefits of this plan are coordinated with the dental benefits of other plans as described in the Coordination of Benefits Section in this booklet. The terms "medical benefits" and "available expenses," as used in that Section, shall include dental benefits and dental expenses.

DENTAL BENEFIT LIMITATIONS
Covered Charges <u>do not</u> include charges for:

(a) any treatment or service which is compensated for or furnished by the U.S. Government or any Agency thereof (except as required by Federal Law)

(b) any treatment or service which is covered by Workers Compensation or similar law.

(c) drugs or medicines, other than antibiotic injections; or

(d) instructions for plaque control, oral hygiene or diet control; or

(e) single crowns connected to a bridge; or

(f) any treatment or service which:

- Does not have uniform professional endorsement, including experimental procedures or implants (except that an alternate allowance will be provided for implants as if they were a standard denture and for a crown attached to an implant as if it were a crown attached to a tooth); or

- Is for the primary purpose of altering vertical dimension or restoring occlusion; or

- Is primarily for cosmetic purposes, including personalization or characterization of dentures and facings on crowns or pontics posterior to the second bicuspid; or

- Is for fabricating a prosthetic device or appliance or replacing such item due to loss or theft; or

Note: In lieu of a benefit for implants, an alternative benefit will be provided as if they were standard dentures. Additionally, crowns attached to implants will be paid as if attached to a tooth.

(g) any treatment or service related to the jaw or alignment of the jaw;

(h) Any dental treatment or service which is also a Covered Charge under the Medical benefits provided by this Plan; or

(i) Any orthodontic treatment or services.

BENEFITS AFTER TERMINATION OF COVERAGE

With respect only to such dental treatment or service shown below, benefits after termination of coverage are continued for Covered Charges which are incurred within two months following termination. Such benefits are payable only if the Covered Charges are incurred because of a condition which existed on the date of termination and for which treatment had begun while covered, and will be reduced by any benefits payable under a successor group dental plan covering the individual.

Benefits after termination of coverage are payable only for the following dental treatment or service:

- Root canal therapy, provided the pulp chamber was opened and the pulp canal explored to the apex while covered; and

- Crowns or inlay or onlay restorations, provided the tooth or teeth were fully prepared while covered.

COVERED DENTAL CHARGES

DIAGNOSTIC AND PREVENTIVE SERVICES

Covered Charges are the actual cost charged for the following Diagnostic and Preventive procedures, to the extent that such charges do not exceed Usual and Customary Charges.

Examinations

Oral examination	Only one routine oral examination is covered per six month period. A "problem-focused oral examination" or emergency examination is covered as often as Medically Necessary.

Radiographs

Intraoral X-rays:	
Complete series	Once per three year period.
Bitewing	Once per six month period.
Occlusal	
Periapical	
Extraoral X-rays: (TMJ, Panoramic, Cephalometric, etc.)	Once per six month period.

Diagnostic X-rays performed in conjunction with root canal therapy or orthodontic treatment are not considered Diagnostic and Preventive Covered Charges.

Preventive Services

Prophylaxis: (cleaning of teeth, including scaling and polishing)	Once per six month period.
Fluoride treatment	Applicable only to Dependent children. Once per twelve month period.
Space maintainers	Applicable only to Dependent children under age 14.
Topical application of sealants	Applicable only to Dependent children under age 14. Once per quadrant per four year period.
Periodontal Prophylaxis	Once per six month period in lieu of routine Prophylaxis.

Other Services

Biopsy of oral tissue
Palliative treatment .....Covered as a separate procedure only if no other service (except x-rays) was rendered during the visit.

Bacteriologic cultures
Histopathologic examinations
Pulp vitality tests
Diagnostic casts .....Once per two year period.

BASIC DENTAL SERVICES

Covered Charges are the actual cost charged for the following basic services, to the extent that such charges do not exceed Usual and Customary Charges.

Restorations

Fillings (Amalgam, silicate, plastic or composite, including pin retention when necessary.)
Stainless steel crowns

Oral Surgery

Extraction of teeth
Alveoplasty
Incision and drainage of dental abscess
Removal of dental cysts and tumors
Tooth replantation
Surgical exposure to aid eruption
Surgical repositioning of teeth
Excision of hyperplastic tissue
Other surgical procedures
- Tooth replantation
- Surgical exposure to aid eruption
- Surgical repositioning of teeth

Periodontal Services

Surgical procedures:
- Gingivectomy
- Gingival curettage
- Osseous surgery
- Osseous graft

Only one of the listed periodontic surgical procedures is covered for each quadrant in a twelve-month period.

Scaling and root planning (each quadrant) -
Once each quadrant each six-month period

Periodontal appliance
One appliance each three-year period

Endodontic Services

Pulp cap
Pulpotomy
Root canal therapy (including treatment plan, diagnostic x-rays, clinical procedures and follow-up care)
Apicoectomy and retrograde fillings (Covered as a separate procedure only if performed more than one year after the root canal therapy is completed.)
Apexification
Apical curettage
Root resection
Hemisection

Anesthesia

General anesthesia (Covered as a separate procedure only when required for complex and oral surgical procedures covered under this plan, and only when not performed in a hospital.)

MAJOR DENTAL SERVICES

Covered Charges are the actual cost charged for the following Major Services, to the extent that such charges do not exceed Usual and Customary Charges. (Each listed service includes one year of follow-up care.)

Restorations

Gold foil
Gold inlays and onlays
Gold restorations are covered only if the tooth cannot be restored by a silver filling, and (for replacements) at least five years have elapsed since the last placement.
Porcelain inlays

Crowns (Single Restorations)

Plastic or porcelain crowns
(with gold, semi-precious metal or non-precious metal)
Full cast crowns
(gold, semi-precious metal or non-precious metal)

[Crowns are covered only if the tooth cannot be restored by a filling, and (for replacements) at least five years have elapsed since the last placement. Crowns for the primary purpose of periodontal splinting, altering vertical dimension or restoring vertical occlusion are not covered.]

Cast post and core (Covered only for teeth that have had root canal therapy.)
Steel post and composite or amalgam

Fixed Prosthodontics

Fixed Bridge

- Initial placement of fixed bridges;

- Initial placement to replace teeth which were missing. Replacement of fixed bridges is covered only if the original bridge cannot be made serviceable and at least five years have elapsed since the last placement.

Removable Prosthodontics

Full or Partial Denture/Initial Placement/Replacement

Replacement will be made only at least five years have elapsed since the last placement.

Covered Charges for removable prosthodontics do not include any additional charges for over-dentures or for precision or semi-precision attachments.

VII. VISION CARE BENEFITS – TIER ONE ONLY

The following benefits are provided for you and your Eligible Dependents through Vision Service Plan (VSP), a prepaid optical benefit program under contract with the Welfare Fund. You may also obtain Vision Care Benefits outside VSP. The Schedule of Benefits inside and outside VSP is summarized in the chart below:

VISION BENEFITS	**IN VSP NETWORK**	**OUTSIDE VSP NETWORK**
Copayment	**$ 10.00**	**$ 10.00**
	WHAT THE PLAN PAYS	
■ **Conventional Vision Exam** (once every 12 months)	Covered in Full	$43
■ **Conventional Lenses** (once every 12 months)		
Single vision	Covered in Full	$35
Bifocal	Covered in Full	$51
Trifocal	Covered in Full	$68
Lenticular	Covered in Full	$80
■ **Frames** (once every 24 months**)**	Covered in Full if from designated frames on display	$45
In lieu of all other Plan vision benefits:		
■ **Contact Lenses used for elective or cosmetic reasons** (once every 12 months)		
Contact Lenses (plus evaluation and fitting costs)	$105	$105
■ **Contact Lenses if medically necessary, with VSP authorization** (once every 12 months) Vision Exam Contact Lenses (plus evaluation and fitting costs)	Covered in Full	$210

You may also receive discounts on vision services not covered under this Plan, if provided by a VSP Provider.

HOW TO USE YOUR VISION SERVICE PLAN

The following steps must be followed to use VSP's services:

1. Chose a participating Vision Service Plan eye doctor. A list of participating eye doctors is available in the Fund Office or call 1-800-877-7195 for doctors in your area. If you would like to check on a particular doctor, you will need the doctor's phone number with area code. You may also refer to VSP's web site (www.vsp.com).

2. Call the VSP doctor for an appointment and identify yourself as a VSP member. Give the doctor your identification number (your Social Security number) and tell him or her that you are covered under the I.A.T.S.E. Local 22 Vision Service Plan.

3. After you have scheduled your appointment, the VSP participating doctor will contact Vision Service Plan to verify your eligibility and plan coverage. The doctor will also obtain authorization for services and materials. The doctor will tell you what benefits you are eligible for.

If you receive services or material from a non-participating eye doctor, you must pay the doctor the full fee for services rendered and submit your *paid* itemized bill to the Fund Office for reimbursement.

COVERED EXPENSES

Exams and Lenses
If services are provided by a VSP provider, vision exams and lenses are covered in full by VSP every 12 months. Refer to the schedule for the amount covered for vision exams and lenses obtained on an out-of-network basis.

Frames
A wide selection of frames is covered in full once every 24 months if prescribed by a VSP provider. When choosing a frame, be sure to ask the VSP provider which frames are covered in full. If frames are prescribed by a non-participating provider, an allowance of $45 retail is allowed once every 24 months.

Contact Lenses
In lieu of all other vision benefits under the Plan, contact lenses can be obtained as follows:

Medically Necessary Contact Lenses

With prior approval from VSP, Medically Necessary contact lenses and associated professional services are covered for any of the following conditions:

1) following cataract surgery;

2) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;

3) certain conditions of anisometropia; and

4) keratoconus.

If contact lenses are determined to be Medically Necessary, expenses are covered as follows:

- If services are provided by a VSP provider, the exam and materials will be covered in full.

- If services are provided from a non-participating provider, the Plan will pay up to $43 toward the exam and up to $210 toward the contact lens evaluation fee, fitting costs and materials.

Replacement of contacts is available up to once every 12 months when a prescription change is needed and only with preauthorization from VSP.

