



IATSE



NATIONAL BENEFIT FUNDS

NATIONAL
HEALTH & WELFARE
FUND
RETIREE-ONLY MEDICAL
REIMBURSEMENT PROGRAM
("MRP") PLAN

Summary Plan Description

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From the Board of Trustees

January 1, 2019

Dear Participant:

We are pleased to present this booklet about the Retiree-Only Medical Reimbursement Program (“MRP”) Plan (the “Plan”) established January 1, 2014. This booklet describes the reimbursement benefits offered by the Plan and the Plan’s eligibility requirements. If you have any questions about the Plan, or would like more information, please contact the Fund Office:

IATSE National Health & Welfare Fund
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204
1-212-580-9092 in New York
1-800-456-FUND (3863) outside New York
Website: www.iatsenbf.org
Email: psc@iatsenbf.org

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INTRODUCTION

The IATSE National Health & Welfare Fund (referred to in this booklet as the “Health Fund” or the “Fund”) was set up to provide health care benefits to eligible participants. It was established as the result of various collective bargaining agreements between employers and the International Alliance of Theatrical Stage Employees, Moving Picture Technicians, Artists, and Allied Crafts of the United States, its Territories and Canada and its Affiliated Locals (the “Union”). These collective bargaining agreements are contracts between employers and the Union that, among other things, require employers to contribute to the Fund on behalf of certain employees. The Retiree-Only Medical Reimbursement Program (“R-MRP”) Plan (“Retiree-Only MRP,” “R-MRP” or the “Plan”) was established on January 1, 2014 to provide reimbursement benefits to those who had been covered by the Fund’s Plan C, and who are no longer working and are enrolled in Medicare Parts A and B. This booklet describes the Plan provisions as of January 1, 2014. To help you understand the defined terms used in this booklet they are capitalized and bolded throughout and included in the glossary at the end of this booklet.

The Plan is administered by a Board of Trustees consisting of representatives appointed by the Union and the contributing employers. The Board of Trustees acts on behalf of you and your fellow Plan participants to manage all aspects of the Fund’s operations.

Although this booklet provides essential information about your benefits, this information is intended only as a summary of the terms under which benefits are provided. Additional information concerning your benefits may be contained in related Plan documents. If there is ever a conflict between this booklet and the official Plan documents, the official Plan documents will govern.

In addition, future changes to the benefits and eligibility rules described in this book will be communicated through newsletters and/or other notices from the Fund Office. Be sure to read all mail from the Fund Office carefully and keep all announcements of Plan changes with this booklet for easy reference. You can also generally find updates on the Fund’s website by logging on to www.iatsenbf.org.

Contacting the Fund Office:

IATSE National Health & Welfare Fund
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204
1-212-580-9092 in New York; or 1-800-456-FUND (3863) outside New York
Website: www.iatsenbf.org
Email: psc@iatsenbf.org

OVERVIEW OF THE PLAN

What Benefits Does the Retiree-Only MRP Plan Provide?

The R-MRP reimburses medical expenses permitted by the IRS. See the list of qualified expenses on page 12. Generally, the Plan will reimburse you for Medicare/Medicare Advantage (Part C) health insurance premiums, other employer or union sponsored group health insurance premiums and amounts you paid for health care that were not reimbursed by such group insurance or Medicare. Please review the list of qualified expenses on page 13 for the details. You are eligible to be reimbursed for qualified medical expenses up to the amount of your available account balance. You also must be enrolled in the Plan **both** at the time you incur the expense **and at** the time your claim is submitted to the Plan.

You may **not** use your R-MRP balance to purchase **Active Plan C** coverage (C-1, C-2, C-3 or C-4). In addition, your R-MRP balance may never be transferred to an **Active Plan C** CAPP account. If you wish to remain in Plans C-1, C-2, C-3 or C-4 *instead of participating in the R-MRP*, please see the section “What if I Do Not Want to Participate” below. Also note that your R-MRP balance is a notional account that has no cash value.

Who Is Eligible to Participate in the Retiree-Only MRP?

You are eligible to participate in the R-MRP if you have a remaining CAPP balance in the **Active Plan C**, and meet *all* of the following conditions:

- You are age 65 or have a Social Security Disability Award,
- You are enrolled in Medicare Parts A and B, and
- You are not “**Active**” * in Plan C.

*“**Active**” means that the Health Fund has both received employer contributions on your behalf in the applicable **Employer Contribution Period** **and** your **Active Plan C** CAPP account balance is sufficient to cover the cost of one quarter of single coverage under the Plan’s least expensive option (which is Plan C-4 (\$902.00) as of January 1, 2015). If you are still working in employment requiring contributions to the Fund, see the “Continuing to Work” section below for more information about how that will affect your eligibility for the R- MRP.

If you meet the conditions for eligibility, you may also enroll your eligible dependents. (See p. 11 for a definition of eligible dependents.)

