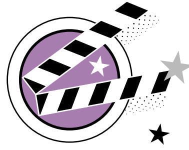
Behind the scenes.

NATIONAL WELFARE FUND

SUMMARY PLAN DESCRIPTION

PLAN A

INTERNATIONAL ALLIANCE
OF THEATRICAL
STAGE EMPLOYES



IATSE NATIONAL HEALTH & WELFARE FUND – PLAN A

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Just as you can be counted on to provide the behind-the-scenes support modern production requires, so too can the IATSE National Health & Welfare Fund be counted on to help provide the health care and other support that modern life requires.

The Board of Trustees is pleased to provide you with this updated booklet describing the benefits available to you under the IATSE National Health & Welfare Fund, Plan A (referred to in this booklet as the "Fund" or the "Plan").

These benefits include:

- **hospital** and **medical** coverage through Empire BlueCross BlueShield
- a **prescription drug** benefit through National Prescription Administrators (NPA), a division of Express Scripts
- **dental benefits** through Self-Insured Dental Services ("A.S.O./S.I.D.S.")
- **vision services** through a choice of several vision care providers
- a **weekly accident and sickness benefit** that can provide a weekly income for up to 26 weeks in the event you cannot work at your customary occupation as a result of disability
- a **life insurance benefit** that pays a lump sum to your beneficiaries in the event of your death.

This booklet provides a description, written in everyday language, of Plan A provisions in effect as of April 1, 2004. Together with the description of benefits provided by Empire BlueCross BlueShield, it constitutes a summary plan description, or "SPD." Please keep both summaries together in a convenient place, where you'll have them for future reference and can share them with your family.

Although these booklets provide essential information about your benefits, this information is intended only as a summary of the terms under which benefits are provided. Additional information concerning your benefits is contained in related documents, such as insurance contracts. If there is ever a conflict between these summaries and the Plan documents, the applicable Plan documents will govern.

If you have any questions about the Fund, please contact the Fund Office. For questions on a particular benefit, contact the provider of that benefit — there's contact information for all providers at the back of this summary.

Sincerely,

The Board of Trustees

April 2004

NO INDIVIDUALS (OTHER THAN THE FULL BOARD OF TRUSTEES) HAVE ANY AUTHORITY TO INTERPRET THIS SPD OR OTHER APPLICABLE DOCUMENTS OR TO MAKE ANY PROMISES TO YOU ABOUT THEM.

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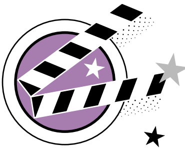

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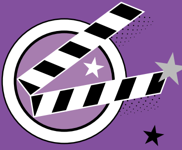
Your Plan A Benefits at a Glance



PLAN A BENEFITS AT A GLANCE Effective April 1, 2004 FOR ACTIVE PARTICIPANTS ONLY
Hospital/Medical
Empire BlueCross BlueShield PPO See your Empire BlueCross BlueShield summary for more details. Generally, though: When you receive "in-network" services, you have no deductible, coinsurance or lifetime maximum, and a copay of $12 for most services (see your Empire materials for exceptions). For out-of-network services, you pay a deductible, and 20% coinsurance (until you reach the Plan's annual out-of-pocket maximum, at which point the Plan starts paying 100% of reasonable and customary charges). You'll also have a lifetime maximum of $1,000,000 per person.
Prescription Drug Benefits
For medications prescribed by a doctor and provided through the NPA program, you have: A $10 copay for generic drugs. A $15 copay for brand-name drugs. If you go to a participating pharmacy, you'll receive up to a 30-day supply of medication, while if you use the mail-order feature, you'll receive up to a 90-day supply. In either case, your copay remains the same. NPA administers the program for the Fund. (If you go to a non-participating pharmacy, you must pay the full cost of the prescription yourself, and then file a claim for the difference between the cost of the drug and the normal copay.)
Dental Benefits
A.S.O./S.I.D.S. (Self-Insured Dental Services): Plan provides an annual maximum of $2,000 per covered person, according to a set fee schedule. Eligible members have a choice of in-network or out-of-network dentists. Using an in-network dentist generally means less out-of-pocket expense. **A.S.O./S.I.D.S.** administers the dental benefit for the Fund.

Vision Services

Davis Vision, Comprehensive Professional Systems and General Vision Services ("GVS"):

The Plan provides both in- and out-of-network services.

You may choose a Davis Vision, Comprehensive Professional Systems or GVS participating provider.

Using an in-network provider allows one exam and one pair of glasses or contact lenses (there may be a charge for contact lenses) from an approved group every 24 months. More expensive glasses or lenses require a copayment. For children, an exam and lenses are provided every 12 months, while frames are available every 24 months.

Using an out-of-network provider allows for a reimbursement of up to $100 every 24 months (every 12 months for an exam and lenses for children). The out-of-network benefit is paid only through Davis Vision.

Physical Exam and Hearing Aid Benefits

Administered through A.S.O./S.I.D.S.

Reimbursement:

If you don't go to a BlueCross provider for a physical examination, the Plan covers up to $300 per calendar year for covered active members and their covered dependents, when these services are provided out of network.

For a hearing aid, up to $1,500 in a 36-month period for a hearing aid and/or batteries or repairs (for active and retired members and their covered dependents).

Weekly Accident and Sickness Benefit

Administered through The Union Labor Life Insurance Co. ("ULLICO"):

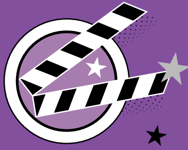
Pays a weekly benefit of 66-2/3% of your "weekly wages," up to $200 a week, in the event an off-the-job disability prevents you from working at your customary job or occupation.

If disability continues, benefits can be paid for up to 26 weeks.

Life Insurance

Plan pays a benefit of $20,000 upon the death of the member only.

Eligibility and Participation



ELIGIBILITY

Plan A is available only to individuals who work in "covered employment."

> "Covered employment" means work covered by a collective bargaining agreement or another agreement that requires your employer to make contributions to the IATSE National Health & Welfare Fund, Plan A, on your behalf.

Participation is also available to your "eligible dependents," as defined later in this section.

The IATSE or local unions negotiate daily employer contribution rates.

WHEN COVERAGE STARTS

Coverage starts once you meet the Plan's eligibility requirement.

You qualify once you work 60 days in covered employment in a period of six consecutive months. Coverage then starts on the first day of the second month after you complete the 60-day requirement and continues for six months. The following table shows how this works.

Applicable Six-Month Period	Month 60 Days Was Satisfied	Coverage Period
January–June	June	August–January
February–July	July	September–February
March–August	August	October–March
April–September	September	November–April
May–October	October	December–May
June–November	November	January–June
July–December	December	February–July
August–January	January	March–August
September–February	February	April–September
October–March	March	May–October
November–April	April	June–November
December–May	May	July–December

For example, if you begin to work in covered employment in February 2002 and you complete 60 days in covered employment in your initial six-month period, ending in July 2002, your initial coverage will be for the six-month period starting in September 2002 and continuing through February 2003. However, if you meet the requirement faster — say you worked 60 days by the end of April — your initial coverage would be for the six-month period starting in June 2002 and continuing through November 2002.

Continuing coverage. Coverage continues uninterrupted beyond your initial eligibility period as long as you have 60 days in covered employment in each successive six-consecutive-month period. You may have an interruption in coverage if you fail to meet this requirement. The Fund Office will notify you if you don't qualify for continued coverage as an active participant, and will send you a notice describing your right to pay for continuation coverage under the federal law known as "COBRA."

LOSS OF ELIGIBILITY

You lose your eligibility for continued participation if you fail to work 60 days in a period of six consecutive months.

When coverage ends for this reason, you will have an opportunity to continue your coverage under the federal law known as "COBRA." COBRA requires that in certain circumstances health plans must offer the ability to self-pay for group coverage for a limited period of time. There are more details on COBRA later in this section.

DEPENDENT COVERAGE

Eligibility for coverage for your dependents generally begins on the same date that your coverage starts or, if later, when they first become your dependents. However, coverage will not begin if you don't provide necessary proof of dependent status.

PLEASE REMEMBER

For coverage to take effect as soon as you've qualified, please provide all information requested by the Fund Office and please carefully review the materials you receive from the Fund Office — they'll tell what information, if any, is required. If you don't promptly send the information, the coverage will be delayed.

ELIGIBLE DEPENDENTS

Your eligible dependents include:

- The spouse to whom you are legally married.
- Unmarried dependent children until the end of the calendar year in which they reach age 19.
- Unmarried dependent children who are-full-time students in an accredited educational institution until the earliest of:
  - — the end of the calendar year in which they reach age 25,
  - — the end of the month they marry, or
  - — the end of the month in which they stop being full-time students.
- Your unmarried children over age 19 who are unable to do any work to support themselves because of physical handicap or mental illness, developmental disability or mental retardation, as defined by applicable laws. The incapacity must have started before the child reached age 19, must be certified by a doctor, and may have to be recertified periodically. Initial written proof of the child's disability must be submitted to the Fund Office within 31 days after the child's 19th birthday. Coverage under this extension ends if the dependent child marries or becomes able to earn a living.
- Your "Domestic Partner," as defined in this section.

PLEASE REMEMBER

When you enroll a dependent you will be asked to provide proof of dependent status — for example, a birth certificate, a marriage certificate, or other proof of dependent status.

Note that the Fund automatically covers all newborn children of covered individuals for 30 days. If a child is born to an unmarried dependent who is covered under the Plan, the newborn child will be covered for the first 30 days of his or her life. However, since this child is not an eligible dependent, coverage cannot be extended beyond the first 30 days.

Dependent children include your natural children, stepchildren, children required to be recognized under a Qualified Medical Child Support Order ("QMCSO"), and adopted children (including a proposed adopted child during a waiting period before finalization of the child's adoption) who are dependent on you for financial support. A foster child is not included.

About QMCSOs. A Qualified Medical Child Support Order, or QMCSO, is an order issued by a court or state administrative agency that requires that medical coverage be provided under a plan for a child or children. A QMCSO usually results from a divorce, legal separation or paternity proceeding.

The Fund Office will notify you if a QMCSO is received with regard to your coverage. If you, your child, or the child's custodial parent or legal guardian would like a copy of the Plan's written procedures for handling QMCSOs, or if you have any questions about this process, please contact the Fund Office.

About "Domestic Partners." Domestic Partners are defined as two unmarried adults of the same sex, neither of whom is married or legally separated, who:

- have resided with each other for six months before the application for benefits and who intend to live continuously with each other indefinitely,
- are not related by blood in any manner that would bar marriage in their state of residence,
- are financially dependent on each other,
- have an exclusive, close and committed relationship with each other, and
- have not terminated the domestic partnership.

Procedure for verifying Domestic Partner status. To cover a Domestic Partner under the Fund, you must satisfy the following requirements:

- You must apply for coverage for your Domestic Partner.
- You must submit a notarized "Affidavit of Domestic Partnership" and a notarized "Statement of Financial Interdependence."
- If you live in an area that offers registration of domestic partners (such as New York and San Francisco), then you must register as domestic partners and submit the registration to the Fund.

You must submit two of the following types of proof of financial interdependence:

- proof of joint bank account (statement, check or passbook with both names)
- joint credit card accounts (statement with both names)
- joint loan obligations (note or other loan origination document with both names)
- joint ownership of a residence (deed or other sale/transfer document with both names, or property or water tax document with both names)
- joint lease of a residence (lease with both names)
- common household expenses (phone, electric bills with both names; public assistance document with both names)
- joint vehicle ownership (title in both names)
- joint wills (copy of will or wills, with each party naming the other as beneficiary and/or executor)
- power of attorney (copies of powers of attorney with each party naming the other party and no limitation on the term of the documents)

- health care proxy (copies of health care proxies/living wills, with each party giving the other party the power to make health care/non-resuscitation decisions upon incapacitation)
- life insurance (copy of policy with one party naming the other as beneficiary)
- retirement benefits (copy of beneficiary designation form with one party designating the other as beneficiary).

