THE INTERNATIONAL ALLIANCE OF THEATRICAL STAGE EMPLOYEES LOCAL 6 HEALTH AND WELFARE FUND

PLAN B

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

SEPTEMBER 2022

THE INTERNATIONAL ALLIANCE OF THEATRICAL STAGE EMPLOYEES
LOCAL 6 HEALTH AND WELFARE FUND
PLAN B COVERAGE

Dear Participant,

This booklet outlines Plan B of The International Alliance of Theatrical Stage Employees Local 6 Health and Welfare Fund (the "Fund") benefits applicable to you, including the nature and extent of benefits, eligibility requirements, rules and regulations, and the manner in which you may file claims for benefits. We urge you to read and review this carefully.

Your Fund was made possible through the process of collective bargaining by and between The International Alliance of Theatrical Stage Employees Local 6 (the "Union") and its signatory employers. That collective bargaining has resulted in the negotiation and execution of written labor agreements which require those employers to make contributions into your Fund to partially finance benefits for you. You have the option to purchase additional benefits for yourself and your family members.

The Fund is a joint labor-management employee benefit trust fund, financed by contributions fixed by collective bargaining or other written agreements, and administered by an equal number of Trustees designated by the contributing employers and by the Union pursuant to a Trust Agreement, which may be amended from time to time. The Trust Agreement gives the Board of Trustees authority and discretion to determine benefits, and the Trustees have accordingly adopted a Plan of benefits set forth and described by this Plan and Summary Plan Description (SPD). Under the Trust Agreement and SPD, the Trustees may, in their discretion, revise, discontinue, improve, reduce, modify or make changes in the Plan, the types and amounts of benefits provided, the coverage and eligibility provisions, conditions and rules, at any time. Any question of interpretation, construction, application or enforcement of the terms of the Plan and SPD are subject to the discretion of the Board of Trustees whose determinations are final and binding.

We sincerely hope that you rarely find it necessary to utilize the benefits provided for you. However, we think you will agree that a sense of personal security is derived from the knowledge that these fine benefits are available in the event they become necessary.

More information about the Plan may be obtained by contacting the Plan Administrator at:

International Alliance of Theatrical Stage Employees
Local 6 Health & Welfare Fund
6525 Centurion Drive
Lansing, MI 48917
517-321-7502

Sincerely yours,

Board of Trustees

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I. GENERAL INFORMATION / SCHEDULE OF PROVIDERS

Name of Plan:

The International Alliance of Theatrical Stage Employees Local 6 Health & Welfare Fund Plan B

Name And Address Of Plan Sponsor:

Board of Trustees
The International Alliance of Theatrical Stage Employees Local 6 Health & Welfare Fund
6525 Centurion Drive, Lansing, MI 48917.

Employer Identification Number (EIN):

43-0791005

Type Of Plan:

This Plan is maintained for the purpose of providing medical, dental and vision benefits. These benefits are insured by the Companies shown in the "Important Contact Information for Benefits" section below.

Type Of Administration:

The Plan is administered by the Board of Trustees. The Trustees maintain a Fund Office to handle the day- to-day operations of the Plan and have entered into agreements with group insurance providers to handle various administrative functions of the Plan.

The companies providing services listed in the "Important Contact Information for Benefits" do insure the benefits provided under this Plan.

Name And Address Of Plan Administrator:

The International Alliance of Theatrical Stage Employees Local 6 Health & Welfare Fund
6525 Centurion Drive, Lansing, MI 48917.

Agent For Service Of Legal Process:

The International Alliance of Theatrical Stage Employees Local 6 Health & Welfare Fund Plan Administrator
6525 Centurion Drive, Lansing, MI 48917 (517) 321-7502.

Board of Trustees

Union Designated Trustees

Tim McDonald
IATSE Local #6
1611 S. Broadway, Suite 110
St. Louis, MO 63104

Employer Designated Trustees

Sean Smith
Municipal Theatre Association
1 Theatre Drive
St. Louis, MO 63112

Joe Rudd
IATSE Local #6
1611 S. Broadway, Suite 110
St. Louis, MO 63104

Jeff Antrainer
The Fox Theatre
527 N. Grand Boulevard, Suite 200
St. Louis, MO 63103

Eli Barrera
IATSE Local #6
1611 S. Broadway, Suite 110
St. Louis, MO 63104

Maggie Bailey
The St. Louis Symphony
718 N. Grand Boulevard
St. Louis, MO 63103

Jeremiah Wolfe, Alternate
Wolfe Production
13609 Lakefront Drive
Earth City, MO 63045

Legal Counsel:

Hammond and Shinners, P.C.
Daniel M. McLaughlin
13205 Manchester Road, Suite 210
St. Louis, Missouri 63131
Phone (314) 727-1015

Health and Ancillary Insurance Broker

AssuredPartners
Scott Robson
12645 Olive Blvd, Suite 300
St. Louis, Missouri 63141
Phone: 844-523-8800

Investment Consultant:

Visionary Wealth Advisors, LLC
Bill Lauber (advisor)
12300 Old Tesson Rd., #100C
Sappington, MO 63128-2228
Phone: (314) 843-9999

Source of Contributions and Funding:

The benefits described in this Plan Document are financed by employer contributions in accordance with their collective bargaining agreements with the Union and by Participant Contributions. The Fund Participants may examine these collective bargaining agreements and may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees at the address listed above. The Fund Office will provide, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of

Participants working under the collective bargaining agreements.

Plan Years:

The financial records of the Plan are kept on a Plan Year basis. The Plan Year ends on each May 31.

Benefit Plan Year:

The Benefit Plan Year ends on August 31 and begins September 1.

Plan Details:

The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, denial or loss of any benefits are described in this document. With respect to medical and pharmaceutical benefits, such circumstances are described in the Group Insurance Certificate issued by the medical insurer. With respect to the dental benefits, such circumstances are described in the Group Insurance Certificate issued by the dental insurer. With respect to the vision benefits, such circumstances are described in the Group Insurance Certificate issued by the vision insurer.

Authority to Interpret, Construe and Apply the Terms of the Plan:

The Board of Trustees has the authority and discretion to interpret, construe and apply all of the terms of this Summary Plan Description, the Trust Agreement and other documents governing the operation of this Plan, including any ambiguous terms in such documents. The Trustees will, pursuant to the terms of the Plan documents, make all final determinations regarding eligibility for benefits and the amount of benefits due Participants and beneficiaries. The decisions of the Trustees will be binding. All decisions made by the Trustees are intended to be subject to the most deferential standard of judicial review.

Amendment or Termination of the Plan or Trust

The Plan may be amended or terminated by a majority vote of the Trustees at any regular or special meeting of the Board of Trustees, subject to applicable collective bargaining agreement provisions. The benefits described in this booklet are those currently provided by the Plan. Those benefits, including benefits provided to retirees, can be altered, modified, reduced or terminated at any time the Trustees determine, in their discretion, such action is necessary. None of the benefits provided by this Plan, including retiree benefits are vested.

Should the Trustees determine to terminate the Trust, any assets remaining in the Trust shall be used consistently with the purposes of the Trust. No assets of the Trust shall revert to any employer.