(For more information on the rules of the **Active Plan C**, please see the Plan C Summary Plan Description, available on the Fund’s website, www.iatsenbf.org, or upon request from the Fund Office.)

How Do I Enroll Myself and My Dependents in the Retiree-Only MRP?

You need to submit your Medicare identification card indicating enrollment in Parts A and B to the Fund Office and, if you are not yet age 65, a copy of your Social Security Disability Award. Once you submit your Medicare identification card (and Social Security Disability Award, if applicable), you will be automatically enrolled in the R-MRP unless you meet the above definition of “**Active.**”

If you wish to enroll your eligible dependents (generally your spouse or child), you must provide the Fund Office with proof of dependent status (e.g., marriage or birth certificate). You must provide this information when you first enroll in the R-MRP unless your dependents are already enrolled in the **Active Plan C**-MRP (or another **Active Plan C** option) immediately before you enrolled in the R-MRP. If you do not enroll your dependents at the time you first enroll, you may do so later. In that case, your dependent will be enrolled as of the first of the month after your enrollment request (including required proof of dependent status) is received by the Fund Office.

Eligibility and enrollment are determined as of each calendar quarter. If you wish to be enrolled in the R-MRP, the Fund must receive a copy your Medicare identification card for Parts A and B (and Social Security Disability Award, if applicable) and the necessary documents to enroll any dependents by the 15th day of the month prior to the start of the calendar quarter, for example, by December 15 for coverage beginning January 1. You will only need to submit a copy of your Medicare identification card once unless there is a change in your Medicare coverage status.

When Does Coverage Begin?

You will be eligible for benefits as of the start of the first quarter in which you are enrolled as shown in the chart on the next page. Remember, however, that you must be enrolled in the R-MRP **both** at the time you incur the expense *and* at the time you submit your claim to the Plan. Similarly, to obtain reimbursement of your enrolled dependents’ medical expenses, your dependents must have been enrolled both at the time the expense was incurred and at the time that you submit the claim. So, when you first enroll you will not be able to submit any expenses you or they incurred before your enrollment effective date. In addition, if your enrollment is suspended for any period because you are **Active** (as described on page 2), your R-MRP account will be frozen, and if you are subsequently re-enrolled you will not be eligible for reimbursement of any claims incurred by you or your dependents while you were deemed **Active** and while your R-MRP balance was frozen.

What Amounts Are Included in My Retiree-Only MRP Account?

In general, your initial R-MRP account balance is your remaining **Active Plan C** CAPP balance at the time you became enrolled in the R-MRP.

When you first enroll in the R-MRP, your available **Active Plan C** CAPP balance will be irrevocably transferred to your R-MRP account. Your available Plan C CAPP balance will be determined as of the end of the **Employer Contribution Period** applicable to the quarter in which your R-MRP enrollment starts. The **Employer Contribution Period** ends two full months prior to the coverage period. See the chart below for the applicable **Employer Contribution Period** for each **Coverage Quarter**.

Timing of Contributions and Coverage:

EMPLOYER CONTRIBUTION PERIOD	COVERAGE QUARTER
August 1- October 31	January 1 – March 31
November 1- January 31	April 1 – June 30
February 1 – April 30	July 1 – September 30
May 1 – July 31	October 1 – December 31

For example, if you submit your Medicare identification card in early December 2018 and are enrolled in the R- MRP as of January 1, 2019, your starting R- MRP account balance will be the balance in your **Active Plan C** CAPP account as of the end of the applicable **Employer Contribution Period**, which is October 31, 2018. Once you enroll in the R-MRP, and your **Active Plan C** CAPP balance transfers over, those amounts will be available **only** for benefits under the rules of the R-MRP. Your R-MRP balance can never transfer back to your **Active Plan C** CAPP account. If you subsequently return to work requiring employer contributions to the **Active Plan C**, you may be able to transfer your future CAPP balance to your R-MRP account once you cease to be “**Active.**” See the section entitled “Rules for Those Who Work After Medicare Eligibility,” starting on page 6, for more details.

You may review your available account balance by calling the Fund Office at 1-800-456-FUND (3863), by e-mailing the Fund’s participant service center at psc@iatsenbf.org, or by logging into your account on the Fund’s website, www.iatsenbf.org.

How and When Do I Submit Claims?

Claims Deadline: You must submit claims for reimbursement within 12 months from the date of service. Any claims received more than 12 months after the date of service will not be reimbursed. The individual (meaning, you or your dependent) must have been enrolled in the R-MRP both at the time he or she incurred the claim and at the time the claim is submitted to the Fund for reimbursement.

You can obtain a claim form from the Fund's website, www.iatsenbf.org, or from the Fund Office. You must submit a separate completed, signed and dated form for each family member.