Elective or Cosmetic Contact Lenses

If contact lenses are elected for cosmetic purposes only or reasons other than those specified above for Medically Necessary contact lenses, the expenses will be covered as follows:

- If services are provided from a VSP provider, the exam will be covered in full and an allowance of $105 will be made toward the cost of the contacts.

- If services are provided from a non-participating provider, the Plan will pay up to $43 toward the exam and up to $105 toward the contact lens evaluation fee, fitting costs and materials.

Replacement of contacts is available up to once every 12 months when a prescription change is needed.

Covered charges for vision care services provided by non-VSP Network Providers shall be consistent with the provisions of the Plan and guidelines used by VSP member providers as to whether contacts are elective or Medically Necessary.

Low Vision Benefit
A Low Vision Benefit is available for individuals with severe vision problems that are not correctable with regular lenses and is subject to prior approval by VSP. The Covered Individual must have a VSP provider approve a treatment plan and charges before services are rendered. The Covered Individual must pay 25% of the cost of a "low vision" program. There is a maximum benefit from the Plan of $1,000 every two years, excluding Copayments.

EXCLUSIONS AND LIMITATIONS

LIMITATIONS

This vision service plan is designed to cover visual needs rather than cosmetic materials. When a covered person selects any of the following extras, the plan will pay the basic cost of the allowed lenses or frames, and the covered person will pay any additional cost.

1. Blended lenses;
2. Contact lenses (except as noted elsewhere herein);
3. Oversize lenses;
4. Photochromic lenses; tinted lenses except pink #1 and pink #2;
5. Progressive multifocal lenses;
6. The coating of the lens or lenses;
7. The laminating of the lens or lenses;
8. A frame that costs more than the Plan allowance;
9. Certain limitations on low vision care (except as noted elsewhere herein);
10. Cosmetic lenses (except as noted elsewhere herein);
11. Optional cosmetic processes; and
12. UV (ultraviolet) protected lenses.

EXCLUSIONS

The Plan does not cover professional services or materials connected with:

1. Orthoptics or vision training and any associated supplemental testing; Plano lenses; or two pairs of glasses in lieu of bifocals;
2. Replacement of lenses and frames furnished under this plan which are lost or broken (except at the regular time intervals when services are otherwise available);
3. Medical or surgical treatment of the eyes;
4. Services or materials for which you may be compensated under any Workers' Compensation Law, or other Employer's liability laws regardless of jurisdiction, or services for which you, without cost, can obtain the needed care from any federal, state, county, municipality, or special service district organization or agency;
5. Any eye examination or any corrective eyewear required by an employer as a condition of employment.

6. Corrective vision treatment of an experimental nature.

VSP may, at its discretion, waive any of the plan limitations if, in the opinion of VSP's optometric consultants, it is necessary for the visual welfare of the Covered Individual.

VIII. PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERAGE – TIER ONE

- **Calendar Year Prescription Drug Deductible**

Individual	You pay $50
Family (3 times Individual)	You pay $150

- **Drug Card (Retail Pharmacy) (45 day supply or less)**

  You pay a $15 Copayment for generic drugs. You pay a $30 Copayment for formulary brand drugs and a $50 Copayment for non-formulary brand drugs (or, if less, the cost of the prescription). If you receive a brand drug when a generic is available you will pay the applicable Copayment (for formulary or non-formulary) plus the difference between brand name and generic, unless your doctor specifies brand name

- **Drug Card (Retail Pharmacy) (46-80 day supply)**

  You pay a $30 Copayment for generic drugs. You pay a $60 Copayment for formulary brand drugs and a $100 Copayment for non-formulary brand drugs (or, if less, the cost of the prescription). If you receive a brand drug when a generic is available you will pay the applicable Copayment (for formulary or non-formulary) plus the difference between brand name and generic, unless your doctor specifies brand name

- **Drug Card (Retail Pharmacy) (more than 80 day supply)**

  You pay a $45 Copayment for generic drugs. You pay a $90 Copayment for formulary brand drugs and a $150 Copayment for non-formulary brand drugs (or, if less, the cost of the prescription). If you receive a brand drug when a generic is available you will pay the applicable Copayment (for formulary or non-formulary) plus the difference between brand name and generic, unless your doctor specifies brand name

- **Mail Order Service (90 day supply)**

  You pay a $30 Copayment for Generic drugs, a $60 Copayment for formulary brand drugs, or a $100 Copayment for non-formulary brand drugs (or, if less, the cost of the prescription). If you receive a brand drug when a generic is available you will pay the applicable Copayment plus the difference between brand name and generic, unless your doctor specifies brand name

PRESCRIPTION DRUG COVERAGE – TIER TWO

- **Calendar Year Prescription Drug Deductible**

Individual	You pay $50
Family (3 times Individual)	You pay $150

- **Drug Card (Network Pharmacy) or Mail Order Service.**

After you satisfy the Calendar Year Drug Deductible, Your Copayment is 50% of the cost of each eligible prescription.

COVERED PRESCRIPTION DRUG BENEFITS

This Plan pays benefits for certain prescription drugs that are prescribed by your Physician or Dentist, after you have satisfied your Drug Deductible and paid your Copayment amount. A Copayment must be paid for each prescription or refill that you receive.

This Plan provides prescription drugs through a contract with a Pharmacy Benefit Manager (PBM). If you or your Eligible Dependent has a prescription filled or refilled at an In-Network pharmacy, the Plan pays for the total cost of the prescription or refill (minus the Copayment amount and your Drug Deductible).

If you or your Eligible Dependent has a prescription filled or refilled at an Out-of-Network pharmacy that does not have an agreement with the PBM, you must pay the entire cost of the prescription or refill at the pharmacy and submit a claim form for reimbursement. If you submit a form to the Fund Office requesting a reimbursement, the Plan will reimburse you (if your Drug Deductible has been satisfied) up to the amount that would have been paid by the Plan if you obtained the prescription from a pharmacy that is In-Network, less the applicable Copayment.

The Plan will also provide benefits for Medically Necessary methadone treatment as Outpatient Benefits under the Substance Abuse Benefits section of this Plan.

Please Note: Prescription Drug Benefits are based on your prescription being filled with a generic drug, if one exists. If there is no generic drug available, or if your Physician specifies "brand only", you will receive the brand name drug specified. **If you choose to receive the brand name drug, even though a generic is available, you will also be responsible for the difference in cost between the generic and the brand name drug (either a Formulary or Non-Formulary drug).**

The Plan offers a mail-order drug program. If either you or your Eligible Dependent are taking any maintenance medications, which are taken regularly to treat an acute or chronic health condition, what you pay for Copayment amounts will be less through the mail-order program and the prescription will be sent to your home. If you need maintenance medication immediately, have your Physician write two prescriptions, one for a short-term immediate supply which can be filled at a pharmacy, and the second for an extended supply filled through the mail-order program.

Forms for the mail-order drug program can be obtained from the Fund Office.

A current listing of the independent pharmacies and chain stores which participate in the network provided by the PBM can be obtained by calling the Fund Office.

COVERED PRESCRIPTION DRUGS

"Covered Prescription Drugs" include the following drugs which must be prescribed by a Physician:

- federal legend drugs;
- state-restricted drugs;
- compounded prescriptions;
- oral contraceptives;
- injectable drugs;
- Ritalin
- the following anorexiants for persons through age 25; Cylert; Dextroamphetamine; Dexedrine; Adderall; and Desoxyn-Desoxyn Gradumet
- Retin-A, Retin-A Micro, Avita, and Differin for treatment of medically active acne (note: prior authorization by the PBM is required if the prescription is for a person aged 25 or older)
- Viagra, limited to 12 tablets in a 30 day period
- drugs necessary to control diabetes (including insulin);
- needles and syringes used to administer approved injectable medications; or
- drugs necessary to aid chemotherapy

In the event a covered injectable is administered in a Physician's office, the resulting bill should be submitted to the Fund Office, where it will be processed for payment under the Plan's Major Medical Provisions.

PRESCRIPTION DRUGS NOT COVERED UNDER THE PLAN

The following are <u>not covered</u> under the Plan's Prescription Drug Benefit:

- any drug, medicine or medication available without a prescription (except insulin), unless two or more of these drugs, medicines or medications must be compounded and the compounding may be done only by prescription;
- anorexiants, except those listed above under "Covered Prescription Drugs";
- any therapeutic devices or appliances such as support garments, or other non-medical substances;
- biological sera, blood or plasma;
- any experimental or investigational drug;
- any charge for the administration of a drug or injectable insulin;
- any medication taken or dispensed while an inpatient in a Hospital or other facility which has a pharmacy on the premises;

- any drugs which may be obtained without charge through a public program, including worker's compensation;
- drugs dispensed in a Physician's office;
- cosmetic drugs including Renova, Propecia and Rogaine;
- state-rejected drugs;
- smoking cessation products;
- fertility drugs; and
- over-the-counter glucagons emergency kits.

Your Prescription I.D. card is very important to you. It should be used only by a person covered by this Plan. The unauthorized or fraudulent use of the card is punishable by law and will be cause for immediate withdrawal of your card. If you lose your card, contact the Fund Office immediately.

IX. DEATH BENEFITS – TIER ONE ONLY

■ **Death Benefits for Covered Employees**	
-Under Age 70	$25,000
-Age 70 to age 75	$16,250
-Over age 75	$12,500
■ **Death Benefits for Covered Retirees**	$ 5,000

DEATH BENEFITS TO BENEFICIARIES

The Plan provides Death Benefits for Covered Employees under a contract for group life insurance with Voya Financial.

Your Designated Beneficiary will be paid the amount of your Life Coverage in the event of your death while you are covered under this Plan. The amount of benefit to be paid will be the amount shown above which is in force for you on the date of your death, subject to the terms and conditions provided in this Plan section.

You may not assign your Death Benefits under this Plan to any individual or entity.

BENEFICIARY DESIGNATION

Your Designated Beneficiary is the party or parties named by you to receive the Death Benefits payable under this Plan upon your death. You may name one or more beneficiaries to receive the Death Benefit.