Important Contact Information for Benefits:

Benefit Description	Provider	Group ID/Name	Customer Service
Medical & Pharmacy Insurance	United Healthcare	Local 6 HW Fund 914510	United Healthcare Customer Service (866) 527-9597 www.myuhc.com See back of ID card for Cust Service and information for Providers and Claims
Dental Insurance	Delta Dental	Local 6 HW Fund 06181101	Customer Service (800) 335-8266 www.deltadentalmo.com P.O. Box 8690 St. Louis, MO 63126-0690
COBRA Administration	TIC International Corporation	Local 6 H&W Fund	(517) 321-7502
Vision Insurance	Eye Med	Local 6 HW Fund 1001085	Customer Care (866) 800-5457 www.eyemed.com Claims: First American Administrators, Attn: OON Claims P.O. Box 8504 Mason, Ohio 45040-7111

FOR ELIGIBILITY OR OTHER INQUIRIES, CONTACT PLAN ADMINISTRATOR

INTERNATIONAL ALLIANCE OF THEATRICAL STAGE EMPLOYEES LOCAL 6

HEALTH & WELFARE FUND

AT (517) 321-7502

II. ELIGIBILITY

GENERALLY

An employee may be eligible for medical, pharmacy, dental, vision benefits when one or more signatory employers is obligated to make Contributions on their behalf to the Fund. Eligibility for coverage is based upon Contributions received from Contributing Employers subject to a formula established between the Union and the signatory employers. The current contribution formula established and agreed to, and requirements for coverage, will be attached to the Trust documents. Eligibility requirements for coverage of Participants under the Trust can be reviewed by the parties and can be amended annually by the Board of Trustees in accordance with Article XI of the Trust Agreement.

The initial eligibility requirement may be waived or reduced for existing Employees of a new Contributing Employer when, as a result of union organizing, the employer first signs a collective bargaining agreement requiring the employer to contribute to the Fund.

All employees working under the jurisdiction of the Union will remain eligible if sufficient Contributions from Contributing Employers are made on their behalf to satisfy the current contribution formula.

A. MEMBERS

1. Member Participation

   a. Member Eligibility Date. The eligibility date for coverage of each Member shall be the September 1st following the immediately preceding Qualifying Period during which the Member was an Active Qualifying Participant. Members shall be eligible for Medical benefits on a Contributory Basis at a Member Contribution rate of 50% of the applicable Member premium. Members shall be eligible for dental and vision benefits at a Member Contribution rate of 100% of the applicable Member premium.

   b. Effective Date of Coverage - Member. Subject to the Member Effective Coverage Date set forth in sub-paragraph (c) below, the coverage of each Member shall become effective on the applicable date given below:

      1. For Active Qualifying Participants, coverage shall become effective on the Member's Eligibility Date.

      2. If coverage for a Member or Dependent has been terminated at their request or due to failure to make any required Member Contribution for such coverage, coverage shall again become effective at the next Member Eligibility Date, provided that the Member or Dependent qualifies for the eligibility period (through open enrollment), absent an otherwise qualifying event.

c. Member Effective Date of Coverage. The effective date of Member coverage shall be subject to the Member being Actively at Work. See Section X, Definitions, subparagraphs 1 and 14 for an explanation of this term.

d. Continuing Coverage. Member coverage shall continue for each Insured Period following the immediately preceding Qualifying Period during which the Member was an Active Qualifying Participant.

e. Termination of Member Coverage. Coverage for each Member shall, subject to COBRA, terminate at midnight on the earliest of the following dates:

1. August 31st of the first year following the year in which the most recent Insured Period began if the Member is no longer an Active Qualifying Participant;

2. The date of Plan termination;

3. The date of expiration of the period for which the last Member Contribution is made by the Member, or

4. As to any particular coverage or benefit, the date such coverage or benefit is terminated, the date the Member ceases eligibility for such coverage or benefit including COBRA for a qualifying event, or the date of the Member's death.

B. DEPENDENTS

1. Generally. The following shall be considered Dependents of a Participant eligible for coverage of medical, dental and vision benefits on a Contributory Basis at a Member Contribution rate of 100% of the applicable Dependent premium.

a. A Participant's spouse (if not legally separated or divorced from the Employee).

b. A Participant's child, from the moment of birth or placement for legal adoption, guardianship or foster care (but not after the child is removed from placement prior to legal adoption), until the end of the month in which the child attains age 26.

c. A Participant's disabled or handicapped child who has attained age 26 provided such child is:

1. Mentally or physically incapable of earning his own living. Proof of incapacity must be furnished to the Plan within 31 days of his attainment of the limiting age; and

2. Dependent on the Participant for support and maintenance; and

3. Covered under this Plan on the day immediately prior to attaining the limiting age.

d. A Participant's child who is recognized under a Qualified Medical Child who is recognized under a Qualified Medical Child Support Order (QMCSO), as determined by federal law, as having a right to receive benefits under the Plan.

The term child includes not only a biological child, but also:

1. A stepchild;

2. An adopted child;

3. A child who has been placed in the Participant's home for adoption;

4. A foster child placed with the Participant by an authorized placement agency, or by judgment, decree or other order of any court of competent jurisdiction.

5. A child for whom the Participant has been appointed permanent legal guardian, provided the child resides with the Participant and is dependent upon the Participant for support.

2. Effective Date of Coverage - Dependent. The Effective Date of Coverage for a Dependent shall be the first date on which the Participant is eligible for and elects personal coverage under this Section and has one or more eligible Dependents, as defined in sub-paragraph 1 herein, provided that a Participant whose Dependents shall all cease to be eligible shall have a new eligibility date for Dependent coverage if, and when, the Participant again has an eligible Dependent while the Participant is eligible for personal coverage under the Plan.

3. Addition of Eligible Dependents. Subject to the foregoing provisions of this Article II, Section B, Dependent coverage shall be extended to cover each additional Dependent of a Participant. Dependents are eligible for coverage only if the Fund is notified by the Participant of the Dependent's eligibility and only if Contributions are received for coverage of the Dependent.

With respect to a newly acquired Dependent, the Participant is responsible for notifying the Fund Office of the addition of a newborn, adopted child or child to which the Participant is legally responsible for providing coverage of benefits. This notification must take place within thirty (30) days of the qualifying event (i.e. date of birth, date of adoption, date of placement or date of legal proceeding).

4. Termination of Dependent Coverage. The Dependent coverage of each Participant's Dependent(s) shall automatically terminate on the earliest of the following dates:

a. The date the Participant's coverage under the Plan terminates;

b. The date the Dependent ceases to be eligible for benefits,

c. The date of expiration of the period for which the last Member Contribution toward the cost of Dependent coverage is made by the Participant;

d. As to any particular coverage or benefit, the date such coverage or benefit is terminated; or

e. The date of Plan termination.

If Dependent coverage has been terminated at the request of the Participant, or because of failure to make the required contribution for such coverage, Dependent coverage may become effective at the next Qualifying Period, provided the Participant or Dependent qualifies for the eligibility period (through open enrollment), absent an otherwise qualifying event, and makes the required Contribution for such coverage.

C. SPECIAL ENROLLMENT RIGHTS PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within thirty (30) days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within thirty(30) days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information contact the Plan Administrator.

Board of Trustees
The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6525 Centurion Drive
Lansing, MI 48917
(517) 321-7502

D. RETIREES

Retirement Criteria: A covered Plan Participant is eligible for retiree status if the Participant transitions from being a covered Plan Participant to Retiree status and has no break in continuous coverage. This continuous coverage can be for a Member who: (1) is actively at work and covered as a Participant; or (2) was an active Member and has continuing coverage through the Fund for the subsequent coverage period as described in the example below; or (3) is a Plan Participant through COBRA Continuing Coverage and remains in the Plan as a covered Participant. If there is any break in continuing coverage a Member will not be eligible for retiree status.

Once an active Member retires, he/she must complete a retirement form. Once the active Member retires, he/she is terminated from all lines of coverage (medical, dental and vision) as an active Member on August 31 of that Plan year and may continue medical coverage only for the subsequent Plan year if they meet the eligibility requirements set forth below. If a retiree is eligible for and receiving Medicare benefits the Fund will provide assistance

with Medicare Supplements by reimbursing fifty percent (50%) of the cost of that Medicare Supplement coverage.

In the event an active Member retires during the Plan Year and their employer made the required amount of Contributions on their behalf during the Qualifying Period said Member shall be eligible for retiree coverage for the subsequent Plan Year under the same terms and conditions as an active Member.