You should submit your claims either by mailing them to:

I.A.T.S.E. Health & Welfare Fund
417 Fifth Avenue, third floor
New York, NY 10016
Attention: Claims Unit

Or

You can submit your claims online via the Fund's website at www.iatsenbf.org.

Do I Pay Any Fees to Participate in the Retiree-Only MRP?

The Fund charges an administrative fee for participants enrolled in the R-MRP, currently \$25 per quarter (or any part of a quarter) that you are enrolled in the R-MRP. This fee is automatically deducted from your R-MRP account balance when statements are generated each quarter. However, the Fund will not charge you more than the balance in your account. So, if your account balance is less than the quarterly fee, your fee will be equal to the amount in your account and you will have no available balance for claim reimbursement(s). You will not be charged the R-MRP administrative fee for any quarter your R-MRP account is suspended for that quarter because you were deemed "**Active.**"

In addition, when you submit a claim for reimbursement, an administrative fee will be deducted from the reimbursement for the claim processing expenses.

See the chart below describing the administrative fee to be charged for claim processing.

AMOUNT OF CLAIM ELIGIBLE FOR REIMBURSEMENT	ADMINISTRATIVE CHARGE AS % OF CLAIM
\$1–\$249	5.0%
\$250–\$499	4.5%
\$500–\$999	3.5%
\$1,000–\$1,999	2.5%
\$2,000 or more	2.0%

RULES FOR THOSE WHO WORK AFTER MEDICARE-ELIGIBILITY

If you have worked recently or are continuing to work in employment requiring contributions to the Fund, please review the questions below carefully.

What Happens to Employer Contributions Received After I Enroll in the Retiree-Only MRP?

If the Fund receives any contributions for you while you are a participant in the R-MRP, and you do not meet the Fund’s definition of “**Active**” (see, “Who Is Eligible for the Retiree-Only MRP Plan?” on page 2 above), the amount of any contributions to Plan C will be added to your R-MRP account as of the end of the applicable **Employer Contribution Period**. How the Fund determines if you are **Active**, and what happens if you are, are described in more detail in the questions below.

When and How Does the Fund Determine if I am **Active**?

When You First Submit Your Medicare Identification Card:

When you first submit your Medicare identification card to the Fund Office, the Fund will determine whether or not you are **Active**. Your status (**Active** or **Inactive**) for a **Coverage Quarter** is determined based on the **Employer Contribution Period** applicable to that **Coverage Quarter**. You cannot enroll in the R-MRP if you are considered **Active** for that **Coverage Quarter**. See the chart below as to which **Employer Contribution Period** applies to a given **Coverage Quarter**.

Timing of Contributions and Coverage:

EMPLOYER CONTRIBUTION PERIOD	COVERAGE QUARTER
August 1- October 31	January 1 – March 31
November 1- January 31	April 1 – June 30
February 1 – April 30	July 1 – September 30
May 1 – July 31	October 1 – December 31

For example, if you submit your Medicare identification card in mid-December 2018 seeking to enroll in the R-MRP for coverage starting January 1, 2019, here is how the Plan will determine if you are **Active**. First, the Plan will see if the Health Fund received any contributions between August 1, 2018 and October 31, 2018 (the **Employer Contribution Period** applicable to the **Coverage Quarter** starting January 1, 2019). If no contributions were received on your behalf during that period then you are not **Active**, and you will be enrolled in the R-MRP as of January 1, 2019.

However, if the Fund did receive contributions on your behalf during that period, then the Fund will next look to see if your total Plan C CAPP account balance as of October 31, 2018 would cover the CAPP charge for single coverage under the lowest cost option under **Active Plan C** (C-4 as of January 1, 2019 (\$902)). If the answer is yes, then you are considered **Active** for the entire quarter beginning January 1, 2019 and you cannot be enrolled in the R-MRP for that quarter. You will need to choose which Plan C coverage option you wish to enroll in (C-1, C-2, C-3 or C-4) or the Fund will automatically enroll you in the Plan C-4 Single option. The Fund will continue to review your **Active Plan C** CAPP account each quarter to determine if you are **Active**. Your status (**Active** or **Inactive**) for each **Coverage Quarter** is determined based on the **Employer Contribution Period** applicable to that **Coverage Quarter**. So even if you are not eligible to enroll in the R-MRP for a given quarter because you are **Active**, the Plan will continue to review your status each quarter, and you may enroll as of the first quarter that you are not **Active**. If the Fund has copies of your Medicare identification card on file, it will automatically enroll you in R-MRP for the first quarter that you cease to be **Active**.