KEEP PERSONAL INFORMATION UP TO DATE

You must notify the Fund Office promptly if:

- you marry
- a child is born
- you change your address or phone number
- you are divorced or legally separated, or a domestic partnership ends
- someone in your family dies
- a child reaches the maximum age, marries or ends his or her education
- you want to change your beneficiary.

CHANGING COVERAGE

You may add or drop an eligible dependent at any time. The change generally takes effect as of the first day of the month following the month the Fund Office receives the applicable birth or marriage certificate. In the case of a newborn child, coverage automatically starts as of the date of birth, but continues beyond the first 30 days only if you submit the required birth certificate.

Eligibility may be terminated retroactively or you may lose benefits if you fail to notify the Fund Office in writing within 30 days of a change in family status. In addition, if you or your dependents fail to submit any requested or required information or proof to the Fund Office, make a false statement material to a claim, or furnish fraudulent or incorrect information material to a claim, benefits under the Fund may be denied, suspended or discontinued, as appropriate. The Fund has the right to recover any excess benefit payments made in reliance on any false or fraudulent information or proof submitted by you or your dependents.

WHEN COVERAGE ENDS

For you. Your coverage ends if:

- you fail to complete the service requirement (60 days in six consecutive months), or
- the Plan terminates.

For your dependents. Coverage for your dependents ends if:

- your coverage ends,
- they no longer meet the definition of "dependent,"
- the Plan cancels Plan A coverage for all dependents,
- your coverage changes from family to single, or
- the Plan terminates.

When your coverage under the Plan would otherwise end, you may be able to continue coverage by electing COBRA continuation coverage (more on this later). The Plan also has rules for limited extensions of coverage in special situations, and they are described below.

CONTINUATION OF COVERAGE DURING CERTAIN ABSENCES

Continuation of coverage during disability. Under some health care insurance, coverage of a disabled participant may continue for a limited period when it would otherwise end, but usually only for treatment of the illness or injury that caused the total disability.

Check your BlueCross BlueShield summary for information on whether that plan has such a provision and under what circumstances such an extension is granted.

Family and medical leave. If your employer has 50 or more employees, you may be eligible for leave under the Family and Medical Leave Act (FMLA). Under FMLA you may take up to 12 weeks of unpaid leave for specified family or medical purposes, such as your own serious medical condition, the birth or adoption of a child, or to provide care for a spouse, child or parent who is ill.

If you take an FMLA leave, your employer is obligated to continue to contribute to the Fund on your behalf and your coverage through the Fund will continue.

If you do not return to employment following an FMLA leave during which coverage was provided, you may be required to provide reimbursement for the cost of coverage received during the leave.

Call your employer if you have questions regarding your eligibility for an FMLA leave. Call the Fund Office regarding coverage during such a leave.

If you don't return to work after the end of your FMLA leave, you may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA, described below.

Military leave. If you are on active military duty for 31 days or less, you will continue to receive health care coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you are on active duty for more than 31 days, your coverage ends, but USERRA permits you to continue health care coverage for you and your dependents at your own expense for up to 18 months. This continuation right operates in the same way as COBRA coverage, which is described later in this booklet. In addition, your dependent(s) may be eligible for health care coverage under the federal program known as TRICARE (which includes the old "CHAMPUS" program). This Plan coordinates its coverage with TRICARE.

If you receive an honorable discharge and return to work with a contributing employer your full eligibility will be reinstated on the day you return to work as long as you return within one of the following time frames:

- 90 days of the date of discharge, if the period of service is more than 180 days;
- 14 days from the date of discharge, if the period of service was 31 days or more but less than 180 days; or
- one day after discharge (allowing eight hours for travel) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits may be extended up to two years.

Under USERRA an active employee is required to notify the employer (in writing or orally) that he or she is leaving for military service unless circumstances or military necessity make notification impossible or unreasonable. Your employer is required to notify the Plan within 30 days after you are reemployed following military service; however, it's a good idea for you to notify the Fund Office, too.

PLEASE REMEMBER

Contact your employer if you have questions regarding your eligibility for a leave. Contact the Fund Office if you have any questions regarding Fund coverage during such a leave.

CONTINUATION OF HEALTH CARE COVERAGE UNDER "COBRA"

COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), requires that this plan offer you and your eligible dependents the opportunity for a temporary extension of health care coverage at group rates in certain instances when coverage under the plan would otherwise end (called "qualifying events"). Continued coverage under COBRA applies to the health care benefits described in this booklet.

The benefits under COBRA are the same as those covering people who are not on continuation coverage. You should also keep in mind that each individual entitled to coverage as the result of a qualifying event has a right to make his or her own election of coverage. For example, your spouse or other covered dependent may elect COBRA coverage even if you do not.

Qualifying COBRA Events. The folowing chart shows when you and your eligible dependents may qualify for continued coverage under COBRA, when coverage may start and when it ends.

If You Lose Coverage Because of This Reason (a "qualifying event")	These People Would Be Eligible	For COBRA Coverage up to (measured from the date coverage is lost)
Your employment terminates*	You and your covered spouse and children	18 months**
Your working hours are reduced	You and your covered spouse and children	18 months**
You die	Your covered spouse and children	36 months
You divorce or legally separate	Your covered spouse and children	36 months
Your dependent child no longer qualifies as an eligible dependent	Your covered children	36 months
You become entitled to Medicare	Your covered spouse and children	36 months

* For any reason other than gross misconduct (and including military leave and approved leaves granted according to the Family and Medical Leave Act).

** Continued coverage for up to 29 months from the date of the initial event may be available to those who are totally disabled within the meaning of Title II or Title XVI of the Social Security Act at the time coverage is lost or become totally disabled within 60 days after that. This additional 11 months is available to employees and enrolled dependents if notice of disability is provided within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of coverage will increase to 150% of the full cost of coverage. Additionally, coverage can be extended for eligible dependents to a maximum of 36 months in the event of death or Medicare entitlement of the employee, or divorce or legal separation.

PLEASE REMEMBER

Proof of good health is NOT required for COBRA coverage.

Newborn children. If you have a newborn child, adopt a child, or have a child placed with you for adoption while continuation coverage under COBRA is in effect, you may add the child to your coverage. To add coverage for the child, notify the Fund Office within 30 days of the child's birth, adoption or placement for adoption. Legal proof of your relationship to the child must also be provided.

Multiple qualifying events. If your covered dependents experience more than one qualifying event while COBRA coverage is in force, they may be eligible for an additional period of continued coverage not to exceed a total of 36 months from the date of the first qualifying event.

> **For example,** if your employment ends, you and your covered dependents may be eligible for 18 months of continued coverage. During this 18-month period, if you die (a second qualifying event), your covered dependents may be eligible for an additional period of continuation coverage. However, the two periods of coverage combined may not exceed a total of 36 months from the date of the first qualifying event (your termination).

Notice of COBRA eligibility. Your employer must notify the Fund Office of your death, termination of employment, reduction in hours of employment or Medicare entitlement no later than 60 days after your loss of coverage due to one of these events. However, you or your family should also notify the Fund Office if such an event occurs, in order to avoid confusion as to your status. You or your eligible dependents are responsible for informing the Fund Office of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the date of the event. If you do not notify the Fund by the end of that period, your dependents will not be entitled to continuation coverage. The Fund must notify you and/or your covered dependents of your right to COBRA coverage within 14 days after it receives notice or becomes aware that a qualifying event has occurred. You will have 60 days to respond if you want to continue coverage — measured from the date coverage would otherwise end or, if later, the date the COBRA notice is sent to you.

Procedures for providing notice to the Fund. You (the participant and/or eligible dependents) must give the Fund Office notice as soon as possible, but no later than the applicable deadline set out above, for these events:

- a divorce or legal separation,
- a child ceasing to be a dependent,
- a second qualifying event that entitles an eligible dependent to additional COBRA coverage,
- a dependent is determined to be disabled under Social Security, or
- a dependent who had been disabled under Social Security receives notice that he or she is no longer considered disabled.

Your notice should be sent to:

IATSE National Health & Welfare Fund
55 West 39th Street
5th Floor
New York, NY 10018

Please include the following in your notice:

- your name,
- the names of your dependents,
- your Social Security number and the Social Security numbers of your dependents,
- your address, and
- the nature and date of the occurrence you are reporting to the Fund.

Paying for COBRA coverage. You have to pay the full cost of continued coverage under COBRA, plus a 2% administrative fee. **Note that family rates apply if COBRA coverage is elected for two or more people in a family.** (If you are eligible for 29 months of continued coverage due to disability, the law permits the Fund to charge 150% of the full cost of the Plan during the 19th to 29th months of coverage.) The following rules apply in making your COBRA payments:

- It is easiest to make your **first payment** when you file your COBRA election form, that is, within 60 days from the date your Plan coverage would otherwise end. In no event may your payment be made later than 45 days from the date you mail your signed election form to the Fund Office. Your first check should cover the period from the date your group coverage ended and COBRA coverage began through the current month.
- All **subsequent payments** after the first payment will be due on the first day of each month for that month's coverage (for example, by June 1 for June coverage). Keep in mind that the Fund Office does not send monthly bills for COBRA coverage and it is your responsibility to see that your payment is at the Fund Office by the due date.
- There is a 30-day **grace period** for all subsequent payments (for example, the end of the grace period for payment for coverage in the month of June is June 30). However, if you have a claim during a month for which you have not paid your premium, the claim will not be paid until after the Fund Office receives your payment for the month.

PLEASE REMEMBER

Don't forget that the Fund Office does not send bills for COBRA coverage and that it is your responsibility to make COBRA payments on time. If you don't make your payments on time, your coverage will end.

COBRA premiums are generally reviewed at least once a year and are subject to change.

You will be notified by the Fund Office if the amount of your monthly payment changes. In addition, if the benefits change for active employees, your coverage will change as well.

When COBRA coverage ends. Your continued coverage under COBRA may end for any of the following reasons:

- Coverage has continued for the maximum 18-, 29- or 36-month period, measured from the date coverage is lost.
- The plan terminates. If the coverage is replaced, you may be continued under the new coverage.
- You or your dependent(s) fail to make the necessary payments on time.
- You or your covered dependent(s) become covered under another group health plan that does not exclude coverage for pre-existing conditions or the pre-existing conditions exclusion does not apply.
- You or your covered dependent(s) become entitled to benefits under Medicare.
- You or your dependent(s) are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Full details of COBRA continuation coverage will be furnished to you or your eligible dependents when the Fund Office receives notice that a qualifying event has occurred. It is important to contact the Fund Office as soon as possible after one of these events occurs.

Special note. Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for trade adjustment assistance under a federal law called the Trade Act of 1974. If you have questions regarding the Trade Act or you are not sure whether you qualify for trade adjustment assistance, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-888-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov.tradeact/2002act_index.asp.

YOUR RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

When your Fund coverage ends, you and/or your dependents are entitled by law to, and will be provided with, a "Certificate of Creditable Coverage." Certificates of Creditable Coverage indicate the period of time you and/or your dependents were covered under the Fund (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy within 63 days after your coverage under this Fund ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to you and/or your dependents under the new group health plan or health insurance policy.