Your beneficiary designation should be kept up to date to assure that benefits will be paid in accordance with your wishes. You may change your Designated Beneficiary(ies) at any time, without the consent of the previously named Beneficiary. To change your Designated Beneficiary, you must file a Change of Beneficiary form (obtainable from the Fund Office). No Designated Beneficiary change is effective until such written notification is received by the Plan Administrator.

Upon receipt of satisfactory proof of your death, a Death Benefit will be payable to your Designated Beneficiary as follows:

1. If you have named more than one Beneficiary, each surviving Beneficiary will share equally, unless otherwise indicated when you named the Beneficiaries.

2. If you did not name a Designated Beneficiary, or if no named Beneficiary is surviving at the time of your death, payment will be made to the first surviving class in the following order of preference:
   a. your surviving spouse;

b. your children, in equal shares;
c. your parents, in equal shares;
d. your brothers and sisters, in equal shares; or
e. the executors or administrators of your estate.

In order to determine which class of individuals is entitled to the Death Benefit, the Plan Administrator may rely on an affidavit made by any individual listed above. If payment is made based on such affidavit, the Plan will be discharged of its liability for the amount paid, unless written notice of claim by another individual listed above is received before payment is made.

3. If the Beneficiary is a minor or someone not able to give a valid release for payment, the Plan will pay the Death Benefit to his or her legal guardian. If there is no legal guardian, the Plan may pay the individual or institution who has, in the opinion of the Plan Administrator, custody and principal support of the Beneficiary.

4. If an individual appears to the Plan to be equitably entitled to compensation because he or she has incurred expenses on behalf of the Participant's burial, the Plan may pay to such individual the expenses incurred up to $500. This amount will be paid from the total amount payable to the Designated Beneficiary(ies).

Satisfactory proof of the claim of death will include a certified copy of the Plan Participant's death certificate, and any other data that the Plan may require to establish the validity of the claim.

TOTAL DISABILITY DEATH BENEFIT

If you become Totally Disabled while covered by this Plan and prior to attaining age 60, your death benefit coverage will be continued while your Total Disability continues. "Totally Disabled" and "Total Disability," for purposes of this Death Benefits section, mean the complete inability, due to Injury or Illness, to engage in any business, occupation or employment for which you are qualified or become qualified by reason of education, training or experience for pay, profit or compensation.

In order for you to have coverage under this provision, you must:

1. remain Totally Disabled; and

2. submit satisfactory written proof to the Plan Administrator within twelve months from the date the disability begins, unless it can be shown that it was not possible to submit proof within this time period, and that proof was filed as soon as reasonably possible.

If acceptable written proof is not received within the twelve month period as shown in item 2. above, any Death Benefit continued under this provision will terminate at the end of such twelve month period.

PROOF OF DISABILITY
The initial proof of disability must be submitted within twelve months of the date of disability and must show that the Total Disability:

1. began while you were covered under this Plan;

2. began before you attained age 60; and

3. has existed continuously for 9 consecutive months.

After the satisfaction of the initial proof of disability, eligibility for Death Benefits coverage may be continued under this provision for further successive 12 month periods if:

1. you remain Totally Disabled; and

2. acceptable written proof of your continued Total Disability is received each year by the Plan Administrator or its designee within 3 months prior to each anniversary of the date the initial proof was received. The Plan Administrator or its designee will request written continued proof of your Total Disability. You must submit such proof within 30 days of receiving the request.

The Plan has the right to have you examined at no expense to you, by a doctor of the Plan's choice, at any reasonable time during the course of your Total Disability. However, the Plan will not require such an examination more than once a year after your coverage under this provision has been continued for at least two full years.

TERMINATION OF TOTAL DISABILITY BENEFIT
These Total Disability Benefit provisions shall cease on the earliest of the following dates:

- The date your Total Disability no longer exists; or
- The date you fail to submit to any required medical examination; or
- The date you fail to submit any required proof of the uninterrupted existence of such Total Disability; or
- The date you attain age 70.

If a death benefit is paid under this provision, it shall be in lieu of all other Death Benefits provided under this Plan.

X. ACCIDENTAL DEATH AND DISMEMBERMENT – TIER ONE ONLY

- **Accidental Death or Dismemberment for Covered Employees**

■ Under Age 70	$25,000
■ Age 70 to age 75	$16,250
■ Over age 75	$12,500

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The Plan provides Accidental Death and Dismemberment Benefits to Covered Employees under a group contract with Voya Financial.

Upon receipt of due proof of loss, Accidental Death and Dismemberment Benefits will be paid if:

1. you, while covered under this Plan, suffer an accidental Injury; and

2. as the direct result of the accident, and independent of all other causes, you suffer a "Covered Loss" within 90 days after the accident; and

3. the accident is not the result of an Injury which arises out of, or in the course of, any employment with any employer.

Except as excluded under the provisions below, a "Covered Loss" means permanent loss of:

1. your life; or

2. your hand, by severance at or above the wrist joint; or

3. your foot, by severance at or above the ankle joint; or

4. your eye, involving irrecoverable and complete loss of sight in the eye.

The amount of the Accidental Death or Dismemberment Benefit will be the full amount shown in the schedule above (based on your age at the time of the accident) if you suffer the loss of your life, the loss of both hands, the loss of both feet, or the irrevocable loss of sight of both eyes. The Benefit amount will be one-half of the amount shown above for the loss of one hand, the loss of one foot, or the irrevocable loss of sight of one eye from accidental Injury. The full amount shown above is also payable for the loss of any combination thereof. (i.e. loss of hand and foot, loss of sight in one eye and hand).

If you suffer more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

FILING A CLAIM AND PROOF OF LOSS

In order to receive a claim form for filing a claim, written notice of the claim must be provided to the Fund Office within 90 days after the date of a loss which is covered under this Plan, or as soon as it is reasonably possible to do so.

Proof of the loss for which a claim is made must be given to the Plan no later than 90 days after the date of the loss. A claim will not be reduced or denied for failure to provide proof within this time, if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible to do so.

The proof of claim must include all information necessary for the Plan Administrator or its designee to determine:

1. the nature of the loss; and

2. the date of the loss.

The Plan may require, as part of the proof, authorization to obtain medical and non-medical information. The Plan Administrator will notify you or your Beneficiary of any additional information required to process the claim.
In addition, the Plan, at no expense to you or your Beneficiary, has the right to:

1. have you examined, by a doctor of its choice; or

2. have an autopsy performed, if it is not prohibited by law.

EXCLUSIONS

No Accidental Death and Dismemberment Benefits will be paid for any loss that is caused directly or indirectly, or in whole or in part, by any of the following:

- bodily or mental illness or disease of any kind;
- bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
- suicide or attempted suicide;
- intentional self-inflicted injury;
- participation in, or the result of participation in, the commission of an assault, or a felony, or a riot, or a civil commotion;
- war or act of war, declared or undeclared; or any act related to war, or insurrection;
- police duty as a member of any military, naval or air organization;

- parachuting, bungee cord jumping, flying, ballooning, hang-gliding, skydiving, parasailing or any other aeronautic activities except as a passenger on a commercial aircraft; or
- intake of any drug, medication or sedative unless prescribed by a Physician.

BENEFICIARY DESIGNATION

In the case of any benefits payable under this provision, other than Accidental Death Benefits payable in the event of your death, the benefits will be paid to you. However, in the case of your death, your Designated Beneficiary is the party or parties named by you to receive any Accidental Death Benefits payable under this Plan. You may name one or more beneficiaries to receive the Benefit.

Your Beneficiary designation should be kept up to date to assure that benefits will be paid in accordance with your wishes. You may change your Designated Beneficiary(ies) at any time, without the consent of the previously named Beneficiary. To change your Designated Beneficiary, you must file a Change of Beneficiary form (obtainable from the Fund Office). No Designated Beneficiary change is effective until such written notification is received by the Plan Administrator.

Upon receipt of satisfactory proof of your loss, an Accidental Death and Dismemberment Benefit will be payable to your Designated Beneficiary as follows:

1. If you have named more than one Beneficiary, each surviving Beneficiary will share equally, unless otherwise indicated when you named the Beneficiaries.

2. If you did not name a Designated Beneficiary, or if no named Beneficiary is surviving at the time of your death, payment will be made to the first surviving class in the following order of preference:
   a. your surviving spouse;
   b. your children, in equal shares;
   c. your parents, in equal shares;
   d. your brothers and sisters, in equal shares; or
   e. the executors or administrators of your estate.

   In order to determine which class of individuals is entitled to the Accidental Death Benefit, the Plan Administrator may rely on an affidavit made by any individual listed above. If payment is made based on such affidavit, the Plan will be discharged of its liability for the amount paid, unless written notice of claim by another individual listed above is received before payment is made.

3. If the Beneficiary is a minor or someone not able to give a valid release for payment, the Plan will pay the Accidental Death Benefit to his or her legal guardian. If there is no legal guardian, the Plan may pay the individual or institution who has, in the opinion of the Plan Administrator, custody and principal support of the Beneficiary.

Satisfactory proof of the claim will include a certified copy of the Plan Participant's death certificate, and any other data that the Plan may require to establish the validity of the claim.

XI. WEEKLY DISABILITY INCOME COVERAGE – TIER ONE ONLY

- **Weekly Income for Disability**
  66 2/3% of highest gross compensation for the three calendar years immediately preceding year in which disability occurred divided by 52 weeks (not to exceed $300 per week). Excludes work-related injuries.

- **Additional Weekly Income Disability Benefit**
  $200 per week in addition to above benefit for first 2 weeks of disability if unable to work and Hospitalized for non mental health or substance abuse related illness. Excludes work related injuries.

WEEKLY INCOME AND ADDITIONAL WEEKLY INCOME BENEFITS

The Plan provides a Weekly Disability Income Benefit for loss of ability to work due to a qualifying disability which begins while you are covered under this Plan. If the qualifying disability is due to an accident, the benefits begin on the first day of disability. If the qualifying disability is due to sickness, Benefits under this provision will begin the earlier of the fifth day of continuous disability or the first day of Hospital confinement. Weekly Disability Income Benefits are payable for a maximum of twenty-six weeks for each period of disability.