Coverage under this Plan shall become secondary to Medicare the first day of the Plan month in which the retired Members becomes eligible for Medicare.

After retirement and once active or retired Member coverage ends the retired Member will be offered COBRA Continuation Coverage. This COBRA coverage is not free and must be paid at the appropriate COBRA rate by the retired Member. That COBRA coverage will last for eighteen (18) months.

If the Fund is not notified in writing of a Member's retirement and the member does not qualify for benefits, he/she will be terminated from coverage and offered COBRA continuation coverage.

*Retiree benefits are not a guarantee of benefits. The Trustees may, at their discretion, terminate retiree coverage at any time.

E. ENROLLMENT AND BENEFICIARY DESIGNATION

You must complete an individual enrollment form in order to activate your coverage for benefits within thirty (30) days of your eligibility date. You may obtain the enrollment form from the Fund Office. Return the completed form to the Fund Office.

In order to enroll your Dependents, you may be required to furnish proof of their status as eligible Dependents. If you have any questions about your Dependents' eligibility, please contact the Fund Office.

You will also be required to complete an annual information form updating information about yourself and your eligible Dependents. The Fund Office will send you this form. Benefits will not be paid until the Fund Office has received the completed annual information form.

Your failure to complete the original enrollment form for yourself or any Dependent or your failure to complete an updated form can make you ineligible for benefits. Further, if you fail to provide the enrollment form or annual information form within the time limit for filing a particular claim, that claim will not be covered.

Children will also be enrolled as required by any Qualified Medical Child Support Order (QMCSO), on the date the Fund Office receives such an order or, later based on the date specified in the QMCSO. If you would like information about the Plan's procedures for processing a QMCSO, call the Fund Office.

F. LEAVE OF ABSENCE PROTECTED BY THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

If your Contributing Employer is subject to the Family and Medical Leave Act of 1993, Plan coverage for you and your Dependents may be continued during a FMLA leave for the maximum period as allowed by law. If your employer approves your leave, the Fund will extend your Plan coverage and that of your covered Dependents at the applicable contributory rate during your leave.

Your employer must properly grant the leave under FMLA and notify the Fund Office in writing.

Any hours you miss from scheduled work because of FMLA leave will count as hours worked in determining your eligibility for benefits.

Your employer is required to allow you to continue your health coverage during your leave under the same terms and conditions as if you had continued to work. In addition, when you return to work, the law generally requires your employer to restore you to the same or an equivalent position and health care benefits you enjoyed when your FMLA leave started.

G. SPECIAL CHIPRA ENROLLMENT RIGHTS

Effective April 1, 2009, CHIPRA (Children's Health Insurance Program Reauthorization Act of 2009) created two new special enrollment events if you are eligible to participate in the Plan but not enrolled in the Plan. First, if you or your Dependents were covered under Medicaid or a state CHIP plan, and lose that coverage, you or your Dependents are entitled to a special enrollment period in the Plan. Second, if you or your Dependents become eligible for the state's premium assistance, you are entitled to a special enrollment period. You have 60 days to notify the Plan of the event, and 31 days to provide proof of eligibility and enroll. To request special CHIPRA enrollment or obtain more information, contact the Fund Office at (517) 321-7502.

III. COBRA CONTINUATION COVERAGE

A. INTRODUCTION

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage under the Plan would otherwise end. This section is intended to inform you, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in regulations issued by the Department of the Treasury and the Department of Labor. This section is intended to reflect the law and does not grant or take away any rights that apply under applicable law. Instructions on COBRA rights and procedures, as well as election forms and other information, will be provided by the COBRA Administrator to Covered Persons who become qualified beneficiaries under COBRA.

You may have other options available to you when you lose group health coverage.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Medicare, the Childrens' Health Insurance Program, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. you can learn more about many of these options at www.healthcare.gov.

B. COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event referred to as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If a qualified beneficiary elects COBRA continuation coverage, the Plan will provide medical, prescription drug, vision and dental benefits, which, as of the time coverage is being provided, are identical to such coverage provided under the Plan to similarly situated active covered individuals

If you're a Participant, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

1. your hours of employment are reduced, or
2. your employment ends for any reason other than your gross misconduct.

If you're the spouse of a Participant, you'll become a qualified beneficiary if you lose your coverage

under the Plan because of the following qualifying events:

1. your spouse dies;

2. your spouse's hours of employment are reduced;

3. your spouse's employment ends for any reason other than his or her gross misconduct;

4. your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

5. you become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

The parent-Participant dies;

1. The parent-Participant's hours of employment are reduced;

2. The parent-Participant's employment ends for any reason other than his or her gross misconduct;

3. The parent-Participant becomes entitled to Medicare benefits (Part A, Part B, or both);

4. The parents become divorced or legally separated; or

5. The child stops being eligible for coverage under the Plan as a Dependent.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired Participant covered under the Plan, the retired Participant will become a qualified beneficiary. The retired Participant's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

C. AVAILABILITY OF COBRA CONTINUATION

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. Continuation coverage must commence the day following termination of the individual's active coverage under the Plan and must be continuous.

Example: An individual whose coverage terminates November 30 because of a Qualifying Event must elect Continuation Coverage starting December 1. He or she cannot skip December and start coverage January 1. Nor can the individual skip any later months after starting Continuation Coverage without losing the right to continue coverage.

The employer must notify the Plan Administrator of the following qualifying events:

1. The end of employment or reduction of hours of employment;

2. Death of the Participant;

3. Commencement of a proceeding in bankruptcy with respect to the employer; or

4. The Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the Participant and spouse or a Dependent child's losing eligibility for coverage as a Dependent), you must notify the Plan Administrator within 60 days after the qualifying event occurs. The notice must be provided, in writing, in a letter addressed to the Plan Administrator. The notice must include:

1. The covered Participant's name, address, phone number and health plan ID number;

2. The name, address, phone number and health plan ID number for any Dependent child or spouse whose eligibility is affected by the Qualifying Event;

3. A description of the Qualifying Event (or a notice of a disability determination or termination of disability status, as described below) and the date on which it occurred;

   and

4. The signature of the person sending the letter.

The qualified beneficiary (or the covered Participant or spouse) must also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date of the divorce or the date the legal separation began. If a qualified beneficiary or anyone else has a question about what type of documentation is required, the individual should contact the Plan Administrator.

Notice should be mailed to the address set forth below under Plan Contact Information.

D. LENGTH OF COBRA CONTINUATION COVERAGE

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. A qualified beneficiary has 60 days from the later of the date on which coverage is lost due to a qualifying event or the date on which the qualified beneficiary is notified of the right to continue coverage to inform the COBRA Administrator that they elect COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the COBRA Administrator in a timely fashion, you and your Dependents may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for the disability extension, the qualified beneficiary must provide the COBRA Administrator with written notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18 month maximum coverage. This notice, along with a copy of the disability determination, should be sent to the COBRA Administrator at the address set forth below under Plan Contact Information.

If a qualified beneficiary becomes entitled to a disability extension and then there is a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled, the qualified beneficiary must notify the COBRA Administrator of that determination within 30 days after the date of the final determination.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any Dependent children getting COBRA continuation coverage if the Participant or former Participant dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the Dependent child stops being eligible under the Plan as a Dependent. This extension is only available if the second qualifying event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

You must notify the COBRA Administrator within 60 days after the second qualifying event occurs. If mailed, your notice must be postmarked no later than the 60th day after the second qualifying event occurs and the notice must include:

1. The covered Participant's name, address, phone number and health plan ID number;

2. The name, address, phone number and health plan ID number for any Dependent child or spouse whose eligibility is affected by the Qualifying Event;

3. A description of the second Qualifying Event and the date on which it occurred;

4. The following statement: "By signing this letter, I certify that the second Qualifying Event

described in this letter occurred on the date described in this letter"; and

5. The signature of the person sending the letter.

The qualified beneficiary (or the covered Participant or spouse) must also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date of the divorce or the date the legal separation began. If a qualified beneficiary

or anyone else has a question about what type of documentation is required, the individual should contact the COBRA Administrator.