The Certificate of Creditable Coverage will be provided to you:

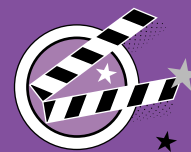
- on your request, within 24 months after your Fund coverage ends
- when you are entitled to elect COBRA
- when your coverage terminates, even if you are not entitled to COBRA
- when your COBRA coverage ends.

You should retain these Certificates of Creditable Coverage as proof of prior coverage for your new health plan. For further information, call the Fund Office.

CONVERSION PRIVILEGE

When your Fund coverage ends, including COBRA coverage, you and/or your covered dependents may be entitled to convert your medical coverage to individual contracts with the companies that provided your benefits through the Fund. You generally have a limited number of days to exercise this right. For more information, review your medical benefits summary or call the company that provides those benefits.

Hospital and Health Benefits



EMPIRE BLUECROSS BLUESHIELD

When you are enrolled, Empire BlueCross BlueShield will provide a comprehensive package of hospital and health care benefits — ranging from office visits to lab tests and X-rays, to major surgery and hospital care.

Under BlueCross BlueShield both in-network ("PPO") and out-of-network ("non-PPO") services are available. You generally pay less when you use in-network services.

Generally, when you receive in-network benefits through Empire you don't have to file any claim forms. You just need to be sure you follow Empire's procedures on receiving benefits (for example, providing your ID card or getting preauthorization when required).

If you use out-of-network services, you will be required to submit a claim form, unless your provider agrees to do this for you. Again, you'll need to follow Empire's procedures on this.

These benefits are described in detail in the description of benefits provided by Empire. **That information (including any updates) should be considered part of, and kept with, this summary plan description ("SPD").** The Empire summary has important information, written in everyday language, on:

- **the full extent of your benefits** (including the methods used to determine whether new treatments and procedures are covered)
- **procedures to be followed to get benefits** (for example, preauthorizations, approvals, utilization reviews, out-of-area services, filing a claim for benefits, etc.)
- **limitations on benefits** — including excluded services and benefits, limits on number of visits, limits on the selection of primary care providers or providers of specialty care
- **claims review procedures** — that is, the procedures to follow if you want to appeal a claim for benefits that was denied either before or after the services were rendered (including claims for "urgent care")
- **the circumstances in which your plan benefit could be reduced** if you have a right to sue or are entitled to reimbursement for your medical expenses from a third party
- **plan definitions,** including such important terms as "Allowed Charge," "Covered Services," and "Medically Necessary"
- **Empire's privacy practices** — that is, how Empire handles participants' personal health information.

PLEASE REMEMBER

If you don't have a summary of Empire benefits, call the Fund Office. If you have a question that summary doesn't answer, call Empire at 800-553-9603. You can also get more information online at www.empireblue.com

LEGAL GUARANTEES

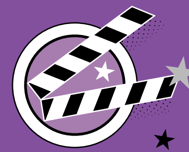
You should be aware of certain rights provided by law.

Minimum maternity stay. Under the federal law called the Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA") a plan may not restrict a mother's or a newborn child's benefits for a hospital stay to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, this law 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 or 96 hours.

Reconstructive surgery. Under the Women's Health and Cancer Rights Act of 1998, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. Benefits for reconstructive breast surgery following a mastectomy will be provided on the same basis as other surgical procedures covered by the Plan, and include:

- reconstruction of the breast on which a mastectomy is performed,
- reconstructive surgery on the other breast to produce a symmetrical appearance,
- breast prostheses and surgical bras following a mastectomy, and
- treatment of physical complications of any stage of mastectomy, including lymphedemas.

Prescription Drug Benefit



The prescription drug benefit, which is administered for the Fund by National Prescription Administrators (NPA), a division of Express Scripts, provides coverage for many drugs that require a doctor's prescription, as well as some diabetic supplies that are prescribed by a doctor.

HOW IT WORKS

You can get prescription drugs two ways — from a participating NPA pharmacy or, in the case of maintenance medications, by mail, through NPA's mail-order provider, the CFI mail-order pharmacy.

At a participating pharmacy. When you go to a participating pharmacy, you need to take your plastic NPA identification card, as well as your doctor's written prescription. You'll receive up to a 30-day supply of your medication, for a copayment of:

- $10 for a generic drug
- $15 for a brand-name drug.

There's no limit to the number of prescription refills allowed through the NPA program, other than the number specified by your physician on the prescription.

At a non-participating pharmacy. If you go to a non-participating pharmacy, you must pay the full charge for your prescription, then file a claim for reimbursement with NPA. You will be reimbursed for the difference between the pharmacy's charge and the appropriate copay. Claim forms are available from the Fund Office.

Through the CFI Mail-Order Pharmacy. If your doctor prescribes a "maintenance medication," that is, a drug you'll be taking on a regular basis over a period of time, you'll save money by using the CFI mail-order pharmacy. In this case you'll pay the same $10 (generic) or $15 (brand) copay you pay at a pharmacy. However, you'll receive up to a **90-day** supply of medication, instead of the maximum 30-day supply you'd receive at a retail pharmacy.

PLEASE REMEMBER

Don't forget. When you use the Mail-Order Pharmacy, you'll receive a three-month supply of your medication.

When your doctor first prescribes a maintenance drug you've never used before, ask for two prescriptions: one for a short-term trial period that you'll have filled at a local NPA pharmacy and the other for a 90-day supply that will be filled through the mail-order program. If the drug proves effective for the trial period, you will already have the prescription to mail to CFI.

PLEASE REMEMBER

Don't forget to take your NPA ID card with you when you go to a participating pharmacy.

To order from CFI, you'll need a CFI order form, which is available from NPA (call 800-467-2006). Complete the required information and enclose the original prescription and your payment ($10 for a generic drug, $15 for a brand-name drug) in the CFI envelope. You may pay for your prescription with:

- personal check
- money order
- credit card.

The first time you use a credit card you'll also be asked to enclose a CFI Pharmacy Credit Card Information Slip, along with the other required information.

COVERED PRESCRIPTION DRUGS

The Plan covers the following:

- medically necessary medications that require a doctor's prescription under either federal or state law
- insulin, by prescription only
- insulin syringes and needles, by prescription only.

Limitations. Some medications are covered only if your physician provides a diagnosis code for the pharmacy. Certain other medications can be dispensed in no more than specified quantities unless a letter of necessity is provided.

WHAT'S NOT COVERED

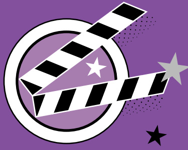
No benefits are provided for the following drugs and supplies:

- medications that may be lawfully obtained without a prescription
- appliances, devices, support garments, non-medical substances
- administration charges for drugs or insulin
- experimental, investigational or unlabeled use of drugs
- unauthorized refills
- prescriptions covered without charge under federal, state or local programs, including Workers' Compensation
- medications while confined in a rest home, nursing home, extended care facility, or similar facility
- medication used for cosmetic purposes (for example, Retin-A for individuals over age 25)
- allergy serums
- anorexiants (diet aids)
- nicotine transdermal systems
- lupron
- fertility drugs (oral and injectable)
- imitrex auto-injector and refill vials
- federal legend vitamins
- children's vitamins
- prenatal vitamins
- diaphragms
- yohimbine
- ostomy products
- sexual dysfunction drugs
- certain restricted medications for which a diagnosis code and/or a letter of necessity was not provided.

PLEASE REMEMBER

If you have any questions about either your NPA or CFI prescription drug benefits, call NPA at 800-467-2006. You can access their website at www.npanet.com.

Vision Care Benefit



Vision care benefits help to pay for the cost of routine eye examinations, frames and lenses for you and your covered dependents.

HOW IT WORKS

In-network benefits. When you use one of the Fund's in-network vision care providers, you're entitled to one eye exam and one pair of glasses from a participating provider every 24 months (for covered dependent children, an exam and lenses are available every 12 months, while frames are available every 24 months). Depending on the vision service you choose, there may be a small copayment if you choose contact lenses instead of regular lenses and frames. In addition, if you choose more expensive frames, lens types or coatings, you will be required to pay part of the cost.

The Fund uses three vision care services for these benefits: **Davis Vision** (which provides both in-network and out-of-network benefits), **Comprehensive Professional Systems** (in-network only) and **General Vision Services** (in-network only).

PLEASE REMEMBER

The vision care benefit provides an eye exam and a new pair of glasses every 24 months.

Out-of-network benefits. If you choose to use an out-of-network provider, you will be entitled to a reimbursement of up to $100 every 24 months (every 12 months for exams and lenses for dependent children). This amount is for all services combined (examination, glasses, contact lenses) and is not available in addition to in-network benefits.

The following table summarizes the benefits through each service. For the most recent information, call the appropriate service or visit its website.

PLAN A VISION CARE BENEFITS

Vision Care Provider	In-Network Services Provided Exam	Lens Coatings	Frames	Contact Lenses	Other
Davis Vision	Yes, every 24 months (every 12 months for examinations and lenses for covered dependent children, with frames available for such children every 24 months)	Yes, every 24 months (every 12 months for covered dependent children) • Plastic or glass single-vision, bifocal or trifocal lenses, in any prescription range • Intermediate lenses • Glass grey #3 prescription lenses • Post-cataract lenses • Fashion, sun or gradient-tinted plastic lenses • Polycarbonate lenses for dependent children and monocular patients • Ultraviolet (UV coating)	Yes, every 24 months From the "Tower Collection" (Others available at additional charge)	Yes, every 24 months with a $25 or $45 copay for standard, soft, daily-wear disposable or planned replacement contact lenses	$14 allowance for private doctor's collection of frames $45 allowance for special-type contact lenses

PLAN A VISION CARE BENEFITS continued					
Vision Care Provider	In-Network Services Provided				
	Exam	Lens Coatings	Frames	Contact Lenses	Other
Davis Vision (Cont'd)		• Blended Invisible bifocals • Photogrey Extra® (sun-sensitive) glass lenses • Others available at additional charge			
Comprehensive Professional Systems	Yes, same frequency as Davis Vision	Yes, same frequency as above • Single Vision plastic lenses and a frame (Photosensitive glass included), or • Toric Kryptok or Flat Top 25/28/35, Executive or Invisible plastic biofocal lenses and a frame, or • Trifocal plastic lenses and a frame	Yes, same frequency as above A choice of frames from boutique selection, "A," "B," "C" or "D" category	Yes, same frequency as above Amsoft or Bausch & Lomb soft clear daily-wear contact lenses	
General Vision Services	Yes, same frequency and types of designated products as above				

More information. Here's how you can find a provider or contact the applicable service for information.

Vision Service	Phone Number	Website
Davis Vision	800-999-5431	www.davisvision.com
Comprehensive Professional Systems, Inc.	888-675-3137	www.UDSCPS.com
General Vision Services	800-VISION-1	www.generalvision.com

Receiving services. To receive services from an **in-network** provider:

- Once you've identified a network provider in the service you've chosen, call that provider to schedule an appointment.
- Identify yourself as a participant in the IATSE National Health & Welfare Fund.
- Provide the member's Social Security number and the year of birth of any covered dependent children needing services.

The provider's office will verify your eligibility for services. No claim forms or ID cards are required.

If you receive services from an **out-of-network** provider, you are responsible for paying the provider directly and then submitting a claim form for reimbursement to:

Davis Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

You will be reimbursed up to $100.00 for the services you receive (eye examination, frame and lenses or contact lenses). Don't forget that this is the maximum amount available every 24 months (every 12 months for an exam and lenses only for dependent children) and that it is not available in addition to in-network benefits. You may choose either in-network or out-of-network benefits, but not both.