The Weekly Disability Income Benefit will pay 66 2/3% of your highest yearly gross compensation for the three years immediately preceding the year in which disability occurred divided by 52 weeks, up to $300.00 per week. This amount will be prorated for partial weeks. In addition, if you are Totally Disabled and in a Hospital, you will receive an Additional Weekly Income Benefit of $200.00 per week for the first two weeks of disability for non mental health or non substance abuse related illness. This amount will be prorated if you are Hospitalized for 4 days or less, or for partial weeks.

ELIGIBILITY FOR WEEKLY DISABILITY INCOME BENEFITS

To qualify for Weekly Disability Income and Additional Weekly Income Benefits you must be Totally Disabled due to a non-occupational Illness or Injury, unable to perform the duties of your occupation and not engaged in any other occupation for wage or profit. Weekly Disability Income and Additional Weekly Income Benefits for disability due to pregnancy or any complication of pregnancy are payable the same as for disability due to Illness. You must also be under the care of a Physician for your disability.

PERIODS OF DISABILITY

Two or more periods of disability due to the same cause are considered one period of disability unless they are separated by your return to full-time work for a continuous period of at least two weeks. Two or more periods of disability due to an unrelated Injury or Illness are considered one period of disability unless separated by at least two consecutive weeks during which time you are on the Union's "available for work" list.

Full-time work, for purposes of this section, will be considered to be your return to the Union's "available for work" list for a period of 2 consecutive weeks.

Total Disability will be considered due to Illness unless disability is the direct result of and commences within thirty days after a bodily Injury.

EXCLUSIONS

No Weekly Disability Income or Additional Weekly Income Benefits are payable for a period of disability:

- during which you are not under the direct care of a Physician (a period of disability will not be considered as having started earlier than three days before the date you first see a Physician); or
- caused while you were committing a felony, a criminal act or misconduct; or
- due to an intentionally self-inflicted injury of any kind, while sane or insane; or
- due to war or any act of war, declared or undeclared; or
- if a claim is not filed within 180 days after the Total Disability begins; or
- for which you are receiving Workers' Compensation benefits.

XII. HOW TO FILE CLAIMS

Please submit your claims in a timely fashion to assist the Plan in the accurate and efficient administration of claims.

Claims must be filed within one year of the date the service is incurred. After one year from the date of service, the claim will no longer be eligible for payment under the Plan.

MEDICAL BENEFITS

Benefits Administration Corp. is the Claims Administrator that administers payment of all **medical claims** (in and out of PPO network), **Weekly Disability Income claims, and Vision Services not provided by VSP**. The name, address and phone numbers of the Claims Administrator is:

IATSE Local 22/772 Welfare Plans Claims Office
9411 Philadelphia Rd., Suite S
Baltimore, MD 21237
Phone: (800) 941-2752
Fax: (410) 687-7600

VISION CARE BENEFITS (IN-NETWORK ONLY)

Claims for **visions services provided by Vision Service Plan (VSP)** will be filed by your VSP physician.

The following steps must be followed to use VSP's services:

1. Choose a participating VSP eye doctor. A list of participating eye doctors is available from the Fund Office or you can call 1-800-877-7195 for doctors in your area. If you would like to check whether a particular doctor is a participating VSP eye doctor, you will need the doctor's phone number with area code. You may also use the VSP web site (www.vsp.com).

2. Call the VSP doctor for an appointment and identify yourself as a VSP member. Give the doctor your identification number and tell him or her that you are covered under the I.A.T.S.E. Local 22 Vision Service Plan.

3. After you have scheduled your appointment, the VSP participating doctor will contact Vision Service Plan to verify your eligibility and plan coverage. The doctor will also obtain authorization for services and materials. The doctor will tell you what benefits you are eligible for.

If you receive services or material from a non-participating eye doctor, you must pay the doctor the full fee for services rendered and submit your *paid* itemized bill to VSP for reimbursement.

OTHER BENEFITS

Claims for Death and AD&D should be sent to:

IATSE Local 22 Welfare Fund Office
11247 C Lockwood Drive
Silver Spring, MD 20901-4556
Phones: (301) 593-1265
Fax: (301) 593-0648

HOW TO FILE CLAIMS

When filing a claim for medical care or similar benefits (if provided for under this Plan) attach itemized bills for any services not shown on the claim form. Be sure the bills clearly identify the patient, the date and nature of treatment or service and the amount of the charge. The claim form will include an authorization to pay benefits directly to the provider of the service (physician, hospital, etc.) If you wish to direct payment to the provider, you must sign the authorization.

You have ninety days in which to file proof of claim. No claim will be denied, however, due to failure to file proof within the time specified if it can be shown that it was not reasonably possible to furnish such proof on time and that it was furnished as soon as was reasonably possible.

A claim will not be payable under this Plan if it is filed more than one year following the date in which services were incurred.

Voya Financial and/or the Board of Trustees (at its own expense) reserves the right to have a physician it designates examine the individual whose loss is the basis of a claim when and so often as it may reasonably require.

No action at law or in equity may be brought to recover on the Group Policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the Group Policy, nor may such action be brought at all unless brought within three years from the expiration of the time allowed for furnishing proof of loss.

PROCESSING OF CLAIMS AND APPEALS

The procedures for filing a claim for benefits under this Plan differ depending on the type of benefit sought. This Section sets forth in detail the procedures that apply to each type of claim. It also discusses the procedures for appealing a claim denial, in whole or in part, or other adverse benefit determination. Should you have any questions about the claims filing procedures, please contact the Fund Office.

ALL CLAIMS OTHER THAN DISABILITY CLAIMS

This section applies to all medical, dental, vision, death, and accidental death and dismemberment claims.

Applicable Definitions

As described below, after you submit a claim for benefits, the notification procedures that apply differ depending on whether your claim involves "Urgent Care," is a "Pre-Service Claim," or is a "Post-Service Claim." These and other important terms are defined below.

- **Urgent Care Claim**. This is a claim for medical care or treatment which—

1. Involves emergency medical care needed immediately in order to avoid serious jeopardy to your life, health, or ability to regain maximum function; or
2. In the opinion of a Physician with knowledge of your medical condition would subject you to severe pain that cannot be adequately managed if your claim were not dealt with in the "Urgent Care" time frame described below. Whether your claim is one involving Urgent Care will be determined by an individual acting on behalf of the Plan, applying the prudent judgment or a layperson with an average layperson's knowledge of health and medicine. If a Physician with knowledge of your medical condition determines that your claim is one involving Urgent Care, your claim will be treated as an Urgent Care Claim.

- **Pre-Service Claim.** This is any claim with respect to which the terms of the Plan condition receipt of a benefit, in whole or part, on precertification by the UM Program in advance of obtaining medical care, such as for surgery or a hospital stay.
- **Post-Service Claim.** This is any claim for a benefit that is not a Pre-Service Claim. In this type of claim, you request reimbursement after medical care has already been rendered.
- **Disability Claim.** This is a claim for a benefit that depends on whether the claimant is "disabled" and which the Plan Administrator or its designee has authority under a specific provision of the Plan to make the disability determination itself.
- **Concurrent Care Claim.** This is any claim to extend a course of treatment beyond the period of time or number of treatments that the Plan has already approved as an ongoing course of treatment to be provided over a period of time or certain number of treatments. A Concurrent Care Claim can be an Urgent Care Claim, a Pre-Service Claim, or a Post-Service Claim.
- **Incomplete Claim.** A claim will be deemed incomplete if you do not provide enough information for the Plan (or the UM Program) to make a determination on whether and to what extent your claim is covered by the Plan. This includes your failure to communicate to a person who ordinarily handles benefit matters for the Plan, your name, your specific medical conditions or symptom, and the specific treatment or service for which you request payment of benefits.
- **Adverse Benefit Determination.** A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary. Any rescission of coverage is also considered an Adverse Benefit Determination.

Notification of Initial Benefit Determination

- **Urgent Care Claims.** The Claims Office or UM Program will notify you whether your claim is approved or denied, in whole or in part, as soon as possible but not later than 72 hours after it receives your claim, unless your claim is an Incomplete Claim. The Claims Office will notify you as soon as possible if your claim is an Incomplete Claim, but not more than 24 hours after receiving your claim. You may be notified orally, unless you or your authorized representative request written notification. You will then have 48 hours to provide the specified information. Upon receiving this additional information, the Claims Office will notify you of its determination as soon as possible, within the earlier of 48 hours after receiving the information, or the end of the period within which you must provide the information.

- **Pre-Service Claims.** The UM Program will notify you whether your claim is approved or denied, in whole or in part, within a reasonable time, but not later than 15 days after receipt of your claim. This period may be extended by one 15-day period, if circumstances beyond the UM Program's control require additional time to process your claim. If an extension is necessary, the UM Program will notify you prior to the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which it expects to reach a decision. If an extension is necessary because you have submitted an Incomplete Claim, you will be notified within 5 days of receipt of your claim. The notice will describe the information needed to make a decision. The UM Program may notify you orally, unless you request written notification. You will have 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the UM Program to decide a claim, the period for making the benefit determination will be tolled from the date on which you are sent notification of the extension until the date you respond to the request for additional information.
- **Post-Service Claims.** The Claims Administrator will notify you of its determination within a reasonable time, but not later than 30 days after receipt of your claim. This period may be extended by one 15-day period, if necessary due to circumstances beyond the control of the Plan. If an extension is necessary, you will be notified prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which the Claims Administrator expects to reach a decision. If an extension is needed because you have submitted an Incomplete Claim, the notice will also describe the information the Claims Administrator needs to make a decision. You will have until 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary to decide your claim, the period for making a benefit determination will be tolled from the date on which you are sent notification of the extension until the date you respond to the request for additional information.
- **Concurrent Care Claims.** If the Claims Office has approved an ongoing course of treatment to be provided over a period of time, it will notify you in advance of any reduction in or termination of this course of treatment. If you submit a claim to extend a course of treatment, and that claim involves Urgent Care, the Claims Office will notify you of its determination within 24 hours after receiving your claim, provided that your claim is received at least 24 hours prior to the expiration of the course of treatment. If the claim does not involve Urgent Care, the request will be decided in the appropriate time frame, depending on whether it is a Pre-Service Claim or a Post-Service Claim.