Notice should be mailed to the address set forth below under Plan Contact Information.

E. PAYMENT FOR COBRA CONTINUATION COVERAGE

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must make timely payment of premiums for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any period for which coverage is obtained pursuant to the disability extension discussed above.

Timely payment means a payment made by the first day of the month for which coverage is to be provided (the "due date") or within a 30-day grace period beginning on that due date. However, the Plan will not require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary. Payment is considered made on the date on which it is sent to the Plan.

F. TERMINATION OF COBRA CONTINUATION COVERAGE

All rights to COBRA continuation coverage permanently end on the earliest of the following occurrences:

1. The expiration of the applicable maximum COBRA continuation period;

2. The qualified beneficiary's failure to make a payment before the end of the applicable grace period;

3. If it occurs after the date that COBRA is elected, the date the qualified beneficiary becomes covered under another group health plan;

4. If it occurs after the date that COBRA is elected, the date the qualified beneficiary becomes entitled to Medicare. A person will be considered to be entitled to Medicare when the person is enrolled for either Medicare Part A or Part B. Please note that enrollment in Part A is automatic when you qualify for it;

5. For COBRA coverage that is extended due to disability, the first day of the first month that begins more than 30 days after the date that a disabled qualified beneficiary is finally determined by the Social Security Administration to be no longer disabled; or

6. The date upon which the employer for whom the Participant worked ceases to provide any group health plan (including a successor plan) to any employee.

G. SPECIAL RULES FOR MEDICARE-ELIGIBLE INDIVIDUALS

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit:

https://www.medicare.gov/medicare-and-you
https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you have questions.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes.

To protect your family's rights, let the COBRA Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

Plan Contact Information.

Any notice that you must provide in accordance with this section must be in writing. you must mail, e-mail, fax, or hand-deliver your notice to the following:

The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6525 Centurion Drive
Lansing, MI 48917
(517) 321-7502

H. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

If you, the covered employee, leave covered employment to enter active duty in one of the uniformed services of the United States (Army, Navy, Air Force, Marines, Coast Guard, or uniformed Public Health Service) your coverage and that of your Dependents will continue for one month without charge. Thereafter, you and your Dependents may purchase COBRA for an additional 23 months (or, if earlier, until the date on which you return to employment with the employer or fail to apply for or return to a position of employment with the employer within the time limit that applies under the Uniformed Services Employment and Reemployment Rights Act (USERRA)). If, after your active duty ends, you return to covered employment within the time set by federal law (which varies depending on the length of your active duty), your coverage under the Plan will resume upon your return as if you had not left covered employment.

You must inform the Plan Administrator if you enter the uniformed services to ensure your rights are protected under the USERRA.

Please Note: No benefits are provided for injuries or illnesses arising out of or in connection with your service in the uniformed service of the United States or any other country.

IV MEDICAL AND PERSCRIPTION DRUG BENEFITS

A. GENERALLY

Medical and Prescription drug benefits are provided through a policy issued by the insurance company providing such benefits as identified in the "Important Contact Information for Benefits" section at the beginning of this SPD. If you are eligible for benefits, you will receive a copy of the Group Insurance Certificate provided by the insurer. In the event of a conflict between this SPD and the Group Insurance Certificate, the Group Insurance Certificate controls.

B. SCHEDULE OF MEDICAL BENEFITS

Please refer to the Schedule of Benefits Insert and the medical insurance provider's Group Insurance Certificate. All deductibles, co-pays, benefits, and benefit limits are listed in the Schedule of Benefits and the Group Insurance Certificate.

C. THE DEDUCTIBLES

1. Medical

The Deductible is the amount each covered individual must pay each calendar year before that person receives certain benefits from the Plan. Further, the Deductibles for in-network providers and out-of-network providers do NOT cross-apply. If you use both in-network and out-of-network providers, the maximum amount you will pay in Deductibles in a calendar year is listed in the Schedule of Benefits and medical insurance provider's Group Insurance Certificate.

Co-payments do not count toward the Deductible (unless specifically identified in the Schedule of Benefits and medical insurance provider's Group Insurance Certificate)

2. Prescription Drugs

As indicated in the Schedule of Benefits, you will have to pay a Copayment each time you fill a prescription. This Copayment is in addition to the medical Deductible and is based on the tier of prescription drugs you are receiving.

D. OUT-OF-POCKET LIMITS

This Plan feature limits the amount you or a Dependent could pay for covered medical or pharmacy expenses during a calendar year.

Generally, for most covered expenses, the Plan pays as outlined in the Schedule of Benefits after the Deductible is satisfied, and the covered individual must pay the remainder of the covered charges by Copayments or coinsurance. Once the covered individual's Deductible and Copayments have reached the out-of-pocket limits outlined in the Schedule of Benefits in a calendar year, the Plan will pay 100% of the covered charges incurred by the same person within the balance of that calendar year.

Currently, the annual out-of-pocket limit for in-network benefits is $3,000 per individual and $6,000 per family. These limits may increase each calendar year.

Once the Deductibles and Copayments paid by all of your covered family members have reached the limits outlined in the Schedule of Benefits during a calendar year, the Plan will pay 100% of any additional charges incurred by any of your covered family members during the balance of that same calendar year.

Some Copayments do not count toward the out-of-pocket maximum. For example, chiropractor Copayments do not count toward the out-of-pocket maximum.

If you use out-of-network providers, the out-of-pocket limits are higher. This is another reason you should always make every effort to use in-network providers.

E. LIFETIME MAXIMUM BENEFITS

This Plan of benefits provided for by the Fund does not establish or recognize lifetime maximum benefit levels. Subject to the specific limitations as outlined in the Schedule of Benefits, all expenses for Covered Services shall be paid in accordance with the terms and conditions of this Plan so long as the Participant remains eligible for coverage.

F. NETWORK PROVIDERS

The medical insurer has made arrangements with a network of doctors, hospitals and other providers of medical services. These in-network providers have agreed to accept as payment for their services, amounts which are often less than amounts charged by other providers. When you and your Dependent(s) use the in-network providers, the Plan will pay a greater percentage of the covered charges you incur than when you or your family use out-of-network providers. You will pay a significantly greater portion of the charges for out-of-network. In addition, because the out-of- network providers often charge more, you will be paying a greater portion of higher charges. Thus, it is always in your best interest to use in-network providers.

In order to make sure you have the most up to date information about which providers are in the network, call the medical and pharmacy plan insurer at the number shown on your medical I.D. card or visit the medical and pharmacy insurer's website. It is your responsibility to verify that your provider is in the network.

G. CLAIM AND APPEAL PROCEDURES

Claim and appeal procedures for medical and pharmacy benefits are described in the Group

Insurance Certificate issued to you by the company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this SPD.

H. MEDICAL BENEFITS EXCLUSIONS AND LIMITATIONS

See Schedule of Benefits Insert. For a complete list of benefit exclusions and limitations, please refer to the Group Insurance Certificate.

V DENTAL BENEFITS

A. GENERALLY

Dental benefits are provided through a policy issued by the insurance company providing such benefits as identified in the "Important Contact Information for Benefits" section at the beginning of the SPD. If you are eligible for benefits, you will receive a copy of the Group Insurance Certificate provided by the insurer. In the event of a conflict between the SPD and the Group Insurance Certificate, the Group Insurance Certificate controls. If you are eligible, dental care benefits are payable when a covered individual incurs expenses for basic dental care, denture replacement and orthodontia by a licensed dentist or orthodontist. An expense is considered to be incurred on the date the service is rendered.

B. SCHEDULE OF BENEFITS

See Schedule of Benefits Insert and the dental insurer's Group Insurance Certificate for a full list of covered dental expenses.