EXCLUSIONS

Vision benefits cannot be provided for any of the following:

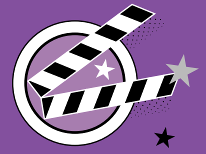
- medical treatment of eye disease or injury (although this may be covered as part of your Empire BlueCross BlueShield medical benefits)
- vision therapy
- special lens designs or coatings other than as specified by the applicable service
- replacement of lost eyewear
- non-prescription (plano) lenses
- services not performed by licensed personnel
- a second pair of eyeglasses instead of one pair of bifocals
- contact lenses and eyeglasses in the same benefit cycle.

PLEASE REMEMBER

Questions? If you have any questions about your vision benefits that are not answered in this summary, contact:

- Davis Vision at 800-999-5431,
- Comprehensive Professional Systems at 888-675-3137, or
- General Vision Services at 800-VISION-1

Dental Benefit



The Fund's dental benefit provides up to $2,000 per covered person, per calendar year. The benefit for any particular procedure is determined by a set fee schedule and the program is administered by A.S.O./S.I.D.S.

HOW IT WORKS

In order to **qualify** for reimbursement, an expense must meet all of the following requirements:

- It must be listed on the Schedule of Dental Benefits.
- It must be performed by or under the direction of a licensed dentist.
- It must both begin and be completed while the patient is covered by the Plan, unless there is an "extension of benefits," as described later in this section.

The **amount** of reimbursement is determined as follows:

- When you go to a **participating** dentist, the Plan pays the amount shown in the left column on the Schedule of Dental Benefits at the end of this section. If you have a copay, it's shown in the right column (most services don't have a copay). Participating dentists have agreed to accept these payments as payment in full. If payment for a covered service is denied due to a Plan maximum or procedure frequency limitation, you are only responsible for paying the participating dentist the scheduled allowance and, if applicable, the established copayment.
- When you go to a **non-participating** dentist, the Plan will still pay up to the amount shown in the left column. However, non-participating dentists have not agreed to accept these amounts as payment in full. Therefore, you will be required to pay any difference between the amount the dentist charges and the amount the Plan pays.

Receiving services. To receive services from a participating dentist, call the dentist's office for an appointment. Identify yourself as an IATSE National Health & Welfare Fund member when scheduling the appointment and verify that the dentist is still participating in the Plan.

COVERED DENTAL SERVICES

The Schedule of Dental Benefits provides a complete list of covered dental services. In general, though, these benefits include the following types of services.

Diagnostic and preventive services. Covered services include:

- oral examination, up to two per calendar year
- prophylaxis (teeth cleaning), up to two per calendar year
- X-rays, subject to annual X-ray maximum
- fluoride treatment, up to age 19
- sealant, up to age 19, for posterior permanent teeth and once per lifetime.

Other services. Other covered services include:

- amalgam, composite and porcelain fillings
- inlays and crowns
- endodontic treatment, including root canal therapy
- oral surgery, including extractions and other surgical procedures
- prosthodontics, including dentures and bridges
- periodontics (treatment of gums and bones).

Orthodontic services. Orthodontic services are not covered under the Plan. However, the network of dental providers includes participating orthodontists who have agreed to provide orthodontic services at reduced fees.

These fees, which you are responsible for paying yourself, are shown at the end of the Schedule of Dental Benefits.

PRETREATMENT REVIEW ESTIMATES

This optional feature gives you and your dentist advance notice of what benefits will be provided by the Plan before your treatment begins. Pretreatment review estimates are not mandatory and claims for benefits will not be denied if a pretreatment review estimate has not been filed.

If you wish to take advantage of this feature of the dental program before starting a planned course of treatment, your dentist should file a "Claim Form for Pretreatment Review" if the course of treatment includes any of the following services: crowns, bridges, dentures, laminate veneers or periodontal surgery.

Once the dentist completes his or her part of the form, you complete your part of the form and mail it, together with required supporting documentation, such as X-rays, to:

A.S.O./S.I.D.S.
P.O. Box 9005, Dept. 7
Lynbrook, NY 11563-9005

After A.S.O./S.I.D.S. reviews the form, both you and your dentist will receive an estimate indicating what the Plan allowances will be.

If you receive a pretreatment estimate for a proposed course of treatment that was submitted by one dentist, the statement will remain valid if you elect to have some or all of the work done by another dentist. Regardless of who does the work, the statement is valid for one year after issuance, provided there has been no significant change in the condition of your mouth or the treatment plan.

PLEASE REMEMBER

Don't forget to submit a pretreatment review request whenever you want to know what will be covered under the Plan before you begin treatment. It can save you money.

Note. You should keep in mind that a pretreatment review estimate is not a promise of payment. The work must be done while the patient is still covered by the Plan, unless there is an "extension of benefits."

An extension of benefits is granted only if the service was:

- For crowns, fixed bridgework or full or partial dentures, a pretreatment authorization was granted, impressions were taken and/or teeth were prepared while the patient was covered, and the device was installed or delivered within one month after that person's coverage ended.
- For root canal therapy, and the pulp chamber of the tooth was opened while the patient was covered and the treatment was completed within one month after that person's coverage ended.

ALTERNATE PROCEDURES

In some cases, there is more than one way to treat a dental problem. When you submit a request for pretreatment review, the Plan will consider alternate procedures and may authorize an amount of reimbursement based on an alternate procedure (which may differ from the one proposed by your dentist) that will provide a professionally acceptable result in a cost-effective manner. In such a case, if you choose to go ahead with the original treatment plan, reimbursement will be based on the alternate course of treatment, and you will be responsible for paying any difference. This should in no way be considered a reflection on your treating dentist's recommendations. Payment for an alternate course of treatment is a benefit determination and not a treatment plan designation.

GUARDED PROGNOSIS LIMITATION

If, in the opinion of the claims administrator, the longevity of the proposed or rendered treatment is limited, payment may be made in accordance with Plan provisions. However, future benefits for additional services may be affected.

IMPLANTOLOGY

Payment for a crown or bridge that is attached to one or more implants will be based on benefit allowances that would be paid if no implant was placed.

WHAT'S NOT COVERED

Expenses not covered under the Plan include expenses incurred as a result of:

- treatment solely for the purpose of cosmetic improvement
- replacement of a lost or stolen appliance
- replacement of a bridge, crown or denture within five years after it was originally installed; replacement of a bridge, crown or denture that is or can be made usable according to common dental standards
- orthodontic services
- procedures, appliances or restorations (except full dentures) whose main purpose is to (a) change vertical dimension, (b) diagnose or treat conditions or dysfunctions of the temporomandibular joint, (c) stabilize periodontally involved teeth, or (d) reposition teeth by orthodontic means
- multiple bridge abutments
- a bridge or denture that replaces a tooth that was missing when the individual became covered by the Plan
- a surgical implant of any type
- services that do not meet common dental standards
- services not included in the Schedule of Dental Benefits
- work-related injury
- an accidental injury that is the responsibility of a third party
- a condition covered by Workers' Compensation or a similar law for which the patient is eligible to receive coverage
- treatment in a hospital owned or run by the U.S. government, unless there is a legal obligation to pay those charges whether or not there is any insurance
- care for which charges would not have been made if the person had no insurance, including services provided by a member of the patient's immediate family
- unnecessary care, treatment or surgery
- experimental procedures or treatment methods
- treatment payment that is unlawful where the patient lives when the expenses are incurred
- treatment for which payment is available through a public program.

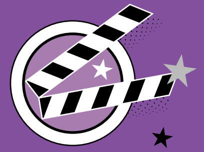
PLEASE REMEMBER

Questions? For help in locating a participating dentist, or for answers to questions not addressed in this summary, contact A.S.O./S.I.D.S. at:

800-537-1238
516-396-5500
Website: www.asonet.com

If you don't already have a *Directory of Participating Dentists,* A.S.O./S.I.D.S. will send you one.

Schedule of Dental Benefits



The schedule shows the maximum amount the Plan pays for various dental services. If a procedure is not listed, it is not covered.

Type of Service	Plan Pays	Member Copay
Diagnostic & Preventive		
Oral Examination (maximum two in a calendar year)	$28.00	
Full-Mouth Series X-rays 10 to 14 periapical and bitewing films	70.00	
Intraoral Film periapical, per film bitewing, first film each additional film	 8.00 8.00 5.00	
Occlusal Film	15.00	
Cephalometric Film	55.00	
Panoramic film	55.00	
Posterior/Anterior, Lateral film	30.00	
Extraoral film	25.00	
Temporomandibular film (maximum of $75 in a calendar year for all X-rays)	45.00	
Specialist Consultation including an oral examination	50.00	
Palliative Treatment no other treatment that visit	40.00	
Prophylaxis, including scaling and polishing adult child (maximum two in a calendar year)	 50.00 35.00	
Fluoride Treatment, to age 19, two per calendar year excluding prophylaxis	17.00	
Sealant, per tooth - permanent posterior teeth (to age 19, maximum one application per lifetime)	25.00	
Space Maintainer	150.00	

Type of Service	Plan Pays	Member Copay
Basic Restorative		
Amalgam Fillings Primary		
one surface	50.00	
two surfaces	65.00	
three surfaces	75.00	
four surfaces	85.00	
Amalgam Fillings Permanent		
one surface	60.00	
two surfaces	75.00	
three surfaces	85.00	
four or more surfaces	95.00	
Composite Resin Anterior		
one surface	70.00	
two surfaces	90.00	
three surfaces	110.00	
Incisal Angle	110.00	
Composite Resin Posterior		
one surface	75.00	
two surfaces	100.00	
three surfaces	115.00	
Major Restorative		
Porcelain/Metallic Inlay		
one surface	225.00	50.00
two surfaces	275.00	50.00
three surfaces	300.00	50.00
Crowns		
acrylic jacket	250.00	100.00
porcelain jacket	375.00	100.00
plastic with metal	350.00	100.00
porcelain with metal	400.00	100.00
full cast	375.00	100.00
3/4 cast	350.00	100.00
Porcelain Laminate - lab processed	325.00	100.00
Stainless Steel Crown, primary tooth	125.00	
Pin Retention - per tooth	25.00	
Post & Core, prefabricated	85.00	
Cast Post & Core	130.00	

Type of Service	Plan Pays	Member Copay
Endodontics (X-ray evidence of satisfactory completion required)		
Pulp cap, direct	30.00	
Pulpotomy	85.00	
Root Therapy		
one canal	350.00	
two canals	425.00	
three canals	475.00	
four or more canals	525.00	
Apicoectomy, 1st root	275.00	
Apicoectomy, maximum per tooth	400.00	
Retrograde Filling - per tooth	100.00	
Prosthodontic Repairs		
Denture Reline		
office procedure - complete	130.00	
office procedure - partial	125.00	
laboratory procedure - complete	200.00	
laboratory procedure - partial	175.00	
Denture Repairs		
denture adjustment	50.00	
rebase denture	250.00	
repair partial acrylic saddle/base	90.00	
repair cast framework	125.00	
broken denture base	90.00	
replace tooth in denture	75.00	
replace broken facing	90.00	
replace broken clasp	110.00	
add tooth to existing partial denture	75.00	
add clasp to existing partial	110.00	
Recementation		
inlay	40.00	
crown	50.00	
bridge	75.00	
space maintainer	50.00	