Denial of Claim for Benefit

Content of Notification of Claim Denial or Adverse Benefit Determination

If any claim for benefits described above is denied, in whole or in part, or there has been a rescission in your coverage, the Claims Administrator (or UM Program, in the case of a Pre-Service Claim) will provide you with a written notice that:

1. States the specific reasons for the denial (including the denial code and its corresponding meaning);
2. Refers to any specific Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial;
3. Describes any additional material or information necessary for your claim;
4. Explains why that information is necessary;

5. Provides sufficient information to identify the claim involved, including where applicable, the date of service of the benefits denied, the health care provider, the claim amount, and the right to receive upon request the diagnosis code, treatment code and the meanings of these codes;
6. Describes any internal or external appeals available, how to initiate them and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review; and
7. Discloses the availability of, and the contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

In addition, you will be provided, if applicable:

8. If an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination and that a copy will be provided to you free of charge upon request.
9. If the adverse determination is based on a Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, the notice will include either an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to your claim or a statement that such an explanation will be provided free of charge upon request.
10. In the case of an adverse benefit determination concerning an Urgent Care Claim, the notice will also describe the shortened time frames for reviewing Urgent Care Claims. In addition, in the case of an Urgent Care Claim the notice may be provided to you orally, within the time frames described above. You will be provided with a written notice within 3 days of oral notification.

The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable after receiving your request. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be an appeal.

Appeals Procedure in General

If the Plan denies your claim for benefits, in whole or in part, or there has been a rescission in your coverage, you may request the Trustees or a designated Committee of the Trustees to review your benefit denial. You may submit a written appeal to the Board of Trustees at the following address:

IATSE Local 22 Welfare Fund Office
Board of Trustees
11247 C Lockwood Drive
Silver Spring, MD 20901-4556

Your written appeal must be submitted within 180 days of receiving the notice of the Adverse Benefit Determination. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, it will notify you at a time sufficiently in advance of the reduction or termination of treatment, which may be a period that is less than 180 days, to allow you to appeal and obtain review before the benefit is reduced or terminated.

If the UM Program denies your Pre-Service Claim, in whole or in part, you may request the Claims Administrator to review the benefit denial by submitting a written appeal to the Claims Administrator within 180 days of receiving the denial notice. If the Claims Office denies your

appeal of a Pre-Service Claim, you then have within 60 days of receiving the denial notice on appeal to submit a second appeal to the Trustees.

Failure to file a timely appeal will result in a complete waiver of your right to appeal and the initial benefit decision will be final and binding.

Upon receipt of an adverse benefit determination, you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial and the reasons for your appeal. You should also submit any documents that support your claim. The review of your claim will take into account all comments and documents that you submit to support your position, even if neither the Plan nor UM Program had this information in making the initial claim determination (or in the case of Pre-Service Claims, the determination on a first level appeal). This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim. The Trustees (or UM Program) can best consider your position if they clearly understand your claims, reasons and/or objections.

The review on appeal will be made by the Board of Trustees or a designated Committee of the Trustees (or, in the case of a first level appeal of a Pre-Service Claim, by the Claims Office), none of whom decided the initial claim for benefits or is the subordinate of any individual who decided the initial claim. The decision on appeal shall give no deference to the initial denial or adverse determination.

In the case of a claim based in whole or in part on a medical judgment (including adverse determinations based on a Medical Necessity or Experimental and/or Investigational treatment exclusion or limitation), a health care professional who has appropriate training and expertise in the field of medicine, and who was not consulted in connection with the initial claim and is not the subordinate of a health care professional who was, will be consulted. The medical or vocational expert(s) whose advice was obtained in connection with the adverse determination will be identified even if the Plan did not rely on the advice of the expert(s).

You will be provided, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by, or at the direction of, the Plan, the Trustees, the designated Committee, or any other person reviewing your appeal. Such information will be provided to you as soon as possible and with sufficient time to give you a reasonable opportunity to respond to such new or additional information. In addition, you will be provided the same opportunity before an adverse benefit determination on appeal may be rendered based on a new or additional rationale.

Also, in case of an Urgent Care Claim, you may request review orally or in writing, and communications between you and the Plan, including the Plan's decision on appeal, may be made by telephone, facsimile, or other similar means.

Notification of Decision on Appeal

Timing of Notification.

1. Urgent Care Claim. The Board of Trustees or a designated Committee of the Trustees will notify you of its decision of an Urgent Care Claim as soon as possible, but not later than 72 hours after it receives your request for review.
2. Pre-Service Claim. The Claims Administrator will notify you of its decision of a first level appeal within a reasonable period of time, but not later than 15 days after it receives your

request for review. The Board of Trustees or a designated Committee of the Trustees will notify you of a Pre-Service Claim second level appeal within a reasonable period of time, but not later than 15 days after receiving your request for review.

3. Post-Service Claim. The Board of Trustees or a designated Committee of the Trustees will review your appeal of an adverse Post-Service Claim at their regularly scheduled meeting (at least quarterly) immediately following receipt of your appeal unless your appeal is received by the Fund Office within 30 days preceding the date of the meeting, in which case, your appeal will be reviewed at the second meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require a further extension of time for review by the Trustees, a benefit determination will be rendered not later than the third Trustees meeting following receipt of your appeal. Prior to the commencement of such an extension, you will be notified, in writing, of the extension, the special circumstances requiring the extension, and the date by which the Trustees will decide your appeal. You will receive written notice within 5 days of the Trustees decision on your appeal.

Content of Notification of Determination on Appeal/Review

If your claim for benefits is denied on review, in whole or in part, you will receive a written notice in the time set forth above. The notice will set forth:

1. The specific reason(s) for the adverse determination (including the denial code and its corresponding meaning) and a discussion of the decision;
2. The specific Plan provisions on which the benefit determination is based;
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
4. Sufficient information to identify the claim involved, including where applicable, the date of service of the benefits denied, the health care provider, the claim amount, and the right to receive upon request the diagnosis code, treatment code and the meanings of these codes;
5. A description of the external review process, including information on how to initiate an external review and applicable time limits, and the right to bring a civil legal action under ERISA;
6. A statement describing any voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA; and
7. Disclosure of the availability of, and the contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

In addition, you will be provided, if applicable:

8. If an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, you will be provided either with the specific rule, guideline, protocol or similar criterion, or y a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request.

9. If the adverse determination was based on a Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to your claim or a statement that such an explanation will be provided free of charge upon request.

The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable after receiving your request. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an external review.

Decision on Appeal is Final and Binding

Except for claims eligible for external review, the decision on review shall be final and binding upon all parties including any person claiming a benefit on your behalf. The Trustees have full discretion and authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. If your appeal of a claim is denied, and you decide to seek judicial review, the decision on appeal shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious. You must exhaust all available administrative remedies prior to seeking judicial review.

DISABILITY CLAIMS & APPEALS

Notification of Initial Benefit Determination

The Claims Office will notify you of its determination within a reasonable period of time, but not later than 45 days after receipt of your claim. This period may be extended by up to 30 days, if circumstances beyond the control of the Plan make additional time to process your claim necessary. The period may be extended by up to 30 days a second time, if circumstances beyond the control of the Plan makes this second extension necessary to process your claim necessary. If an extension is necessary, you will be notified prior to the expiration of the initial 45-day period (or, in the case of a second extension, you will be notified prior to the expiration of the first 30-day extension) of the circumstances requiring an extension and the date by which the Claims Office expects to reach a decision. The notice will also explain the standards on which entitlement to the benefit is based, and the unresolved issues that prevent the claim from being decided. If an extension is needed because you have not submitted information necessary to decide the claim, the notice will also describe the information the Claims Office needs to make a decision. You will have until 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary to decide your claim, the period for making the benefit determination will be tolled from the date on which you are sent notification of the extension until the date you respond to the request for additional information.

Content of Notification of Claim Denial or Adverse Benefit Determination

If your application for a Disability Benefit is denied, in whole or in part, or any other adverse determination is made regarding your claim, the Claims Office will provide you with a written notice that:

1. States the specific reasons for the denial (including the denial code and its corresponding meaning);

2. Refers to any specific Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial;
3. Describes any additional material or information necessary for your claim;
4. Explains why that information is necessary;
5. Includes either a copy of the specific rule, guideline, protocol or similar criterion relied on in making the adverse determination or, alternatively, a statement that such a rule, guideline, protocol, or similar criterion does not exist;
6. States that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
7. Provides sufficient information to identify the claim involved, including where applicable, the date of service of the benefits denied, the health care provider, the claim amount, and the right to receive upon request the diagnosis code, treatment code and the meanings of these codes;
8. A description of any internal or external appeals available, how to initiate them and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review; and
9. Disclosure of the availability of, and the contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

In addition, you will be provided, if applicable:

10. If the adverse determination is based on a Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to your circumstances or a statement that such explanation will be provided free of charge upon request.
11. A discussion of the Plan's basis for disagreeing with or not following (a) views presented by your treating health care professionals and/or vocational professionals who evaluated you; (b) views of medical or vocational experts whose advice the Plan obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination; or (c) a disability determination made by the Social Security Administration.

The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable after receiving your request. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be an appeal.

Appeals of Disability Determinations

An appeal of an adverse determination regarding a disability claim is subject to the same timelines and procedures described above under **Appeals Procedure in General**.

The Board of Trustees or a designated Committee of the Trustees will review your appeal of an adverse Disability Claim at their regularly scheduled meeting (at least quarterly) immediately following receipt of your appeal unless your appeal is received by the Fund Office within 30 days preceding the date of the meeting, in which case, your appeal will be reviewed at the second

meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require a further extension of time for review for the Trustees, a benefit determination will be rendered not later than the third Trustees meeting following receipt of your appeal. Prior to the commencement of such an extension, you will be notified, in writing, of the extension, the special circumstances requiring the extension, and the date by which the Trustees will decide your appeal. You will receive written notice within 5 days of the Trustees decision on your appeal.