C. DEDUCTIBLE AND MAXIMUM BENEFITS

Covered individuals have a calendar year Deductible which applies to certain dental services. Covered individuals also have a calendar year maximum. There is also a lifetime maximum benefit for orthodontic treatments per person. See the Schedule of Benefits Insert for the Deductible, lifetime and calendar year maximum amounts.

D. DENTAL BENEFITS EXCLUSIONS AND LIMITATIONS

See Schedule of Benefits Insert. For a complete list of benefit exclusions and limitations please refer to the Group Insurance Certificate.

E. CLAIM AND APPEAL PROCEDURES

Claim and appeal procedures for dental benefits are described in the Group Insurance Certificate issued to you by the company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this SPD.

VI VISION CARE BENEFITS

A. GENERALLY

Vision benefits are provided through a policy issued by the insurance company providing such benefits as identified in the "Important Contact Information for Benefits" section at the beginning of this SPD. If you are eligible for benefits, you will receive a copy of the Group Insurance Certificate provided by the insurer. In the event of a conflict between the SPD and the Group Insurance Certificate, the Group Insurance Certificate controls.

If you are eligible, vision care benefits are payable when a covered individual incurs expenses for eye examinations, eyeglasses and contact lenses performed or prescribed by a licensed optometrist or licensed doctor of medicine. An expense is considered to be incurred on the date the service is rendered.

B. SCHEDULE OF BENEFITS

See Schedule of Benefits Insert and vision insurer's Group Insurance Certificate for a full list of covered vision benefits.

C. MAXIMUM BENEFITS

Benefits are payable in the amount of the covered vision care expense incurred by a covered individual, up to the maximum benefit amount. For a complete listing of maximum benefit amounts, see the Schedule of Benefits and vision insurer's Group Insurance Certificate. Certain products and services selected may result in costs to you the covered individual or your Dependent(s) over and above the maximum benefits allowable under the Plan.

D. VISION BENEFITS EXCLUSIONS AND LIMITATIONS

See Schedule of Benefits Insert. For a complete list of benefit exclusions and limitations please refer to the Group Insurance Certificate.

E. CLAIM AND APPEAL PROCEDURES

Claim and appeal procedures of vision benefits are described in the Group Insurance Certificate issued to you by the company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this SPD.

VII COORDINATION OF BENEFITS UNDER THIS PLAN WITH OTHER COVERAGE

A. MEDICARE BENEFITS

As between Medicare and this Plan, this Plan will pay as the Primary Plan (as defined below) for all active Participants and the covered Dependents of such active Participants regardless of the age of such active Participants and their Dependents.

There are special coordination rules for individuals who have end stage renal disease. Generally, if an individual first becomes eligible for Medicare by virtue of having end state renal disease, this Plan will be primary for the first thirty (30) months of the individual's Medicare eligibility. Thereafter, Medicare becomes primary.

B. COORDINATION OF BENEFITS

1. Benefits Subject To This Provision

All medical benefits and dental benefits provided under this Plan are subject to this provision, except prescription drug benefits. If another plan is primary with respect to an individual this Plan will not pay any part of the cost of prescription drugs for that individual.

2. Effect On Benefits

Coordinate of Benefits (COB) means that the benefits provided by this Plan will be coordinated with the benefits provided by any other plans covering the individual for whom the claim is made. If this Plan is a Secondary Plan, the benefits payable under this Plan may be reduced, so that a covered individual's total payment from all plans will not exceed 100% of his or her total Eligible Expenses under this Plan. Thus, if another plan is primary and pays first, this Plan will subtract the amount paid by the other plan from the amount this Plan would have paid and will pay the remainder, if any. If the other plan paid more then this Plan would have paid in the absence of the other plan, no benefits will be due from this Plan.

3. Primary and Secondary Plan

"Primary Plan" means the Plan which pays benefits or provides services first under the Order of Benefit Determination Rules below. The Primary Plan does not reduce its benefits because of duplicate coverage.

"Secondary Plan" means any Plan which provides coverage for the individual for whom claim is made and which is not a Primary Plan.

4. Eligible Expense

"Eligible Expense" means any necessary, reasonable and customary item of expense which is covered, in whole or in part, under this Plan.

5. Claim Determination Period

"Claim Determination Period" is the period of time during which Eligible Expenses are compared with total benefits payable to determine how much each Plan will pay. The Claim Determination Period is a calendar year.

6. Plans Considered for COB

A "plan" is any arrangement which provides medical coverage for the individual for whom claim is made.

COB applies to the following plans:

a. Group insurance or individually purchased health insurance or other medical benefits plans;

b. Other arrangements, whether insured or uninsured, covering medical expenses of individuals in a group;

c. Plans designed to pay a fixed-dollar benefit per day while the individual is hospital confined, but which, at the time of claim, allow the individual to elect an alternate benefit. COB will be applied only to the portion of the daily benefit;

d. Plans of other hospital or medical service organizations;

e. Group practice plans;

f. Pre-payment plans;

g. Coverage under Federal Government plans or programs, including Medicare;

h. Coverage required or provided by law. COB will not apply to state programs which provide benefits for individuals unable to pay for their care;

i. Individual no-fault auto insurance, by whatever name called;

j. Medical payments coverage under any auto or property insurance policy.

Note: This Plan is always a Secondary Plan to benefits provided under any mandatory No-Fault Auto Insurance Act in the state in which the Covered Individual resides.

7. Order of Benefit Determination

Any plan which does not have a COB or similar provision and any plan that provides it is always Secondary will pay its benefits first (Primary Plan).

When all plans involved contain COB or similar provisions, the first of the following rules that describes the situation determines the order in which the plans pay their benefits.

a. Non-Dependent or Dependent

The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary, and the plan that covers the person as a dependent is secondary.

However, when a person is covered as the dependent of his or her spouse who is actively employed and is also covered as a retiree or former employee, the Medicare statute and regulations provide that Medicare is Primary to the plan that covers the person as other than a dependent and Secondary to the plan that covers the person as a dependent. In such circumstances, the plan that covers the person as a dependent of an active employee pays first, Medicare pays second, and the plan that covers the person as a former or retired employee pays last.

b. Child Covered Under More Than One Plan

(1) The Primary Plan is the plan of the parent whose birthday is earlier in the calendar year if:

(a) The parents are married;

(b) The parents are not separated (whether or not they ever have been married); or

(c) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

(2) If both parents have the same birthday, the plan that has covered either of the parents longer is Primary.

(3) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is Primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is Primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.

(4) If the parents are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

(a) The plan of the custodial parent;

(b) The plan of the spouse of the custodial parent;

(c) The plan of the non-custodial parent; and then

(d) The plan of the spouse of the non-custodial parent.

c. Active or Inactive Employee

The plan that covers a person as an employee who is neither laid off nor retired (or that employee's dependent) is Primary. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Subsection 7(a) of this Section.

d. Spouse or Dependent Child

The plan that covers a person as a spouse is Primary and the Plan covering that person as a dependent child is secondary.

e. Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is Primary and the continuation coverage is Secondary.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

f. Longer or Shorter Length of Coverage

If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is Primary.

(1) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within twenty-four (24) hours after the first ended.

(2) The start of a new plan does not include:

(a) a change in the amount or scope of a plan's benefits;

(b) a change in the entity that pays, provides or administers the plan's benefits; or

(c) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(3) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plans has been in force.

g. If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

8. Operation of COB

In order to make this COB provision work properly:

a. Upon request, the covered individual is required to furnish to the Plan complete information concerning all plans which cover the individual for whom claim is made.

b. As permitted by law, this Plan may, without the covered individual's consent:

(1) obtain information from all plans which may cover the individual; and

(2) release to such other plans any information it has with respect to any individual.

c. If payments which should have been made by this Plan have been made under any other plans, this Plan may reimburse such other plans to the extent necessary to make this provision work. Any such payment will be a benefit paid under this Plan.

d. If this Plan has paid benefits which result in payment in excess of the amount necessary under this Plan to make this provision work, this Plan has the right to recover such excess payment from:

(1) any person;

(2) any insurance company; or

(3) any other organization

to or for or with respect to whom such payments were made. This Plan may also withhold future benefits payable on behalf of the covered person and family members as an offset to benefits it paid erroneously. (See

Section XI, B2 of this booklet regarding the Plan's rights to recover overpayments).