Type of Service	Plan Pays	Member Copay
Prosthodontics		
Partial Denture - unilateral	300.00	
Partial Denture - bilateral acrylic base with clasps and rests,	325.00	75.00
cast metal base	675.00	75.00
Bridge Abutment		
crown - plastic with metal	350.00	100.00
crown - porcelain fused to metal	400.00	100.00
crown - full cast	375.00	100.00
Retainer - Cast Metal Etch	300.00	
Bridge Pontic		
full cast	350.00	100.00
plastic with metal	350.00	100.00
porcelain with metal	375.00	100.00
Tissue Conditioning	65.00	
Precision Attachment	85.00	
Periodontics		
Root Scaling & Gingival Curettage, including prophylaxis		
per quadrant	70.00	
maximum per visit	110.00	
Periodontal Maintenance following surgery	70.00	
Occlusal Adjustment Complete (maximum payment for all periodontal treatment procedures in a calendar year - $240)	70.00	
Periodontal Surgery confirmation by charting and/or X-rays required per quadrant of at least 5 teeth		
Gingivectomy, Gingivoplasty and Mucogingival surgery		
per quadrant	250.00	
soft tissue graft - per quadrant	300.00	
pedicle soft tissue graft	200.00	
osseous surgery, including gingivectomy		
per quadrant	375.00	100.00
osseous graft - single site	100.00	
osseous graft - per quadrant	250.00	
Osseous graft - per jaw	350.00	

Type of Service	Plan Pays	Member Copay
Oral Surgery		
Routine Extraction	75.00	
Surgical Extraction (must be demonstrated by pre-operative X-ray)		
erupted tooth	145.00	
removal residual roots	150.00	
retained root	125.00	
impaction - soft tissue	200.00	
impaction - partial bony	225.00	
impaction - complete bony	300.00	
Alveoloplasty - per quad	125.00	
Biopsy of Soft Tissue	100.00	
Biopsy of Hard Tissue	115.00	
Removal of Cyst or Tumor		
less than 1.25 cm	125.00	
greater than 1.25 cm	150.00	
Incision & Drainage	100.00	
Frenulectomy	150.00	
Hemisection	175.00	
Root Resection	150.00	
General Anesthesia/IV Sedation (plan pays for first 30 minutes only).	150.00	

DISCOUNTED ORTHODONTIC SERVICES

Orthodontic services are **not** covered by the Plan. However, participating orthodontists have agreed to provide these services at reduced fees, which you are responsible for paying yourself. The current fee schedule appears below. Check with A.S.O./S.I.D.S. and your orthodontist before services are provided to make sure you have the most current figures.

Minor Tooth Movement & Interceptive Treatment	Your Charge
removable appliance	270.00
fixed appliance	300.00
active treatment, per 3 months	60.00
maximum amount dentist can charge patient for this type of treatment	**780.00**

Comprehensive Treatment	Your Charge
removable appliance	270.00
fixed appliance	480.00
active treatment, per month of treatment	60.00
per three months of treatment	60.00
post-treatment stabilization device	120.00
maximum amount dentist can charge patient for this type of treatment	**2,520.00**

FILING A CLAIM FOR DENTAL BENEFITS

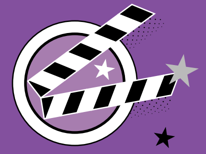
Claim forms are available from the Fund Office. Here is how you should complete and file your claim forms:

- After dental work is performed, have your dentist complete all items in the "Dentist Information" portion of the claim form and list the procedures, dates of services and charges, and then sign in the space provided for the dentist's signature.
- You should then complete all items in the "Member Information" portion of the form. Be sure to include requested spouse and dependent information.
- Completed claim forms, together with X-rays and other attachments, should be sent to:

  A.S.O./S.I.D.S.
  P.O. Box 9005, Dept. 7
  Lynbrook, NY 11563-9005

- Dental claims must be filed within 18 months after the date of service. Claims filed later than 18 months from the date of service will not be reimbursed. If you want payment to be made directly to your dentist, you may do this by signing the "Authorization to Assign Benefits" box on the claim form. Don't forget that the plan never pays more than 100% of the maximum shown on the Schedule of Dental Benefits. If you go to an out-of-network dentist who charges more, you will be responsible for the difference.

Additional Health Care Benefits



Two additional health care benefits are provided by the Fund. These benefits are paid directly by the Fund, rather than by BlueCross BlueShield.

These include:

- When you're covered by BlueCross BlueShield, reimbursement of up to $300 per calendar year for a complete annual physical and any related tests for each covered individual, as long as services are rendered by out-of-network providers.
- Reimbursement of up to $1,500 in a 36-month period for a hearing aid or aids and/or batteries or repairs.

These benefits are available only for services that were rendered on or after January 1, 2001 and were provided by a licensed provider.

Claiming the benefits. Contact the Fund Office for a claim form. Fill out the claim form and attach a detailed itemized statement for each expense that you have incurred and any explanation of benefit statements you have received from other insurance coverages you may have. Once completed, the form and attachments should be submitted to:

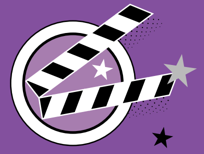
A.S.O./S.I.D.S.
P.O. Box 9005, Dept. 7
Lynbrook, NY 11563-9005

PLEASE REMEMBER

Questions? If you have any questions on these benefits, contact A.S.O./S.I.D.S. at:

516-396-5525 (in New York)
877-390-5845 (outside New York)

Weekly Accident and Sickness Benefits



This benefit provides a weekly income in the event a disabling accident or injury that occurs **off the job** prevents you from working at your regular or customary occupation. You do not have to be confined to your home to receive benefits.

The Union Labor Life Insurance Co. ("ULLICO") insures this benefit.

WHAT THE BENEFIT IS

The weekly benefit is 66-2/3% of your "weekly wages," up to a maximum benefit of $200 a week.

WHEN PAYMENTS START AND END

Benefits begin as of the first day of a disability due to an accident and as of the fourth day of a disability due to an illness. (However, if you're hospitalized due to either accident or illness, your benefits start as of the first day of hospitalization, if that is earlier than the date that would otherwise apply.)

Payments continue for as long as you remain disabled, up to 26 weeks.

Successive periods of disability. Generally, successive periods of disability are subject to one combined 26-week limit unless the second (or subsequent) period of disability:

- begins after you have returned to active full-time work for at least two consecutive weeks, or
- results from causes entirely unrelated to the causes of the previous disability and you returned to work for at least one full day between the two disabilities.

EXCLUSIONS

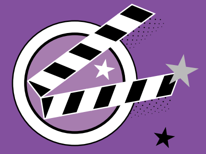
Benefits cannot be provided for a period of disability:

- Involving Workers' Compensation cases.
- 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.
- Caused while you were committing a felony, a criminal act or misconduct.
- Due to an intentionally self-inflicted injury of any kind, while sane or insane.
- Due to war or any act of war, declared or undeclared.

PLEASE REMEMBER

Questions? If you have any questions about weekly sickness and accident benefits, call ULLICO Customer Service at 877-800-2956.

Life Insurance Benefit



The Fund also provides a lump-sum life insurance benefit for your survivors in the event of your death, from any cause, while you are covered by the Fund. This insurance is provided through The Union Labor Life Insurance Co. (ULLICO).

If you die while covered by the Fund, your designated beneficiary or beneficiaries will receive a $20,000 life insurance benefit.

ULLICO has the right to pay up to $500 of the $20,000 death benefit to a person it determines has incurred funeral or other expenses related to your last illness or death.

Your beneficiary. When you enroll for medical coverage, you'll be asked to fill out a death benefit beneficiary designation form. You may name any person or persons you wish, subject to the following rules:

- If you name more than one beneficiary and do not specify how much each should receive, the total amount will be shared equally.
- If you do not designate a beneficiary or if your beneficiary dies before you, this benefit will be paid (in this order) to the surviving individual(s) in the first of the following groups that has at least one surviving member:
  - — your surviving spouse,
  - — your children (in equal shares),
  - — your parents (in equal shares), or
  - — your sisters and brothers (in equal shares).

If none of these survive you, the benefit will be paid to your estate.

- When a beneficiary dies before you, that person's interest in this benefit automatically ends.
- You may change your beneficiary designation at any time by completing a new beneficiary designation form and sending it to the Fund Office. The change or changes will be effective when the Fund Office receives the new form. You do not need anyone's consent to change your beneficiary designation.
- Designation or revocation of a beneficiary by any means other than a signed beneficiary form provided by and filed with the Fund Office will not be effective.

PLEASE REMEMBER

The beneficiary you name for this insurance is not automatically your beneficiary under any of the other National Benefit Funds in which you may participate. Nor is your beneficiary under one of those plans automatically your beneficiary under this Plan. Each Fund has its own rules, procedures and forms regarding the designation of beneficiaries.

PLEASE REMEMBER

Changes in family status. Whenever a change in family status occurs — whether it's a marriage, a separation, a divorce, a death, or the birth or adoption of a child — it's important to think about the effect of that event under all your benefit plans — not just this Plan — and any beneficiary designations and coverage elections you may have made. Contact the Fund Office if you have any questions about the effect of these events under the National Benefit Funds.

In the event a beneficiary is a child, is mentally incapacitated, or is otherwise unable to manage his or her affairs, and no legal guardian has been appointed, the Plan may pay any amount due to the party it believes is entitled to receive it on behalf of that individual.

PLEASE REMEMBER

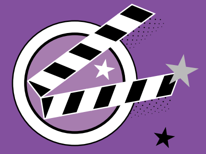
You should review your beneficiary designation every year to make sure your choice is up to date. To change your beneficiary, you need to complete and return a new beneficiary designation form to the Fund Office. Your change will not be effective until the Fund Office receives the form.

Filing a claim for benefits. Information on this life insurance, as well as required forms and supporting documentation, are available from the Fund Office.

PLEASE REMEMBER

Questions? If you have any questions about the life insurance benefit, you should contact the Fund Office at 800-456-FUND (3863).

Retiree Benefits



While Plan coverage generally stops once you no longer meet the active eligibility requirements described in the section called "Eligibility and Participation," if you meet the requirements for retiree coverage you will be entitled to the special retiree benefits described in this section.

ELIGIBILITY

You're entitled to retiree benefits if:

- your retirement starts on or after January 1, 2001 at age 65 or older
- you're on Medicare
- you had 15 "years of service" under the Health & Welfare Fund
- four of your years of service under the Health & Welfare Fund must have been in the five years immediately before you retired at age 65 or older.

"Year of service" means you were covered for at least six consecutive months of a calendar year.

In the case of a plan that merged into this Plan, the merger agreement may provide for the recognition of service or retiree status under the merged plan. In addition, certain retirees under age 65 may be eligible for active participant benefits. If you have any questions about these rules, you should contact the Fund Office.

Enrollment. To take advantage of these benefits, you'll need to provide the Fund Office with a copy of your retirement check or verification of retiree status and a copy of your Medicare card.

WHAT THE BENEFIT IS

If you meet the requirements described above, you'll be entitled to:

- $75 per quarter reimbursement toward the cost of the Medicare Part B premium
- up to $246.00 per quarter reimbursement toward the cost of your "Medigap" health care premium (proof of payment will be required)
- up to $500 in reimbursement per calendar year for prescription drugs (with reimbursement based on the amount the Plan pays for the same medications). Your copay will be $5 for generic drugs and $10 for brand-name drugs

PLEASE REMEMBER

Retiree prescription drug reimbursement. The $500 maximum for prescription drug reimbursement is based on Plan payments for the same prescriptions for active members.

For example, assume you regularly get a brand-name medication that costs you $60 per prescription. If the Plan pays $50 for that prescription for an active member, then it will apply $50 toward your annual $500 maximum and you will have reached the limit for this benefit after the prescription has been filled 10 times (10 x $50 = $500). Each of those 10 times, you would have paid only your $10 copayment.

- an optical benefit that consists of one pair of glasses and one exam in a 24-month period
- a hearing aid benefit that will reimburse you up to $1,500 in a 36-month period.