Content of Notice of Adverse Decision of Appeal

If your claim for disability benefits is denied on review, you will receive a written notice. The notice will set forth:

1. The specific reason(s) for the adverse determination (including the denial code and its corresponding meaning) and a discussion of the decision;
2. The specific Plan provisions on which the benefit determination is based;
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
4. Either a copy of the specific rule, guideline, protocol or similar criterion relied on in making the adverse determination or, alternatively, a statement that such a rule, guideline, protocol, or similar criterion does not exist;
5. Sufficient information to identify the claim involved, including where applicable, the date of service of the benefits denied, the health care provider, the claim amount, and the right to receive upon request the diagnosis code, treatment code and the meanings of these codes;
6. A description of the external review process, including information on how to initiate an external review and applicable time limits, and the right to bring a civil legal action under ERISA;
7. A statement describing any voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA; and
8. Disclosure of the availability of, and the contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

In addition, you will be provided, if applicable:

9. If the adverse determination was based on a Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to your circumstances or a statement that such explanation will be provided free of charge upon request.
10. A discussion of the Plan's basis for disagreeing with or not following (a) views presented by your treating health care professionals and/or vocational professionals who evaluated you; (b) views of medical or vocational experts whose advice the Plan obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination; or (c) a disability determination made by the Social Security Administration.

The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable after receiving your request. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an external review.

EXTERNAL REVIEW OF AN ADVERSE HEALTH CARE BENEFIT DETERMINATION AFTER APPEAL

Standard External Review: If you receive an adverse benefit determination on your appeal concerning your health care claim or a rescission of your coverage, you have the right to request an external review. The request should be sent to the address identified above for submitting an appeal to the Trustees. Your request for an external review must be made no later than four (4) months after the date you receive the adverse decision on your appeal. If there is no corresponding date four (4) months after the date of receipt of such notice, the request must be filed by the first day of the fifth (5th) month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is not February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

Within five (5) business days following receipt, the Fund Office will make a preliminary review to determine whether:

1. You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

2. The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility to participate under the terms of the Plan (eligibility claims are not subject to external review);

3. You have exhausted the Plan's internal appeal process unless you are not required to exhaust the final internal appeals process; and

4. You have provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Fund Office will issue a written notification to you. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and the toll-free (if available) contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. The Plan will allow you to perfect the request for external review within the later of: (a) the four-month filing period, or (b) the 48 hour period after the receipt of notification.

If your case is eligible for external review, it will be forwarded to an Independent Review Organization (IRO) accredited by a nationally-recognized accrediting organization, and the IRO will contact you. The Fund Office will contract with at least three (3) IROs for assignments under the Plan and rotate claim assignments among them or incorporate other independent, unbiased methods for selection of IROs, such as random selection.

The external review process applies to cases involving:

1. An adverse benefit determination (including a final adverse benefit determination) by the Plan that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or the Plan's determination that a treatment is Experimental or Investigational), as determined by the external reviewer.

2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Once assigned, you will receive notice directly from the IRO. This notice will include, among other things, a statement that you have ten (10) business days following the date you receive the notice to submit additional information directly to the IRO if you choose to do so. Additional information submitted during this time must be considered by the IRO when conducting its external review. The IRO is not required to, but may accept and consider additional information submitted after ten (10) business days. The IRO will use legal experts where appropriate to make coverage determinations under the Plan.

Within five (5) business days after the assignment of the IRO, the Fund Office will provide to the IRO the documents and information considered in making the adverse benefit determination or final internal appeal including information that you previously submitted to the Fund Office. Failure by the Fund Office to timely provide the documents and information will not delay the conduct of the external review. If the Fund Office does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one (1) business day after making such a decision, the IRO must notify you and the Plan.

Upon receipt of any information that you submit, the IRO must forward the information to the Plan within one (1) business day. The Fund Office may, but is not required to, reconsider its adverse benefit determination or final internal adverse benefit determination. Reconsideration by the Plan will not delay the external review. If the Fund Office decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment, the Fund Office will provide written notice of its decision to you and the IRO within one (1) business day after making its decision. The IRO will terminate the external review upon receiving this notice from the Fund Office.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (that is, starting from the beginning) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

1. Your medical records;

2. The attending health care professional's recommendation;

3. Reports from appropriate health care professionals and other documents submitted by you, your treating provider, the Plan or issuer;

4. The terms of the Plan to ensure that the IRO's decision is not contrary to the Plan's terms, unless the terms are inconsistent with applicable law;

5. Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

6. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the Plan's terms or with applicable law; and

7. If the IRO's final decision maker is different from its clinical reviewers, the opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents to the extent the clinical reviewer or reviewers consider appropriate.

Within 45 days after the IRO receives your request for external review from the Fund Office, the IRO will issue to you a written notice of its final external review decision. The written decision of the IRO will contain:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date(s) of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

3. References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

5. A statement that the determination is binding except to the extent that other remedies may be available under the State or federal law to either the group health plan or to you;

6. A statement that judicial review may be available to you;

7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

IROs must maintain records of all claims and notices associated with the external review process for six (6) years. An IRO must make such records available for examination by you, the Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide

coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review: When external review is otherwise available, the Plan will allow you to make a request for an expedited external review at the time you receive:

1. An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

2. A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency care services, but have not been discharged from the facility.

Immediately upon receipt of the request for expedited external review, the Fund Office will review the request to determine whether the request meets the reviewability requirements using the same criteria above that apply to a standard external review. The Plan will immediately send a notice of its eligibility determination that meets the requirements above for a standard external review eligibility determination notice.

Upon determination that request is eligible for expedited external review following the preliminary review, the Fund Office will assign an IRO in accordance with the requirements for assigning an IRO for a standard external review above. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefits determination to the assigned IRO electronically or by telephone or fax or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO will provide written notice to you and the Plan of the final external review decision, in accordance with the requirements above for standard external review, except that the notice will be provided as expeditiously as possible, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, then within 48 hours after the date of providing that notice, the IRO must provide written confirmation of that decision to you and the Plan.

If the IRO reverses the Plan's adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The IRO's decision is binding on you and the Plan, except to the extent other remedies are available under State or Federal law, and

except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

IROs must maintain records of all claims and notices associated with the external review process for six (6) years. An IRO must make such records available for examination by you, the Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

XIII. COORDINATION OF BENEFITS, MEDICARE AND CASES INVOLVING A THIRD PARTY

COORDINATION OF BENEFITS OVERVIEW

Your medical, dental, and vision benefits are coordinated with any benefits payable to you or your Eligible Dependents for the same expenses from any other health and welfare benefit plan, whether insured or self-insured.

Coordination means that one of the plans (the "primary plan") pays benefits first and that benefits from this Plan and benefits from other plan(s) can equal, but not exceed, 100% of "allowable expenses" incurred. The purpose of coordination is to permit full payment of actual allowable expenses without unnecessary duplication of payments. Coordination of Benefits is only applicable when you, your spouse or your dependents are eligible under more than one group health plan.

DEFINITION OF TERMS

- "Allowable Expenses" are Covered Charges, in full or in part, for benefits and services covered in full or in part under this Plan. Expenses not covered by any plan to which a person belongs are not allowable. For example, coordination of benefits would not cover personal convenience items such as television rental in the hospital.

- "Other health and welfare benefit plans" include group plans (insured or self insured) such as your spouse's employer's group health plan and Medicare.

HOW COORDINATION OF BENEFITS WORKS - WHICH PLAN PAYS FIRST

Benefits are coordinated with other insurance plans in the following order:

1. This Plan pays allowable expenses second, after any plan that does not have a coordination of benefits provision.

2. The plan covering you or an Eligible Dependent as an employee, laid off employee, retiree, member or subscriber (or a dependent of such person) pays allowable expenses first before a plan covering you as a dependent. If the plan covering the person is Medicare and Medicare is by law secondary to the plan covering the person as dependent and primary to the plan covering the person as other than a dependent (e.g., a retiree), the order of payment is reversed. An Eligible Dependent, except a Spouse, who earns coverage as a Participant is not covered as a dependent under this Plan. If a husband and wife are both eligible participants of this Plan, both will be covered as an individual and as a dependent.

3. For someone who is covered as an Eligible Dependent under the plans of both parents, the plan of the parent whose birthday falls earlier in the Calendar Year will pay before the plan of the other parent. If both parents have the same birthday, whichever plan has covered one of the parents longer is the plan that pays first. This "Birthday Rule" applies only if both plans have adopted the Birthday Rule. If either plan does not have the Birthday Rule, then the father's plan pays first. This provision applies if the parents are married and not living separately, or if a court has not specified that one parent has legal responsibility to provide health coverage to the child (see below).

4. A plan covering someone as a laid off or retired employee or a dependent of such person, pays benefits after any other plan covering the person as an employee.

5. If you or your dependents are receiving COBRA coverage because of a pre-existing condition, the COBRA coverage of this plan pays after the other plan for all medical expenses not related to the pre-existing condition.

6. If priority still is not established according to the previous rules listed above, the plan that has covered the person for the longer period of time pays benefits first. If priority is still not established under any of these rules, each plan shall pay an equal share of covered expenses incurred.

The following special rules apply in place of the above rules for dependent coverage in case of legal separation or divorce:

1. When parents are separated (whether or not ever married) or divorced and there is a court decree which established financial responsibility for medical, dental, or other health care expenses for the child, benefits are determined in accordance with the court decree.

2. If there is no specification of responsibility in a court decree, and if the parent with custody has not remarried, the benefit plan covering the parent with custody pays first. The plan covering the parent without custody pays second.

3. If there is no specification of responsibility in a court decree, and if the parent with custody has remarried, the benefit plan covering the parent with custody pays first. The stepparent's plan pays second. The plan of the parent without custody pays third.

COORDINATION OF BENEFITS WITH MEDICARE

MEDICARE COORDINATION AT AGE 65 FOR COVERED EMPLOYEES

If you or your spouse becomes eligible for Social Security at age 65, coverage by Medicare is available even if you do not retire. Medicare includes Hospital Insurance benefits (called "Part A") as well as supplementary medical insurance (called "Part B").