9. Prescription Drug COB

These Coordination of Benefits Rules do not apply to prescription drugs.

If with respect to a covered individual, another health plan pays first under these COB rules, and that other plan requires the person to make a co-payment for prescription drugs, this Plan will not treat that co-payment as a covered expense. This Plan will not reimburse you for any part of that co-payment.

10. Coordination of Medical Benefits with Dental Benefits

To the extent that a treatment, service, or supply is covered under both the medical provisions of this Plan and the dental provisions of this Plan, a claim for such treatment, service or supply, will be considered first under the medical provisions of the Plan and then under the dental provisions.

VIII FILING OF CLAIMS AND SUPPORTING DOCUMENTS

A. GENERALLY

You may obtain any necessary claims forms from the Fund Office or the appropriate group insurance provider. Additionally, more specific claim filing procedures for insurance benefits are described in the respective Group Insurance Certificate issued to you by each specific provider. However, generally, if submitting a claim for benefits you must submit a claim form for any benefits within the time frame prescribed within the appropriate provider's Group Insurance Certificate. Generally, the claim should be accompanied by all supporting documentation. Generally, no claim for any benefits will be considered if it is received by the Fund Office or the appropriate provider after the allotted time in which to file a claim after the loss of which benefits are claimed.

To the extent you are required to file a claim form, read it and complete it carefully and provide all documents it indicates are required. If you need copies of bills, receipts and medical records, make copies of those before you submit the documents to the Plan or provider. Neither the Fund Office nor the provider can return the documents you submit.

1. Claims for Medical and Prescription Drug Benefits

a. Medical Benefits

(1) Generally

In most cases, you will not be required to submit a claim for medical benefits. Your doctor, hospital or other provider will forward the bills to the medical insurer. Receipt of such bills will be regarded as receipt of a claim. In some circumstances, the medical insurer will contact you for additional information. You should provide any such information as soon as possible after requested.

(2) When Another Plan is Primary

When another plan pays its benefits first under the Coordination of Benefits rules set out at Section VII of this Booklet, you must submit a copy of the explanation of benefits provided by the other plan along with a copy of the itemized bills from the medical provider to the appropriate provider.

The most common circumstances in which you must submit a claim to another plan first are:

(a) Your spouse works and has health benefits through his or her own employer and the claim is for services rendered to the spouse. In such circumstances, you must submit the claim to the spouse's plan first, then to this Plan.

(b) The claim is for your child and your spouse's birthday is earlier in the year than yours. The claim must go to your spouse's insurer or health benefit plan first.

For greater detail about coordination of benefits and which plan pays first, see Section VII of this Booklet.

b. Prescription Drug Benefits

In most cases, you will not file a claim in order to receive prescription drug benefits. You will simply present your pharmacy card to a network pharmacy, pay the required co-pay, and get your prescription. However, in order to file a claim for reimbursement for amounts you have paid for prescription drugs to out-of-network pharmacies, send the itemized pharmacy prescription receipt or the itemized pharmacy billing statement to the prescription drug benefit insurer. You should use this procedure when, for any reason you have not used your pharmacy card or mail order service or when you believe the amount you were required to pay when using the pharmacy card or mail order service was in excess of the amounts set out in this the Schedule of Benefits, if you are denied a drug by a network pharmacy or the mail-order service.

In order to take advantage of the mail-in drug program for maintenance drugs, you must obtain an order form from the Fund Office and send the completed order form, along with your doctor's prescription and the appropriate co-payment, to the address indicated on the order form.

2. Claims for Dental Benefits

If you or a covered Dependent has incurred an expense for dental services, your in-network provider will submit an itemized bill to the dental benefit insurer. If you use an out-of-network provider, you must submit a claim form to the dental insurer.

3. Claims for Vision Benefits

If you or a covered Dependent has incurred an expense for an eye exam, eyeglasses or contact lenses, your in-network provider will submit an itemized billing to the vision benefit insurer. If you use an out-of-network provider, you must submit a claim form with the itemized doctor bill and itemized paid receipt for the eyeglasses or lenses to the vision benefit insurer.

4. Time Limits for Filing Claims

All claims for medical, prescription drug, dental and vision benefits must be submitted within one (1) year from the date you received the service or supply for which claim is being made, or as required by the appropriate insurer. The claim should be accompanied by all completed documentation. If the appropriate insurer does not receive the claim and all documentation necessary for the Plan to decide the claim within this one-year period, the claim will be denied as untimely. The required documentation includes: itemized bills; paid receipts if you are seeking reimbursement; the original enrollment forms and annual updates reflecting the individual in question is

covered; Explanation of Benefits (EOB's) from primary plan, if any; and any other documents and information requested by the appropriate insurer.

B. PAYMENT OF CLAIMS

1. Generally

Medical and dental benefits will be paid directly to the doctor, hospital, or other provider who provided the services unless you prove you paid the provider, in which case reimbursement will be made to you or to the person indicated in a QMCSO or applicable law governing the payment of benefits.

Similarly, reimbursements for vision benefits will be made to you or as required by a QMCSO or applicable law.

2. Plan's Right to Recover Overpayments or Mistaken Payments

If a payment for a claim paid on behalf of you or one of your Dependents is found to be more than the amounts payable under the terms of the Plan or is found to have been made in error, then a refund of the excess or erroneous payment may be requested.

IX CLAIMS REVIEW AND APPEAL PROCEDURES

A. MEDICAL AND PRESCRIPTION DRUG BENEFITS

Claim and appeal procedures for medical and prescription drug benefits are described in the Group Insurance Certificate issued to you by the company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this document.

B. DENTAL BENEFITS

Claim and appeal procedures for dental insurance benefits are described in the Group Insurance Certificate issued to you by the company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this document.

C. VISION BENEFITS

Claim and appeal procedures for vision insurance benefits are described in the Group Insurance Certificate issued to you by the Company providing such benefits identified in the "Important Contact Information for Benefits" section at the beginning of this document.

D. MISCELLANEOUS PROVISIONS PERTAINING TO CLAIMS AND APPEALS

You may designate another person to act as your authorized representative for purposes of the Plan's claims and appeals procedures. Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), to designate an authorized representative you will need to fill out a form which may be obtained from the Fund Office.

Under federal law you have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act ("ERISA") if you are dissatisfied with the decision on appeal. Before bringing such an action you must exhaust the applicable claims and appeals procedure. Any such action under ERISA must be filed within two years of the date on which your appeal was denied.

E. ASSIGNMENT OF BENEFITS

No individual covered under this Plan has the right to anticipate, alienate, sell, transfer, pledge, assign or otherwise encumber any interest in benefits payable under the Plan. Further, no individual covered under this Plan has the right to anticipate, alienate, sell, transfer, pledge or otherwise encumber any right (legal, equitable or otherwise) to which he or she is entitled by virtue of coverage under the Plan, including but not limited to, requesting documents or filing any court proceeding. At the discretion of the applicable insurer, all or a portion of benefit payable under the Plan may be paid directly to the hospital or provider that renders the services being claimed. Such direct payment does not violate any attempted assignment or other action prohibited under this section.