SPOUSE COVERAGE

Your spouse is also entitled to these benefits if he/she is on Medicare (the Fund Office will require a copy of the Medicare card as proof of coverage). If you die after your retiree coverage begins, your spouse's coverage will continue for one year. If your spouse dies, and you remarry, your new spouse will not be eligible for coverage.

HOW TO CLAIM BENEFITS

For Medicare Part B premium reimbursement, when you first become eligible for retiree benefits, you will be required to provide:

- a copy of your Medicare card
- if your spouse is on Medicare, a copy of his/her Medicare card
- if your spouse is on Medicare, a copy of your marriage certificate.

For Medigap premium reimbursement, you are required to submit the following every quarter:

- a copy of your insurance premium notice, with your full name and Social Security number included
- a copy of your canceled check.

For all other retiree benefits, claims are administered in the same way as for active members, specifically:

- prescription drug claims are submitted to NPA
- optical benefits are provided through Davis Vision, Comprehensive Professional Systems, Inc. or General Vision Services, as the case may be
- the hearing aid benefit is provided through A.S.O./S.I.D.S.

PLEASE REMEMBER

For more information on filing claims for prescription drug, optical and hearing aid benefits, please refer to the appropriate sections of this booklet.

MEDICARE BENEFITS

Medicare has traditionally consisted of two parts: Part A, which provides hospital benefits, and Part B, which provides medical benefits. Part A is provided at no cost to you, while there is a monthly premium for Part B.

CONTINUATION OF BENEFITS

Like other Fund benefits, retiree benefits are subject to change or termination at any time, in the sole and absolute discretion of the Board of Trustees.

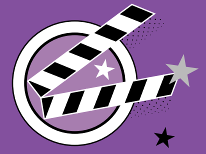
It's a good idea to contact the Social Security Administration at least three months before you reach age 65 to sign up for both Medicare and Social Security retirement benefits.

PLEASE REMEMBER

If you have any questions about retiree coverage, you should contact the Fund Office at 800-456-FUND (3863).

If you have questions about Medicare, you should contact the Social Security Administration. In addition, you can get much information on Medicare, and the optional arrangements now available under Medicare, at the Medicare website: www.Medicare.gov.

Coordination of Benefits



Our Plan has a coordination of benefits (COB) provision. This provision ensures that if you or a covered dependent is covered by another group medical plan, benefits from all plans combined will not exceed:

- 100% of allowable expenses in the case of Empire BlueCross BlueShield hospital and medical benefits ("allowable expenses" is defined in your BlueCross BlueShield materials)
- 100% of the maximum amount payable for a procedure on our Plan's Schedule of Dental Benefits
- 100% of the maximum allowable expense in the case of any other benefit.

OTHER GROUP MEDICAL PLANS

Today it is common for members of a family to have more than one group medical plan, particularly if both spouses are working. For this purpose, "group medical plan" generally means a plan that provides medical benefits through:

- group insurance
- group Blue Cross, group Blue Shield, group practice and other prepayment coverage on a group basis
- coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans
- coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans
- coverage under governmental programs or coverage required or provided by any statute
- school or association plans.

WHICH PLAN PAYS FIRST

First, if you're covered by two plans and the other plan does not have a coordination of benefits provision, the other plan will always pay its benefits first, before this Plan pays any benefits.

Second, if **both** plans have COB provisions, benefits will be paid in the following order.

Employee/dependent rule. The plan covering an individual as an employee is primary (i.e., pays first) and the plan covering an individual as a dependent is always secondary (i.e., pays second).

Birthday rule. For dependent children of parents who are not separated or divorced, the plan of a parent whose birth date (month and day, not year) falls earlier in the calendar year is primary and the plan of the parent whose birthday falls later is secondary.

Children of separated/divorced parents rule. For dependent children of parents who are separated or divorced, the plan of the parent with custody is the primary plan; the plan of a stepparent (spouse of parent with custody) is the secondary plan; and the plan of the parent without custody is tertiary (i.e., pays third). However, if a court decree (such as a Qualified Medical Child Support Order, or "QMCSO") designates one parent as responsible for medical expenses, then benefits will be paid according to that decree.

Active/inactive rule. The plan covering an individual who is an active employee (or a dependent of an active employee) is primary and the plan covering an individual as an inactive employee (such as a retired, laid-off or former active employee or a dependent of an inactive employee) is secondary.

Longer/shorter rule. For situations not governed by the above rules, the plan that has covered the individual longer is the primary plan and the plan that has covered the individual for less time is secondary.

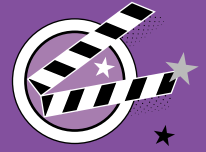
Medicare. For active employees and spouses of active employees covered by our Plan who are also Medicare-eligible, there are different COB rules. This Plan is always primary unless you work for an employer that normally employs fewer than 20 employees throughout the year or you or your spouse rejects this coverage and chooses Medicare as primary coverage. However, if you or your spouse does this, the Plan cannot pay any difference between the amount of the Medicare benefits that Medicare pays and the amount that is actually charged (and you will therefore be waiving coverage from this Fund), which means you will have no coverages for certain types of expenses — such as prescription drugs — that Medicare does not cover.

For disabled members and disabled covered dependents of active members who are under age 65 but are also eligible for Medicare, this Plan is primary until the individual reaches age 65. This Plan is also primary during the first 30 months you or a covered dependent is an end-stage renal patient.

PLEASE REMEMBER

Check your BlueCross BlueShield materials for any variations in this procedure for your BlueCross BlueShield benefits.

Claims and Appeals Procedures



These procedures are effective with respect to initial claims filed on or after January 1, 2003. These procedures supersede any prior version.

CLAIMS AND APPEALS PROCEDURES

This section describes the procedures for filing claims for benefits. It also describes the procedure for you to follow if your claim is denied in whole or in part, or if any adverse determination is made with respect to your claim, and you wish to appeal the decision.

DEFINITION OF A CLAIM

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures including filing a claim (where necessary). The claims procedures vary depending on the specific benefit you are requesting. A specific request for eligibility relating to a particular person or period shall be treated as a claim under these procedures. Simple inquiries about the Plan's provisions or about Plan eligibility that are unrelated to any specific benefit claim will not be treated as a claim for benefits. A request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits. In addition, the presentation of a prescription to a pharmacy which exercises no discretion on behalf of the Plan is not considered a claim.

HOW TO FILE A CLAIM

In order to file a claim for benefits offered under this Plan, you must submit a completed claim form.

A claim form may be obtained from the Fund Office by calling 212-580-9092 or 800-456-FUND (3863).

The following information must be provided on the claim form before your claim can be decided:

- Participant name
- Patient name
- Patient Date of Birth
- SSN of participant
- Date of Service
- The code for physician, dental and other health care services (the "CPT" code or the "CDT" code)
- The diagnosis code (the "ICD" code)
- Billed charge
- Number of Units (for anesthesia and certain other claims)
- Federal taxpayer identification number (TIN) of the provider
- Billing name and address
- If treatment is due to accident, accident details

Note: Claims involving **Urgent Care** (defined below) may be submitted by telephone to the organization, other than the Fund Office, that is responsible for administering the particular benefit you are requesting. (See section below entitled "Where to File Claims" for organization names and telephone numbers.) The phone call must be followed in writing within 24 hours with the information listed above.

WHEN CLAIMS MUST BE FILED

Hospital, Medical, Dental, Vision, Prescription, Physical Exam and Hearing Aid Benefit claims must be filed within eighteen (18) months following the date the charges were incurred. Weekly Accident and Sickness Benefit claims must be filed as soon as possible after the accident or onset of sickness. Life Insurance claims must be filed within eighteen (18) months of the date of death.

WHERE TO FILE CLAIMS

In-Network Services

You do not have to file a claim for any services you receive from "in-network" providers under Empire BlueCross BlueShield, A.S.O./S.I.D.S., Davis Vision, Comprehensive Professional Systems, Inc. or General Vision. Your provider will file these claims for you.

Out-of-Network Services

You must file a claim form for all services you receive which are "out-of-network." Your claim will be considered to have been filed as soon as it is received at the specific health organization that is responsible for making the initial determination of the claim ("Health Organization"). The only claims mailed to the Fund Office are claims for Life Insurance benefits and eligibility. Mail all other claims to the Health Organizations listed below, not to the Fund Office. The Health Organizations are:

For "Out-of-Network" **Hospital and Medical Claims,** contact:

> Empire BlueCross BlueShield at the local office that administers your benefits. The address of this office is listed in your Empire Booklet.

For "Out-of-Network" **Dental Claims,** the Health Organization to contact is:

> A.S.O./S.I.D.S.
> P.O. Box 9005, Dept. 7
> Lynbrook, NY 11563-9005
> 516-396-5525 (in New York)
> 877-390-5845 (outside New York)

For "Out-of-Network" **Vision Claims,** the Health Organization to contact is:

> Davis Vision Care Processing Unit
> P.O. Box 1525
> Latham, NY 12110
> 800-999-5431

For **Retail Prescription Claims:**

Most prescriptions are filled directly by a participating pharmacist. The presentation of a prescription to a pharmacist does not constitute a claim covered by this portion of the SPD. However, if the pharmacist rejects your prescription request, in whole or in part, you may submit the prescription, with a completed claim form which you obtain from the Fund Office, directly to NPA at the address below. Also, if you purchased covered medication from a non-participating pharmacist or without your NPA card, you may submit the paid receipt for the prescription, with a reimbursement form which you obtain from the Fund Office, directly to NPA at the following address:

> National Prescription Administrators, Inc. (NPA)
> 711 Ridgedale Avenue
> East Hanover, NJ 07936
> 800-467-2006

Note: ***Appeals of denials of retail prescription claims must be made to the Fund Office, not NPA.***

For **Prescriptions Requiring Preauthorization**

If your prescription is subject to a "Preauthorization Requirement," your prescription (and the required documentation) should be submitted to NPA at the above address.

Note: ***Appeals of denials of prescriptions requiring preauthorization must be made to the Fund Office, not NPA.***

For **Mail Order (CFI) Prescription Claims**

Mail Order prescriptions are filled by the CFI mail order pharmacy, an affiliate of NPA. To file a claim, you must first obtain a CFI mail order envelope from NPA. Complete the information on the envelope, insert your prescription and include a check for the copayment (or credit card information) in the envelope, and mail it to CFI at the address printed on the front of the envelope.

Note: ***Appeals of denials of mail order prescription claims must be made to the Fund Office, not NPA.***

For **Physical Exams and Hearing Aid Benefit Claims,** the Health Organization to contact is:

A.S.O./S.I.D.S.
P.O. Box 9005, Dept. 7
Lynbrook, NY 11563-9005
516-396-5525 (in New York)
877-390-5845 (outside New York)

For **Weekly Accident and Sickness Benefit Claims,** contact:

ULLICARE Inc.
178 Middle Street
Suite 200
Portland, ME 04101-4075
1-866-376-9495

For **Life Insurance and Eligibility Claims,** contact:

Fund Office
IATSE National Health & Welfare Fund
55 West 39th Street – 5th Floor
New York, NY 10018-3813
212-580-9092; 800-456-FUND (3863)

AUTHORIZED REPRESENTATIVES

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. If you wish to designate an authorized representative to file claims on your behalf, you must contact the specific Health Organization that provides the benefit to you by calling the telephone number listed in that Health Organization's benefits booklet or listed earlier in this section. The Health Organization will inform you of the procedure to follow in designating your authorized representative. The Health Organization may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an **Urgent Care Claim** (defined below) without you having to complete the special authorization form.