You have the following options at age 65 if you do not retire:

1. Choose this Plan as your primary coverage and Medicare as your secondary coverage.

You would continue to submit all your claims to the Plan and receive the same benefits as any other employee. Medicare would then consider a claim for any remaining expenses. Having coverage under both Medicare and this Plan obviously provides you with the greatest protection. Medicare Part A benefits are free but payment of premiums is required for Medicare Part B coverage. You should notify the Plan as well if you have enrolled in Medicare, so the Fund Office can be aware of your need for payment information to file Medicare claims. The Fund Office cannot file Medicare claims for you.

2. Choose Medicare alone

You may choose not to participate in this Plan and have Medicare as your only insurance. You would submit claims only to Medicare. Medicare has certain deductibles and co-payments for most services as well as premiums for Part B coverage. You must notify this Plan in writing if you choose Medicare alone. Otherwise, this Plan will continue to pay benefits the same as before as long as you are eligible. You should notify the Plan as well if you have enrolled in Medicare, so the Fund Office can be aware of your need for payment information to file Medicare claims. The Fund Office cannot file Medicare claims for you.

3. This Plan Alone

You may choose not to enroll under Medicare and have this Plan as your only insurance. You should contact your nearest Social Security Administration Office for information on the consequences of delaying enrollment in Medicare; some of these are described below.

4. Choose Your Spouse's Employer-Provided Coverage as Primary

If your spouse is employed and is provided coverage through his/her employer, you may choose this as primary coverage. Generally, in this instance, Medicare would be the secondary payer and this Plan would be tertiary. However, if you (or your spouse) do not enroll in Medicare Part B as a result of having other primary coverage, this Plan would be secondary for claims that would otherwise be covered by Part B.

MEDICARE FOR DISABLED INDIVIDUALS

Medicare becomes the primary payer for any totally disabled individuals who are not actively working. If you are enrolled in Medicare prior to age 65, Medicare will be the primary payer. Claims must be sent to Medicare first. The I.A.T.S.E. Local 22 Welfare Plan remains the secondary payer and the Plan will pay secondary to Medicare.

MEDICARE FOR INDIVIDUALS WITH END-STAGE RENAL DISEASE (ESRD)

If, while you are a Covered Employee, you or an Eligible Dependent becomes entitled to Medicare because of ESRD, this Plan pays first and Medicare pays second for a limited period of time starting the earlier of:

1. the month in which Medicare ESRD coverage begins, or

2. the first month in which the individual receives a kidney transplant.

After the Social Security required number of months after Medicare ESRD coverage begins, or following a kidney transplant, Medicare pays first, and this Plan pays second.

ENROLLING IN MEDICARE IF YOU RETIRE ON OR BEFORE AGE 65

If you retire on or before your 65th birthday, it is important that you and your spouse visit an office of the Social Security Administration during the three-month period prior to the 65th birthday for each of you to enroll in Medicare. If you fail to enroll in Medicare within 90 days after your 65th birthday, you may be subject to lower medical protection.

Lower coverage can occur two ways:

1. Medicare charges higher premiums if you enroll late and limits when you can enroll. (See penalties in next paragraph.)

2. If you have questions concerning enrolling in Medicare, please contact Social Security.

RULES FOR ENROLLMENT IN MEDICARE IF YOU WORK PAST AGE 65 AND RETIRE

If you are over age 65 and stop working, you must enroll in Medicare within seven months of the last day you worked. This rule applies even if you are still receiving health care benefits from this plan for a period beyond 7 months because of the plan's eligibility rules. If you do not enroll in Medicare within this time period, you may be subject to the following penalties:

1. A 10% higher premium for each year you could have enrolled in Medicare but did not.

2. You can enroll only during the months of January, February, or March of the following year and your protection will not begin until the following July 1.

3. If you are retired under the International Alliance of Theatrical Stage Employees Pension Plan Local 22 and you or your spouse is over 65, Medicare becomes your primary payer. This plan pays claims after Medicare becomes your primary payer if you have met the requirements for continuation of coverage. This Plan will not pay claims that Medicare would have paid because you failed to enroll.

Therefore, if you are over 65 and stop working, visit an office of the Social Security Administration promptly to enroll within the 7-month limit, even if Plan coverage continues longer. Otherwise, a gap of no medical coverage at all may occur when your Plan eligibility runs out.

This plan will not pay claims that Medicare would have paid because you failed to enroll.

CASES INVOLVING A THIRD PARTY

If you or your Eligible Dependents is involved in an accident or sustains an Illness or Injury for which another party might be liable to you for medical expenses, the Plan will pay benefits towards expenses incurred as a result of your injury. However, you may be required to reimburse the Plan for the payments it has made if you recover damages or receive payments from any insurance company, including a homeowner's, renter's, or automobile policy on which you have paid premiums, or from the other party.

In cases in which an injury to, or resulting medical condition of, a Participant or Beneficiary under the Plan is the result of or is causally related to the conduct of a third party, and such Participant or Beneficiary advances or maintains any claim or cause of action against such third party for such

injury or condition, all payments or benefits received by such Participant or Beneficiary under this Plan shall be in the nature of an advance to such Participant or Beneficiary, and shall be repaid to the Plan from any proceeds or payment received by such Participant or Beneficiary from such third party or the insurer of such third party, by way of any judgment, settlement, or award, regardless of whether the award is characterized to be for medical costs or for other reasons, such as punitive damages or pain and suffering.

In cases where it appears that a Participant's or Beneficiary's Illness or Injury is or may be the result of the conduct or negligence of a third party which may rise to a claim or cause of action against such third party by the Participant or Beneficiary, or where the Participant or Beneficiary may receive payment for such Illness or Injury from another party including an automobile or homeowner's or renter's or other insurance policy even if the Participant or Beneficiary has paid for the coverage, the Plan may withhold further benefits to such Participant or Beneficiary until the Participant or Beneficiary shall agree in writing to repay such advance as set forth above by executing an appropriate agreement.

EQUITABLE LIEN

All funds received by or for any covered person up to and including the amount of claims paid, are subject to the Plan's equitable lien thereon and are deemed to be held in constructive trust for the benefit of the Plan until such funds are delivered to the Plan or its Attorney.

For example:
If you or your dependents were injured in an automobile accident which was another person's fault, and the Plan paid $1,000 in benefits to you as a result of the accident, and you subsequently recover money from a lawsuit or the insurance company, the Plan may be entitled to receive up to $1,000 of the money you receive.

If you are involved in such a case, you may be asked to sign an agreement to reimburse the Fund for any advance of payment of benefits. Should you choose not to sign this agreement, benefits under this plan may be withheld or terminated at the discretion of the Board of Trustees for the injuries involved.

XIV. GENERAL PLAN INFORMATION

INFORMATION ABOUT THE PLAN

This Plan is maintained pursuant to Collective Bargaining Agreements between the International Alliance of Theatrical Stage Employees Locals 22 and 772 and Employers signatory to the Collective Bargaining Agreements. Copies of these agreements may be obtained by Plan Participants and Eligible Dependents upon written request to the Plan Administrator. The Collective Bargaining Agreements are also available at each employer establishment where at least 50 persons covered under the Plan are customarily working.

Participants may receive from the Fund Office, upon written request, information as to whether or not a particular Employer is a Contributing Employer and any applicable Collective Bargaining Agreement. If an Employer is a Contributing Employer, you will be provided the Employer's address.

Name of Plan and Plan Sponsor:

The name of the Plan is the International Alliance of Theatrical Stage Employees Local 22 Welfare Fund for Local 22 and Local 772 Participants. The Plan is commonly known as the IATSE Local 22 Welfare Fund.

The Plan Sponsor is the Board of Trustees of the IATSE Local 22 Welfare Fund.

Type of Plan:

The Plan is an Employee Welfare Benefit Plan providing benefits including:

1. Medical expense benefits;
2. Dental expense benefits;
3. Vision expense benefits;
4. Death benefits;
5. Accidental death and dismemberment benefits;
6. Short term disability coverage; and
7. Prescription drug benefits.

The Plan is a self-insured multiemployer plan governed by ERISA and the Laborer Management Relations Act of 1947 (The Taft-Hartley Act).

Source of Funding:

The Plan is funded by contributions made by Contributing Employers under the provisions of Collective Bargaining Agreements and similar agreements, by self-payments made under certain circumstances by employees, retirees or dependents in accordance with the terms of the Plan, and any income earned from investment of such contributions and payments. All monies are used exclusively to provide benefits to Participants, and to pay all expenses incurred with respect to the operation of the Plan.

Type of Administration:

The IATSE Local 22 Welfare Fund is a collectively bargained trust fund administered by a joint Board of Trustees with equal representatives from participating Employers and the Union. The IATSE Local 22 Welfare Fund is self-insured for all benefits provided under the Plan, except for Death Benefits and Accidental Death & Dismemberment Benefits for Covered Employees, which are insured by Voya Financial.

The Plan has arrangements with various organizations, such as a dental benefits program, which coordinate claims payments and processing. The Plan has arrangements with the following: Benefits Administration Corp. administers payment of medical claims, Vision Service Plan administers payment of vision claims, Express Scripts administers payment of prescription claims, Delta Dental administers payment of dental claims, and Voya Financial administers death and accidental death and dismemberment insurance claims. All other benefits are administered under the direction of the Trustees. Except as otherwise indicated, no payments provided for in this Plan are insured by any contract of insurance and there is no liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amount in the Fund.