X DEFINITIONS

GENERALLY

Because the Fund provides benefits on a fully insured basis each individual insurance provider may have special meanings for various terms. If a word or phrase in this Summary Plan Description has a special meaning it will be capitalized. If a Participant needs clarification for any capitalized word in this Summary Plan Description not defined within this Article, the Participant should consult the Group Insurance Certificate for the particular benefit insurer in question. If you do not have, or have lost, any of the applicable Group Insurance Certificates copies may be obtained by contacting the Fund Office:

International Alliance of Theatrical Stage Employees
Local 6 Health & Welfare Fund
6525 Centurion Drive
Lansing, MI 48917
(517) 321-7502

This section will contain definitions that are generally applicable to benefits provided under the Plan. The terms listed in this Article shall have the meaning set forth below whenever the capitalized term is used in this document.

1. **Active Work on a Full-time Basis**
The Performance of work by the Member for their employer, either at their customary place of employment or such other place or places as required by their employer in the course of such work for the full number of hours and full rate of pay in accordance with the established employment practices of their employer and with respect to Members whose employment is covered by a Collective Bargaining Agreement, in accordance with the applicable provisions of that Agreement.

2. **Active Qualifying Participant**
A Member on whose behalf Contributing Employers have made the minimum amount of Contributions to the Trust during the most recently ended Qualifying Period to qualify for coverage under the Plan. The Contribution amount is subject to change per Qualifying Period as determined by the Trustees.

3. **Benefits**
The health and welfare benefits provided pursuant to this Plan.

4. **Collective Bargaining Agreement**
Any written agreement governing the wages, hours and conditions of employment of Members which has been entered into by and between the Union and one or more Employers.

5. **COBRA**
The Consolidated Omnibus Budget Reconciliation Act of 1986.

6. **Contributions**
Monies paid to the Fund on behalf of Members by Contributing Employers in accordance with a Collective Bargaining Agreement. Member Contributions shall be monies paid to the Fund by Members in order to maintain coverage.

7. **Contributory Basis**
The conditions under which attaining or maintaining coverage under the Plan requires Member Contributions.

8. **Contributing Employer**
Any employer who has entered into a Collective Bargaining Agreement or agreement to make Contributions on behalf of a Member.

9. **Copayment**
A specified dollar amount of the Maximum Allowable Amount for Covered Services you must pay as a condition of the receipt of certain services as provided in this Plan or the appropriate providers group insurance Certificate. There may be more than one Copayment charged by the same Provider on the same day.

10. **Covered Services**
The services and supplies provided to you for which the Plan will make payment, as described in the Summary Plan Description and Group Insurance Certificates.

11. **Deductible**
The dollar amount of Covered Services, listed in the applicable Schedule of Benefits for this Summary Plan Description or Group Insurance Certificate, which you must pay for before the applicable insurance provider will pay for those Covered Services in each Insured Period.

12. **Dependent**
Those individuals eligible for dependent coverage as set forth in Section 2.B..

No person may be covered as a dependent of more than one Member. For purposes of this Plan, each person shall derive eligibility through a Member.

13. **ERISA**
The Employee Retirement Income Security Act of 1974, as amended by law.

14. **Effective Date of Coverage**
The applicable date as set forth in Section II.

If at any time during the day immediately preceding the date any coverage of a Member would otherwise first become effective the Member was, by reason of injury or sickness, unable to perform Active Work on a Full-time Basis, whether or not the Member was scheduled to work on such preceding day, such coverage shall not become effective until such time on or after the date that the Member returns to Active Work on a Full-time Basis. However, this provision will not apply to a Member if, on such preceding day, the Member was covered for the Benefits provided under the respective Article to which this provision applies.

15. **Fund**
The International Alliance of Theatrical Stage Employees Local 6 Health and Welfare Fund.

16. **Insured Period**
The period during which the total amount of yearly benefits under your coverage is

calculated. The Insured Period is the period of twelve (12) consecutive months commencing on September 1 and ending August 31 of each respective year.

17. **Maximum Allowable Amount**
The maximum amount that the applicable insurance provider will pay for Covered Services you receive.

18. **Medicare**
The programs of health care for the aged and disabled established under Title XVIII of the Social Security Act of 1965.

19. **Member**
A person who is or has been an employee of any Contributing Employer whose employment is or has been subject to the terms of a Collective Bargaining Agreement.

20. **Member Contributions**
Monies submitted to the Fund by Members or their Dependents whose coverage under the Plan is on a Contributory Basis.

21. **Participant**
Any covered Member. It is an individual who performs work falling under the jurisdiction of the Union for whom one or more Contributing Employers that are required to make Contributions to the Plan.

22. **Plan**
The plan or program of health and welfare benefits established by the Trustees pursuant to this document and any amendments made to this document.

23. **Qualifying Period**
The twelve (12) consecutive month period beginning June 1 and ending May 31 of each respective year.

24. **Trust**
The entity created by the Trust Agreement for the purpose of establishing and administering the Fund and the Plan, and for other purposes as described in the Trust Agreement.

25. **Trust Agreement**
The written agreement establishing the International Alliance of Theatrical Stage Employees Local No. 6 Health and Welfare Trust Fund.

26. **Trustees**
Those individuals elected to serve as fiduciaries of the Trust on behalf of the Union and Contributing Employers.

27. **Union**
International Alliance of Theatrical Stage Employees Local No. 6.

XI ERISA INFORMATION

As a participant in The International Alliance of Theatrical Stage Employees Local 6 Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, your spouse or 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.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department

of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

XII NOTICE OF PRIVACY PRACTICES FOR THE INTERNATIONAL ALLIANCE OF THEATRICAL STAGE EMPLOYEES LOCAL 6 HEALTH & WELFARE FUND

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Review It Carefully.

The International Alliance of Theatrical Stage Employees Local 6 Health and Welfare Fund (the Plan) has a duty under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to outlines its legal obligations regarding your private medical information. The Plan is required by law to:

1. Maintain the privacy of your health information;

2. Give you this notice of the Plan's legal duties and privacy practices with respect to health information about you; and

3. Follow the terms of the notice that is currently in effect.

This notice is effective as of [date of SPD].

A. HOW THE PLAN MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The Plan may use your health information, as described in each category below, for treatment purposes, for payment purposes, and for our health care operations. The Plan has set out for each of these categories an example of how your health information might be used.

1. **Treatment**

The Plan may use or disclose your health information to facilitate your health care treatment. For example, the Plan might disclose information to your health care provider to assist the provider in making a determination on a course of treatment for you or the Plan may disclose your health information to a case manager retained by the Plan.

2. **Payment**

The Plan may use and disclose health information about you for purposes related to payment. For example, the Plan may use your health information to obtain premiums or to determine its responsibility under the Plan. As another example, the Plan may use your health information to coordinate benefits with another health plan.

3. **Health Care Operations**

The Plan may use and disclose health information about you in order to carry-out the day-to-day health care operations of the plan. For example, the Plan may use health information in connection with:

a. legal services;

b. audit services;

c. business planning and development;

d. business management of the Plan; and

e. Contracting for reimbursement; however, consistent with the Genetic Information Nondiscrimination Act (GINA), the Plan is prohibited from disclosing genetic information for underwriting purposes; and

f. Reporting to Trustees as described below.

B. <u>The Plan's Disclosure of PHI to the Trustees</u>

In the course of business practices, the Plan may disclose information to the Board of Trustees of The International Alliance of Theatrical Stage Employees Local 6 Health and Welfare Fund, acting as Plan Sponsor, for reviewing and making determinations regarding an appeal or for monitoring benefit claims or analyzing benefit structure and claim experience including those that may or do involve stop-loss insurance. Generally, the Plan will disclose PHI to the Plan Sponsor only if necessary for Plan operations. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law;

2. Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to Plan Sponsor with respect to such information;

3. Not use or disclose PHI for employment-related actions and decisions;

4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of Plan Sponsor;

5. Report to the Plan's designee any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provide for;

6. Make PHI available to an individual based on HIPAA access requirements;

7. Make PHI available for amendment and incorporate any PHI amendments based on HIPAA amendment requirements;

8. Make available the information required to provide an accounting of disclosures;

9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Health Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Health Plan's compliance with HIPAA;

10. Ensure that the adequate separation between the group health plan and the Plan Sponsor is established as required by HIPAA (45 CFR 164.504(f)(2)(iii)); and

11. If feasible, return or destroy all PHI received from the Health Plan that Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

C. Other Potential Uses and Disclosures

In addition to the general uses and disclosure of your information discussed above, there may be other special situations where it is necessary, and permissible, for the Plan to use or disclose your health information. These situations are discussed below:

1. **As Required by Law**

   The Plan may use or disclose PHI to the extent that such use or disclosure is required by law and complies with and is limited to the relevant requirements of such law.