CLAIMS PROCEDURES

The claims procedures for hospital, medical, dental, vision, prescription, physical exam and hearing aid benefits will vary depending on whether your claim is for a **Pre-Service Claim,** an **Urgent Care Claim,** a **Concurrent Care Claim,** or a **Post-Service Claim.** The claims procedures for **Weekly Accident and Sickness Benefit Claims** and **Life Insurance Claims** also vary. Please read each section carefully to determine which procedure is applicable to your request for benefits.

PRE-SERVICE AND URGENT CARE CLAIMS

A **Pre-Service Claim** is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained.

Important: If you fail to precertify these services, no Plan benefits will be payable for those services.

If you improperly file a **Pre-Service Claim,** the Health Organization will notify you, as soon as possible but not later than *5 days* after receipt of the claim, of the proper procedures to be followed in filing a claim. This notification may be oral, unless you (or your representative) request written notification. You will only receive notification of a procedural failure if your claim is received by the Health Organization and it includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim.

For properly filed **Pre-Service Claims,** you and your health care provider will be notified of a decision within *15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the Health Organization. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the Health Organization needs additional information from you, the extension notice will specify the information needed. In that case

you and/or your doctor will have at least *45 days* from receipt of the notification to supply the additional information. The normal period for making a decision on the claim will be suspended until the date you respond to the request. The Health Organization then has 15 days to make a decision on a **Pre-Service Claim** and notify you of the determination. You have the right to appeal a denial of your **Pre-Service Claim**. (See "Review Process" and "Timing of Notice of Decision on Appeal" below.)

An **Urgent Care Claim** is any **Pre-Service Claim** for medical, dental or prescription care or treatment with respect to which the application of the time periods for making **Pre-Service Claim** determinations:

(1) could seriously jeopardize your life or health or your 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 without the care or treatment that is the subject of your claim.

Whether your claim is an **Urgent Care Claim** is determined by the Health Organization, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an **Urgent Care Claim,** within the meaning described above, shall be treated as an **Urgent Care Claim.**

If you improperly file an **Urgent Care Claim,** the Health Organization will notify you, as soon as possible but not later than *24 hours* after receipt of the claim, of the proper procedures to be followed in filing a claim. This notification may be oral, unless you (or your representative) request written notification. You will only receive notification of a procedural failure if your claim is received by the Health Organization and it includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim.

For properly filed **Urgent Care Claims,** the Health Organization will respond to you and/or your doctor with a determination by telephone as soon as possible taking into account the medical exigencies, but not later than *72 hours* after receipt of the claim by the Health Organization. The determination will also be confirmed in writing.

If an **Urgent Care Claim** is received without sufficient information to determine whether or to what extent benefits are covered or payable, the Health Organization will notify you and/or your doctor as soon as possible, but not later than *24 hours* after receipt of the claim, of the specific information necessary to complete the claim. You will then have a period of no less than 48 hours, taking into account the circumstances, to provide the specified information to the Health Organization. The Health Organization will then notify you of the benefit determination no later than 48 hours after the earlier of (i) the Health Organization's receipt of the specified information, or (ii) the end of the period afforded to you to provide the specified additional information.

CONCURRENT CLAIMS

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

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

If you make a claim to extend a course of treatment beyond the approved period of time or number of treatments, and the claim involves urgent care, the Health Organization will make a determination on your claim as soon as possible, taking into account medical exigencies, and will notify you of the decision within 24 hours after receipt of your claim, provided that your claim was filed at least 24 hours before expiration of the previously approved period of time or number of treatments.

POST-SERVICE CLAIMS

The following procedure applies to **Post-Service Claims.** A **Post-Service Claim** is a claim that is not a **Pre-Service Claim** (for example, a claim submitted for payment after health services and treatment have been obtained).

(1) Obtain a claim form.

(2) Complete the employee's portion of the claim form.

(3) Have your Physician/Dentist either complete the Attending Physician's/Dentist's Statement section of the claim form, submit a completed HCFA health insurance claim form, or submit an HIPAA-compliant electronic claims submission.

(4) Attach all itemized hospital bills, or physician or dental statements that describe the services rendered.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

You do not have to submit an additional claim form if your bills are for a continuing disability and you have filed a claim within the past calendar year period. (Claims for dental benefits do require that a claim form be completed and filed with each submission.) Mail any further bills or statements for any Medical or Hospital services covered by the Plan to the appropriate Health Organization as soon as you receive them.

Ordinarily, you will be notified of the decision on your **Post-Service Claim** within *30 days* from receipt of the claim by the Health Organization. This period may be extended one time by the Health Organization for up to *15 days* if the extension is necessary due to matters beyond the control of the Health Organization. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Health Organization expects to render a decision.

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you will have at least *45 days* from receipt of the notification to supply the additional information. The normal period for making a decision on the claim will be suspended until the date you respond to the request. The Health Organization then has *15 days* to make a decision on a **Post-Service Claim** and notify you of the determination.

WEEKLY ACCIDENT AND SICKNESS BENEFIT CLAIMS

A **Weekly Accident and Sickness Benefit Claim** is a claim for weekly income due to a disabling accident, injury or illness off the job. Claim forms for **Weekly Accident and Sickness Benefit Claims** may be obtained from the Fund Office. The completed claim form, and the required documentation of the accident, injury or illness, must be forwarded to ULLICO. ULLICO will make a decision on the claim and notify you of the decision within *45 days*. If ULLICO requires an extension of time due to matters beyond its control, ULLICO will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the *45-day* period. A decision will be made within *30 days* of the time ULLICO notifies you of the delay. The period for making a decision may be delayed an additional *30 days*, provided ULLICO notifies you, prior to the expiration of the first *30-day* extension period, of the circumstances requiring the extension and the date by which it expects to render a decision.

If an extension is needed because ULLICO needs additional information from you, the extension notice will specify the information needed. In that case you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to ULLICO's request for the information, you will be notified of its decision on the claim within *30 days*.

LIFE INSURANCE CLAIMS

A **Life Insurance Claim** is a claim made by your beneficiary on the occasion of your death. Claim forms may be obtained from the Fund Office. The completed claim form and death certificate must be mailed to the Fund Office. The Fund Office will verify the eligibility of the deceased and the identity of the beneficiary, review the claim for completeness and forward the claim to ULLICO for processing. ULLICO will make a decision on the claim and notify your beneficiary within *90 days*. If ULLICO requires an extension of time due to matters beyond its control, it will notify your beneficiary of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the *90-day* period. A decision will be made within *90 days* of the time ULLICO notifies your beneficiary of the delay. If an extension is needed because additional information is needed from your beneficiary, the extension notice will specify the information needed. Until your beneficiary supplies this additional information, the normal period for making a decision on the claim will be suspended.

ELIGIBILITY CLAIMS

Submit claims for Eligibility under the Plan directly to the Fund Office. You do not have to fill out any claim forms to make an Eligibility claim. However, you must provide the Fund Office with a written description of the circumstances surrounding your claim so that your claim can be adjudicated properly.

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

NOTICE OF DECISION

You will be provided with written notice of a denial of a claim (whether denied in whole or in part) or any other adverse benefit determination. This notice will state:

- The specific reason(s) for the determination
- Reference to the specific Plan provision(s) on which the determination is based
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary
- A description of the appeal procedures and applicable time limits
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or subject to another similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination

applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

- For **Urgent Care Claims,** the notice will describe the expedited review process applicable to **Urgent Care Claims**. For **Urgent Care Claims,** the required determination may be provided orally and followed with written notification.

For all **Pre-Service Claims** (including **Urgent Care Claims**), you will receive notice of the determination even when the claim is approved.

REQUEST FOR REVIEW OF DENIED CLAIM

If your claim is denied in whole or in part, or if any adverse benefit determination is made with respect to your claim, you may ask for a review, that is, an "appeal."

Appeals are made to the specific Health Organization that processed the claim, with the following exceptions:

- Appeals for Prescription Benefits are made to the Fund Office for review by the Board of Trustees of the Fund.
- Appeals for Life Insurance Benefits are made to the Fund Office. These appeals will be forwarded to ULLICO for review.
- Appeals of Eligibility claims are made to the Fund Office for review by The Board of Trustees of the Fund.

The name, address and telephone number of the Fund Office and of all the Health Organizations that service the Plan are listed earlier in this section.

Your request for review must be made in writing within 180 days after you receive notice of denial for all claims except Life Insurance Claims. Appeals regarding Life Insurance and Eligibility Claims must be made within 60 days.

Note: Appeals involving **Urgent Care Claims** may be made orally to the Fund Office (for prescription appeals only) and to the Health Organization that administers the particular benefit you are requesting.

REVIEW PROCESS

The review process works as follows:

You have the right to review, free of charge, documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Fund Office or Health Organization in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon in making the benefit determination); it demonstrates compliance with the Fund Office's or Health Organization's administrative processes for ensuring consistent decision-making; or it constitutes a statement of plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund Office or Health Organization on your claim, without regard to whether their advice was relied upon in deciding your claim.

Your claim will be reviewed by a person who is not subordinate to (and shall not afford any deference to) the one who originally made the adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

TIMING OF NOTICE OF DECISION ON APPEAL

Pre-Service Claims

Some of the Health Organizations that service the Plan offer two (2) levels of appeal for pre-service claims. Each level of appeal will be decided within *15 days*. If you are dissatisfied with the outcome of your first appeal, you may file a second appeal. The second appeal must be

filed within *180 days* of your receipt of the decision regarding the first appeal. All decisions will be in writing. The following Health Organizations offer two levels of appeals for the benefits they administer:

Empire Blue Cross Blue Shield
A.S.O./S.I.D.S. (for post-service only, not for pre-service, urgent care, or concurrent)

All other pre-service appeals are to be directed to the Board of Trustees of the Fund, which will provide one level of appeal. This appeal will be decided within 30 days. You will receive a written notice from the Board of Trustees indicating its decision.

Urgent Care Claims: The Fund and the individual Health Organizations will decide urgent appeals within *72 hours* of their receipt. You will receive verbal notice of the decision, followed by written notification.

Concurrent Claims: The Fund and the individual Health Organizations will decide urgent concurrent appeals within *24 hours*, provided the appeal was received *24 hours* before the care ends. All concurrent appeals that involve a reduction or termination of treatment that had previously been approved will be decided before the treatment ends. All other concurrent appeals will be decided using the pre-service appeals procedures above.

You will receive verbal notice of the decision of an urgent concurrent appeal, followed by written notification. Non-urgent appeals will result in written notification only.

Post-Service Claims

Some of the Health Organizations that service the Plan offer two (2) levels of appeal for post-service claims. Each level of appeal will be decided within *30 days*. If you are dissatisfied with the outcome of your first appeal, you may file a second appeal. The second appeal must be filed within *180 days* of your receipt of the decision regarding the first appeal. All decisions will be in writing.

The following Health Organizations offer two-level appeals processes for the benefits they administer:

Empire Blue Cross Blue Shield
A.S.O./S.I.D.S.
Davis Vision

All other post-service appeals are directed to the Board of Trustees of the Fund, which will provide one level of appeal. This appeal will be decided within 60 days. You will receive a written notice from the Board of Trustees indicating its decision.

Weekly Accident and Sickness Benefit Claims

Appeals of denials of Weekly Accident and Sickness Benefit Claims must be mailed to ULLICO for review. ULLICO will decide your appeal and notify you in writing within *45 days* of its receipt of your request for review. In special circumstances, an extension of time, not exceeding *45 days*, may be required. If an extension is required, ULLICO with notify you in writing before the initial *45-day* period expires of the special circumstances and the date when a decision will be made.