The name, address and phone of the Claims Administrator is:

Benefits Administration Corp, Inc.
9411 Philadelphia Rd. Suite S
Baltimore, MD 21237

Phones: (410) 319-7264
(800) 941-2752
Fax: (410) 687-7600

The name, address and phone of the Fund Administrator is:

I.A.T.S.E. Local 22 Welfare Fund
11247 C Lockwood Drive
Silver Spring, Maryland 20901-4556

Phones: (301) 593-1265/6
Fax: (301) 593-0648

The Employer Identification Number (EIN) is: 52-1021473

The Plan number is: 501

The Plan's fiscal year end date is: December 31

Agent for services of legal process is:

Board of Trustees
c/o Natalia Jordan
IATSE Local 22 Welfare Fund
11247 C Lockwood Drive
Silver Spring, Maryland 20901-4556

The Plan Administrator of the Fund is the Board of Trustees. The members of the Board of Trustees, each of whom may also be served with legal process, are as follows:

Employer Trustees	***Employee Trustees***
Lynne Pratt John F. Kennedy Center for the Performing Arts Washington, D.C. 20566	Irving C. Clay I.A.T.S.E. Local 22 1810 Hamlin St. NE Washington, DC 20018
Barrett Newman 3701 Massachusetts Ave., NW Suite 102 Washington, DC 20016	Donald E. Tillett I.A.T.S.E. Local 22 1810 Hamlin St. NE Washington, DC 20018
Ryan Haderlie Wolf Trap Foundation 1624 Trap Road Vienna, VA 22182	John R. Daley Jr. I.A.T.S.E. Local 22 1810 Hamlin St. NE Washington, DC 20018

STATEMENT OF ERISA RIGHTS

This Welfare Plan was established as the result of collective bargaining agreements and its purpose is to improve the security and well-being of the Plan Participants and their beneficiaries. The Trustees, the Employers, and the Union want you as a Participant in the Plan to enjoy its benefits.

However, in addition to what the Trustees, the Employers and the Union have done to see that the Plan's benefits are fulfilled, Federal regulations require the following summary of rights and protection to which every Participant in the Plan is entitled under the law (ERISA).

YOUR RIGHTS UNDER ERISA
As a Participant in the IATSE Local 22 Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE
Continue health care coverage for yourself, your Spouse or Eligible Dependents if there is a loss of coverage under the Pan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and 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.

SPECIAL ENROLLMENT RIGHTS

Special enrollment Rights Under the Health Insurance Portability and Accountability Act (HIPAA)

If you did not enroll for Health care coverage within 30 days of becoming eligible, you may be able to enroll at a later date under the Plan's Special Enrollment Rights provided that:

- You were eligible for coverage, but declined it when it was previously offered;
- You stated in writing that you had health care coverage from another source;
- Your other coverage terminated because:
  - It was COBRA Continuation Coverage and that coverage had been exhausted;
    or
  - Your eligibility for the other coverage was lost (for reasons other than you failure to pay premiums) or employer contributions toward the cost of coverage terminated.

If you meet these conditions, you must request enrollment within 30 days after the date your COBRA coverage was exhausted or your other coverage terminated. Your enrollment will be effective the first day of the calendar month beginning after the date on which the Plan receives your completed enrollment form.

In addition, you may enroll yourself and your dependents for coverage at any time provided that:

- You are eligible for coverage under the Plan and not currently enrolled;
- You declined coverage under the Plan when it was offered previously; and
- You've married or acquired a dependent through marriage, birth adoption or placement for adoption.

If you meet these conditions, you must submit a completed enrollment form within 30 days of the marriage, birth, adoption, or placement of adoption. Enrollment in the Plan will be effective on the first day of the first calendar month beginning after:

- The date the Plan receives your completed enrollment form, in the case of your marriage;
- The date of your new dependent's birth; or
- The date of your new dependent's adoption or placement for adoption with you.

PLAN AMENDMENTS OR TERMINATIONS

The Board of Trustees of the IATSE Local 22 Welfare Fund reserves the right to amend or terminate this Plan, or any part of it at any time. Amendments may be made in writing by the Board of Trustees and become effective on the date approved, or such other date as may be specified in the document amending the Plan. The Plan or any coverage under it may be terminated by the Board of Trustees, and new coverages may be added by the Board of Trustees.

The Fund may be terminated by a written instrument executed by the Trustees. The Fund may be terminated if, in the opinion of the Trustees, it is not adequate to carry out the intent and purpose of the Fund as stated in its Trust Agreement, or is not adequate to meet the payments due or which may become due under the Plan. The Fund may also be terminated if there are no individuals living who can qualify as Participants or Beneficiaries under the Plan. Finally, the Fund may be terminated if there are no longer any Collective Bargaining Agreements requiring contributions to the Fund. The Trustees have complete discretion to determine when and if the Fund should be terminated.

If the Fund is terminated, the Trustees will: (a) pay the expenses of the Fund incurred up to the date of the termination as well as the expenses in connection with the termination; (b) arrange for a final audit of the Fund; (c) give any notice and prepare and file any reports which may be required by law; and (d) apply the assets of the Fund in accordance with the Plan, including amendments adopted as part of the termination until the assets of the Fund are distributed.

No part of the assets or income of the Fund will be used for purposes other than for the exclusive benefit of the Participants and the Beneficiaries or the administrative expenses of the Fund. Under no circumstances will any portion of the Fund revert or inure to the benefit of any Contributing Employer, any Employer association, or the Union either directly or indirectly.

Upon termination of the Fund, the Trustees will promptly notify the Union, Employers, and all other interested parties. The Trustees will continue as Trustees for the purpose of winding up the affairs of the Fund.

DISCRETIONARY AUTHORITY OF THE PLAN ADMINISTRATOR AND ITS DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated by the Board of Trustees, will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan, including the standard of proof, amount and type of proof required for any claim. Any interpretation or determination under such discretionary authority will be binding on all

Participants and/or Beneficiaries, unless it can appropriately be shown that the interpretation or determination was arbitrary and capricious or in derogation of any fiduciary obligation.

MISCELLANEOUS INFORMATION

ASSIGNMENT OF BENEFITS

No Participant is permitted to assign any benefits, rights or claims for benefits to any third party including, but not limited to, a provider or facility, without the express written consent of the Plan Administrator or its designee. "Benefits, rights or claims for benefits" includes, but is not limited to, a claim for payment of a benefit under the terms of the Plan or other Plan document or communication, a claim for benefits under Section 502(a) of ERISA, a claim under ERISA for breach of fiduciary duty, or a claim for penalties assessable under law or regulation.

A Participant may direct that benefits payable from this Plan to him or her instead be paid to the provider or facility that provided the related medical care. However, the Plan is not obligated to accept such direction, and no payment made pursuant to such direction, nor any communication about benefits or payment between representatives of the Plan and a provider or facility, shall be considered an assignment of the benefit, a contract to pay benefits or a recognition by the Plan of a duty or obligation to pay a provider or facility, except to the extent the Plan actually chooses to do so.

All benefits under the Plan are exempt, to the extent permitted by law, from the claims of creditors and from all orders, decrees, garnishments, executions or other legal processes or proceedings.

NO LIABILITY FOR PRACTICE OF MEDICINE

The Plan, Plan Administrator or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you or your Eligible Dependent by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

PRIVACY, CONFIDENTIALITY, RELEASE OF RECORDS OR INFORMATION

Any information collected by the Plan will be treated as confidential information, and will not be disclosed to anyone without your authorization, except in accordance with the Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("Privacy Rules"), which is generally as follows:

1. Information will be disclosed to those who require that information to administer the Plan or to process claims.

2. Information with respect to duplicate coverages will be disclosed to the plan or insurer that provides duplicate coverage.

3. Information needed to determine if health care services or supplies are Medically Necessary or if the charges for them are Usual and Customary will be disclosed with the individual or entity consulted to assist the Plan Administrator or its designee to make those determinations.

4. Information will be disclosed as required or permitted by law or regulation or in response to a duly issued subpoena.

The Plan has provided participants with a Notice of Privacy Practices for Protected Health Information. If you need a copy of the Notice or would like additional information about the Plan's use and disclosure of protected health information or your rights with regard to this information, you may request a copy of the Notice from the Fund Administrator.

INFORMATION YOU OR YOUR DEPENDENTS FOR WHOM YOU CHOOSE TO SELF-PAY MUST FURNISH TO THE PLAN

In addition to information you must furnish in support of any claim for Plan Benefits under this Plan, you or your Eligible Dependents must furnish, within 60 days after the event, any information you or they may have that may affect eligibility for coverage under the Plan. This includes, but is not limited to:

1. Change of name.

2. Change of address.

3. Marriage, divorce, or death of you or any covered Spouse or Dependent Child.

4. Any information regarding the status of a Dependent Child, including, but not limited to:

   - The Dependent Child reaching the Plan's limiting age; or
   - The existence of any physical or mental Handicap.

5. Medicare enrollment or disenrollment.

6. The existence of other health coverage.

HEADINGS DO NOT MODIFY PLAN PROVISIONS

The headings of sections and subsections, paragraphs and subparagraphs, are included for the sole purpose of generally identifying the subject matter of the substantive text so that a table of contents can be constructed for the convenience of the reader. The headings are not part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

RIGHTS OF RECOVERY

When payments have been made by the Plan with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Plan shall have the right to recover such excess payments. If a Covered Employee is paid a benefit greater than that allowed by the Plan, the Covered Employee will be required to refund the overpayment. If the refund is not received from the Covered Employee, the amount of the overpayment will be deducted from future benefits. Similarly, if payment is made on the behalf of a Covered Employee to a hospital, physician, or other provider of health care, and that payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider.

In the event the Plan pays any benefits on a fraudulent claim, the amounts due to the Plan may be deducted from any benefits due to the Employee, Retiree, or their Eligible Dependents until the Plan is fully reimbursed for the benefits improperly paid.

NO VERBAL MODIFICATIONS
The Participant shall not rely on any oral statement from any employee of the Benefits Systems Management, or any other employee of any service provider to the Plan, including, but not limited to, a customer service representative to:

- Modify or otherwise affect the benefits, General Limitations and Exclusions, or other provisions of this Plan; or

- Increase, reduce, waive or void and coverage of benefits under this Plan.

Further, such oral statement shall not be used in the prosecution or defense of a claim under this Plan. Any written or oral verification received from Benefits System Management or any other service provider to the Plan is based upon eligibility information and Plan benefits, which are subject to change. Therefore, any verification should not be interpreted as a guarantee of coverage or payment for any service rendered or otherwise provided to Participant.

CONFORMITY WITH THE LAW
This Plan of benefits shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, ACA and other group health plan laws to the extent required by such laws. If any provision of this Plan is contrary to any applicable law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirements.

PREEMPTION OF STATE LAW
With respect to any insured benefit under the Plan, nothing in this section shall be construed to supersede and provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of this section.

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