2. **Public Health Activities**

   For example, the Plan may disclose information to a public health authority for the purposes of preventing or controlling disease.

3. **Reporting Abuse, Neglect or Domestic Violence**

   For example, circumstances may arise where the Plan needs to disclose to appropriate authorities suspected abuse or domestic violence.

4. **Health Oversight Activities**

   The Plan may disclose health information to a government agency conducting an audit. For example, it may be necessary for the Plan to disclose information pursuant to a Medicare audit.

5. **Judicial or Administrative Proceedings**

   For example, the Plan may disclose information pursuant to a court or agency order in a legal proceeding.

6. **Law Enforcement Purposes**

   For example, it may be necessary for the Plan to disclose information to law enforcement officials regarding the identification or location of suspects, fugitives, or missing persons.

7. **Medical Directors, Coroners, and Funeral Directors**

In the event of your death, the Plan may disclose your health information to medical directors, coroners, or funeral directors. For example, disclosure may be necessary for determining a cause of death.

8. **Organ and Tissue Donation**

The Plan may disclose your information to organizations handling organ and tissue donation.

9. **Disclosures to Avert a Serious Threat to Health or Safety**

For example, the Plan may disclose information to appropriate authorities in order to protect the safety of an individual.

10. **For Specialized Government Functions**

The Plan may disclose health information pursuant to certain governmental functions, for example, for military, veteran, or national security activities.

11. **Workers' Compensation**

The Plan may release information in accordance with applicable Workers' Compensation laws.

12. **Disclosures to the Plan Sponsor**

The Plan may disclose health information to the Trustees of the Plan in order to carry out plan administration functions.

D. All Other Uses or Disclosures

The Plan may not use or disclose your health information for any purpose other than as described above without your specific written authorization. You may revoke any such authorization in writing at any time. However, any revocation is limited to the extent that the Plan has already taken action in reliance upon your authorization.

E. YOUR RIGHTS REGARDING HEALTH INFORMATION

Federal law provides you with several rights regarding your health information:

1. **Right to Inspect and Copy Your Health Information**

You have the right to inspect and copy the health information that the Plan maintains about you. You must submit any request to inspect or copy your health information in writing. All such written requests should be forwarded to:

The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6525 Centurion Drive
Lansing, MI 48917
(517) 321-7502
ATTENTION: Privacy Officer

If you request a copy of your information, the Plan may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

2. **Right to Amend Your Health Information**

You have the right to request an amendment to your health information maintained by the Plan, for as long as the information is kept by the Plan. You may wish to request an amendment to your information if you feel that the information is inaccurate or incomplete. You must make any request for amendment in writing. Your request should be submitted to:

The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6525 Centurion Drive
Lansing, MI 48917
(517) 321-7502
ATTENTION: Privacy Officer

A request must state the reason you feel the amendment is necessary.

3. **Right to an Accounting of Disclosures**

You have the right to receive an accounting of certain disclosures of your health information made by the Plan. This accounting does not include disclosures made pursuant to treatment, payment, healthcare operations, or pursuant to your individual authorization.

You must make any request for amendment in writing. Your request should be submitted to:

The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6525 Centurion Drive
Lansing, MI 48917
(517) 321-7502
ATTENTION: Privacy Officer

Your request should state the time period for which you would like an accounting, which cannot to beyond the six (6) years prior to the date of your request. You are not entitled to an accounting of disclosures made prior to April 14, 2004.

You are entitled to one free accounting within any twelve (12) month period. The Plan may charge you a reasonable fee for any other accounting made within this same twelve (12) month period. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

4. **Right to Request Restrictions**

You have the right to request specific restrictions on the Plan's uses and disclosures of your health information. For example, you have the right to request that the Plan not disclose any of your health information for treatment purposes. The Plan does not have to agree to a requested restriction. Agreeing to a restriction is within the sole discretion of the Plan.

5. **Right to Request Confidential Communications**

You have the right to request that the Plan communicate specific information to you in a certain manner or at a certain location, if you feel that the communication might otherwise place you in danger. For example, you may request that an explanation of benefits be sent to your work rather than to your home if you feel that this information may put you in danger if sent to your home.

Any request for a confidential communication must be made in writing and be accompanied by a statement that the confidential communication is necessary to avoid your personal endangerment. All requests should be submitted to:

The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6525 Centurion Drive
Lansing, MI 48917
(517) 321-7502
ATTENTION: Privacy Officer

6. **Right to a Paper Copy of This Notice**

You have the right to receive a paper copy of this notice at any time. To request a paper copy of this notice, please contact:

The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6525 Centurion Drive
Lansing, MI 48917
(517) 321-7502
ATTENTION: Privacy Officer

F. REVISIONS TO THIS NOTICE

The Plan reserves the right to change the terms of this notice. Any changes to this notice will be effective for health information that the Plan maintains about you. Should the Plan revise this notice, it will promptly provide you with a new Notice by mailing you a written copy of the new notice, sending you information on where to find the Notice, or including it in the newsletter that is sent to you periodically from the Welfare and Pension Plans.

G. COMPLAINTS

If you believe your privacy rights have been violated, you have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. Your privacy rights will not be affected by filing a complaint. Further, you will not be retaliated against in any manner for filing a complaint. To file a complaint with the Plan, contact:

The International Alliance of Theatrical Stage Employees Local 6
Health & Welfare Fund
6525 Centurion Drive
Lansing, MI 48917
(517) 321-7502
ATTENTION: Privacy Officer

H. SECURITY RULE

The HIPAA Security Rule addresses the security of electronically maintained protected health information. While security measures have always been in place, the Security Rule requires that certain safeguards be documented in Plan documents. Accordingly, the Trustees have implemented the following measures:

1. Administrative, physical, and technical safeguards have been implemented that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information created, received, maintained, or transmitted on behalf of the Plan;

2. There is adequate separation (or firewall) between the information that is received from the Plan and other employment information and decisions, and this separation is supported by reasonable and appropriate security measures;

3. Any agent, including any subcontractor, to whom the Plan provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and

4. The Trustees will report to the Plan any security incident of which they becomes aware.

I. BREACH NOTIFICATION

The Plan is subject to the HITECH breach notification rules. In the unlikely event that your protected health information is breached, as that term is defined under HITECH, the Plan will provide you with written notice of the breach. The notice will be sent without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. The notice will be written in plain language and will contain the following information:

1. A brief description of what happened, the date of the breach, if known, and the date of discovery;

2. The type of PHI involved in the breach;

3. Any precautionary steps you should take;

4. What the Plan is doing to mitigate the breach and prevent future breaches; and

5. How you may contact the Plan to discuss the breach.

The Plan will also report the breach to the U.S. Department of Health and Human Services.

IN WITNESS WHEREOF, The International Alliance of Theatrical Stage Employees Local 6 Health and Welfare Fund Plan B is hereby adopted effective September 1, 2022.

Tim McDonald	3/25/2025 Date	Sean Smith	Date
~~Joe Rudd~~ Tom Berg	3-25-2025 Date	Jeff Antrainer	3/25/25 Date
~~Eli Barrera~~ Michael Lenek	3/25/25 Date	Maggie Bailey	03/26/25 Date