Life Insurance Claims

Appeals of denials of life insurance claims must be mailed to the Fund Office. The Fund Office will then forward these to ULLICO for review. ULLICO will make a decision within *60 days* following receipt of your request for review. If there are special circumstances which require an extension of time (up to an additional *60 days*), ULLICO will provide written notification of the delay. The final decision will be made in writing, clearly stating the reasons for the decision and the provision of the Plan on which the decision is based.

Eligibility Claims

Eligibility Claims appeals are directed to the Board of Trustees of the Fund, which will provide one level of appeal. Ordinarily, decisions on appeals involving Eligibility Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within *30 days* of the next regularly scheduled meeting,

your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, *but no later than 5 days* after the decision has been reached.

NOTICE OF DECISION ON REVIEW

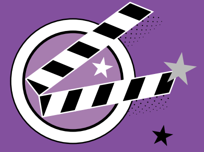
The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination.
- Reference to the specific plan provision(s) on which the determination is based.
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
- A statement describing the Plan's voluntary appeal procedures and your right to obtain the information about such procedures.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than 3 years after the end of the year in which medical or dental services were provided, or, if the claim is for short term disability benefits, more than 3 years after the start of the disability.

Repayment of Medical Benefits (Subrogation)



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

If you and/or your dependents are injured as a result of the negligence or other wrongful acts of a third party and you/your dependents apply to this Plan for benefits and receive such benefits, this Plan shall then have a first priority lien for the full amount of the benefits that are paid to you and/or your dependents should you seek to recover any monies from the third party that caused the injuries.

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

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

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

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

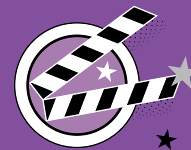
By applying for benefits, you agree that any lien the Plan may seek will not be reduced by any attorney fees, court costs or disbursements that you and/or your attorney might incur in your action to recover from the third party, and these expenses may not be used to offset your obligation to reimburse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

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

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

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

Board of Trustees HIPAA Statement



A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you certain rights with respect to your health information, and requires that employee welfare plans, like the IATSE National Health & Welfare Fund, that provide health benefits, protect the privacy of your personal health information. (These rules do not apply to the death and disability benefits provided under our Plan.) A complete description of your rights under HIPAA will be found in the Plan's Notice of Privacy Practices, which must be distributed to you by April 14, 2003 (or when you enroll in the Plan, if you enroll after April 14, 2003) and which will be available from the Fund Office. The statement that follows is not intended and cannot be considered the Plan's Notice of Privacy Practices.

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

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

- The following categories of employees under the control of the Board of Trustees are the only employees who may obtain protected health information in the course of performing the duties of their job with or for the Board of Trustees who obtained such health information:

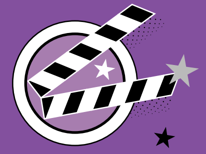
  The Fund Manager, the Health and Welfare Manager, the Health and Welfare Fund staff, Operations Manager and accounting staff.

  These employees will be permitted to have access to and use the protected health information only to perform the Plan administration functions that the Board of Trustees provides for the Plan.

- The employees listed above will be subject to disciplinary action and sanctions for any use or disclosure of protected health information that violates the rules set forth in this Summary Plan Description. If the Board of Trustees becomes aware of any such violations, the Board of Trustees will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the participants whose privacy has been violated.
- The Board of Trustees will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of protected health information received from the Plan in order to allow the Secretary to determine the Plan's compliance with HIPAA.

The Board of Trustees will return to the Plan or destroy all your protected health information received from the Plan when there is no longer a need for the information. If it is not feasible for the Board of Trustees to return or destroy the protected health information, then the Trustees will limit their further use or disclosures of any of your protected health information that it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Important Information About the Health & Welfare Fund



The Employee Retirement Income Security Act of 1974 (ERISA) requires that participants in employee benefit plans receive certain administrative information about their plans and the people who run them. Our Plan is subject to those rules and this section will tell you more about Plan operations.

Name of Plan. The Plan's formal name is the IATSE National Health & Welfare Fund.

Board of Trustees. The Board of Trustees and/or its duly authorized designee(s) has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan, including this booklet, the Trust Agreement and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Fund or Trust. Without limiting the generality of the foregoing, the Board of Trustees and/or its duly authorized designee(s) shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan.
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with the terms of the Plan.
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan.
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this booklet, the Trust Agreement or other Plan documents.
- Process and approve or deny benefit claims.
- Determine the standard of proof required in any case.

All determinations and interpretations made by the Board of Trustees and/or its duly authorized designee(s) shall be final and binding upon all participants, beneficiaries and any other individuals claiming benefits under the Plan. The Board of Trustees may delegate any other such duties or powers as it deems necessary to carry out the administration of the Plan.

The Board of Trustees also reserves the right in its sole and absolute discretion to amend or terminate the Plan at any time and for any reason. Continuation of benefits is not guaranteed. Neither you, your beneficiaries nor any other person has or will have a vested or nonforfeitable interest in the Plan. In the event of the Plan's termination (which might occur if the Union and the employers negotiate the discontinuance of contributions or if the contributions called for by the collective bargaining agreements are insufficient to allow the Plan to continue), the Board of Trustees will apply the monies in the Fund to provide benefits or otherwise carry out the purpose of the Plan in an equitable manner until the Fund assets have been disbursed. In no event will any part of the Fund assets revert to the employers or to the Union. The Board of Trustees consists of an equal number of employer and IATSE representatives.

Plan Sponsor and Administrator. The Board of Trustees is the Plan Sponsor and the Plan Administrator.

Identification Numbers. The "employer identification number" assigned to the Fund by the Internal Revenue Service is 13-3088695. The plan identification number assigned to the Plan by the Board of Trustees, pursuant to IRS instructions, is 501.

Plan Year. Plan records are kept on a calendar-year basis, that is, from January 1 through December 31.

Type of Plan. Our Plan is known as a "welfare" plan under ERISA. It provides medical, prescription drug, vision, dental and death benefits.

Agent for Service of Legal Process. In the event of a legal dispute involving the Plan, legal documents may be served on:

Anne J. Zeisler
Executive Director
55 West 39th Street – 5th Floor
New York, NY 10018-3813

Legal process may also be served on any individual Trustee at the Fund Office address.

Collective Bargaining Agreement/Contributing Employers. The Fund is established and maintained in accordance with one or more collective bargaining agreements. A copy of any such agreement(s) may be obtained upon written request to the Fund Office, and is available for examination during normal business hours at the Fund Office. In addition, a complete list of the bargaining units participating in the Fund may be obtained upon written request to the Fund Office and is available for examination by participants and beneficiaries during normal business hours at the Fund Office. The Fund Office may charge a reasonable amount for copies.

Participants and beneficiaries may also receive from the Fund Office, upon written request, information as to whether a particular employer or employee organization is participating in the Fund and, if the employer or employee organization is participating, its address.

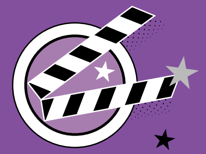
Source of contributions. The benefits described in this booklet are provided through employer contributions and, in some cases, employee contributions. The amount of employer contributions and the employees on whose behalf contributions are made are determined by the provisions of the applicable collective bargaining agreements. The Fund Office will provide, upon written request, information as to whether a particular employer is contributing to the Fund on behalf of employees.

Trust Fund. All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants, either through the direct payment of benefits or the payment of premiums to entities that insure these benefits, and defraying reasonable administrative expenses.

Identification of Insurance Companies and Other Entities Guaranteeing Benefits. Weekly Accident and Sickness and Life Insurance benefits are insured through ULLICO. The vision benefits that are provided by Davis Vision are also insured. Contact information for all of these entities (and any successors to them) appears at the end of this booklet.

Self-Funded Benefits. Currently, medical benefits, hospitalization, prescription drug, dental, physical exam and hearing aid benefits are self-funded, which means benefits are paid directly out of Fund assets, rather than through an insurance policy. However, in most of these cases, the Fund has contracted with outside providers to administer these benefits — process claims, etc. These entities (and any successors to them) are described at the end of this booklet.

Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)



As a participant in the IATSE National Health & Welfare Fund, 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 Fund Office and at other specified locations, such as work locations and union halls, all documents governing the Plan, including summary plan descriptions, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Trustees are required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

- Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan 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.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

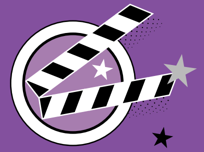
ASSISTANCE WITH YOUR QUESTIONS

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 (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 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.

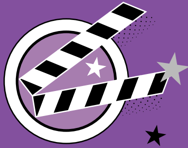
Administration and Contact Information



BENEFIT	TYPE OF ADMINISTRATION	TYPE OF FUNDING
Hospital and Health	Empire BlueCross BlueShield 11 West 42nd Street New York, NY 10036 800-553-9603 www.empireblue.com	Self-funded. The Fund pays the cost of benefits, which are administered by Empire BlueCross BlueShield.
Prescription Drug	NPA (A division of Express Scripts) 711 Ridgedale Avenue East Hanover, NJ 07936 800-467-2006 www.npanet.com	Self-funded. Fund pays cost of benefits, which are administered under a contract with NPA.
Vision Services	Davis Vision Capital Region Health Park 711 Troy Schenectady Road Suite 301 Latham, NY 12110 800-999-5431 www.davisvision.com Comprehensive Professional Systems, Inc. 48 West 21st Street New York, NY 10010 888-675-3137 www.UDSCPS.com General Vision Services 520 Eighth Avenue New York, NY 10036 800-VISION-1 www.generalvision.com	For Davis Vision, the Fund pays premiums to Davis Vision, and Davis Vision provides benefits. Self-funded. The Fund pays the cost of benefits, which are administered under contracts with Comprehensive Professional Systems, Inc. and General Vision Services.
Dental	A.S.O./S.I.D.S. P.O. Box 9005 Lynbrook, NY 11563-9005 516-396-5500 800-537-1238 www.asonet.com	Self-funded. Fund pays cost of benefits, which are administered under a contract with A.S.O./S.I.D.S.

BENEFIT	TYPE OF ADMINISTRATION	TYPE OF FUNDING
Weekly Accident and Sickness	ULLICO 451 Park Avenue So. New York, NY 10026 866-376-9495	Insured. Fund pays premiums to ULLICO and ULLICO guarantees benefits.
Physical Exam and Hearing Aid Benefit	A.S.O./S.I.D.S. P.O. Box 9005 Lynbrook, NY 11563-9005 516-396-5525 (in NY) 877-390-5845 (outside NY) www.asonet.com	Self-funded. Fund pays the cost of benefits, which are administered through a contract with A.S.O./S.I.D.S.
Life Insurance	ULLICO 451 Park Avenue So. New York, NY 10026 Phone Fund Office with questions: 800-456-3863	Insured. Fund pays premiums to ULLICO to provide coverage.

Notes



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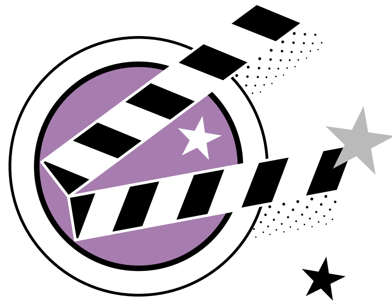

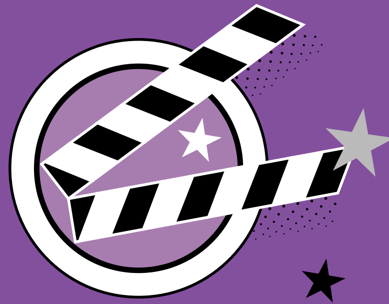

INTERNATIONAL ALLIANCE OF THEATRICAL STAGE EMPLOYES