Continuing the above example, the Fund would next look at the **Employer Contribution Period** from November 1, 2018 to January 31, 2019 to determine if you are **Active** for the **Coverage Quarter** starting April 1, 2019. If no contributions were received by Health Plan C during that period you are not **Active** and will be enrolled in the R-MRP as of April 1, 2019. Even if the Fund received contributions on your behalf during that period, you would not be considered **Active** if your **Active Plan C** CAPP account balance as of January 31, 2019 was less than the charge for the lowest cost single option (Plan C-4). You would therefore be enrolled in R-MRP (unless you choose to timely enroll in and make the required payment for an **Active Plan C** coverage option).

After You Are Enrolled in the Retiree-Only MRP:

After you first enroll in the R-MRP, the Plan will continue to look at each **Coverage Quarter** to see if you remain **Inactive**. See the section below entitled “What Happens if I Am **Active**?” on page 9, for more information on what occurs if you are determined to be **Active**.

If you are already enrolled in the R-MRP, and then return to employment requiring contributions to **Active** Health Plan C, any contributions received on your behalf will be credited first to Plan C in a CAPP account for you, separate from your R-MRP account. The rules as to whether you are **Active** are generally the same as before you enrolled in the R-MRP Plan, except that the Fund will look only at your **Active Plan C** CAPP balance to determine if it is sufficient to *default you into C-4 single coverage*. *The Fund will **not** look at your R-MRP balance in determining if you are **Active** because that R-MRP balance is available for use only when you are retired (i.e., no longer **Active**).* So, as long as contributions received on your behalf in an employer contribution quarter (plus any prior contributions remaining in your **Active** CAPP account if you were **Active** the prior quarter) are less than the cost of one quarter of the lowest cost single coverage option, which is currently C4, you will not be defaulted into **Active Plan C** coverage and you may use your R-MRP account balance for reimbursements.

For example, assume that as of October 31, 2018 you had an **Active Plan C** CAPP balance of \$2,000 and had not received any contributions to Plan C during the period August 1 to October 31, 2018. If you sent the Fund your Medicare identification card by December 15, 2018, the Fund would enroll you in the R-MRP Plan as of January 1, 2019. (Since you had no contributions during the period August 1 to October 31, 2018 you are not considered **Active** for the quarter beginning January 1, 2019.) Your initial R-MRP account balance is \$2,000 (your **Active Plan C** CAPP balance as of October 31, 2018) and will be available to you as of January 1, 2019 for reimbursement of expenses incurred on or after January 1, 2019. Your **Active Plan C** CAPP balance is now zero.

Assume you return to work in 2019 for a few days and the Fund receives \$50 in Plan C contributions on your behalf in July 2019. The Fund will look *only* at your **Active Plan C** CAPP account balance (\$50) as of July 31, 2019 to determine whether you are **Active** under the Fund’s rules for the **Coverage Quarter** beginning October 1, 2019. Since you do not meet the definition of **Active** based on your **Active Plan C** CAPP account balance (because the amount received in the **Employer Contribution Period** is less than the cost of one quarter of Plan C-4 single coverage), the newly received \$50 in employer contributions will be added to your R-MRP account and will be available for reimbursements submitted on or after October 1, 2019 (the applicable period). Again, once this sum is added to your R-MRP account it is no longer available for **Active** coverage at that time or in the future.

If you wish to remain in **Active Plan C**, even when you are no longer **Active**, please see the question below “Can I Voluntarily Re-Enroll in **Active Plan C**?”

What Happens if I Am **Active**?

If you have not yet enrolled in the R-MRP:

As explained above, if you are **Active**, you cannot enroll in the R-MRP at that time. You will need to wait until the first **Coverage Quarter** that you are no longer **Active** based on the corresponding **Employer Contribution Period**.

If you have already enrolled in the R-MRP:

If, after you were already eligible for and enrolled in the R-MRP, you meet the definition of “**Active**” as explained on page 2, you will automatically be enrolled in the lowest cost single coverage option under Plan C unless you elect a different coverage option and co-pay any necessary difference as shown on the quarterly Plan C statement you receive from the Fund. Your R-MRP balance will be frozen (**but not forfeited**) for any quarter that you are deemed **Active**. You cannot be reimbursed from the R-MRP for any claims **submitted or incurred** during **Coverage Quarters** that you are **Active**. Remember that, under the **Active Plan C**, Medicare does not count as other group health coverage for purposes of being eligible to enroll in the **Active Plan C-MRP** as a stand-alone option, as dictated by the Affordable Care Act (“ACA”).

Once you are enrolled in **Active Plan C** coverage (C-1, C-2, C-3, or C-4) for a quarter then two things happen:

- (i) Medicare becomes your *secondary coverage*, and Plan C becomes your primary coverage. Medicare will only pay expenses **AFTER** receiving a statement of payment (an Explanation of Benefits (EOB)) from Plan C. Medicare rules, which the Fund must follow, require that Plan C become primary and Medicare become secondary in this situation.
- (ii) Your R-MRP balance is frozen for that quarter and cannot be used for any medical reimbursements until you are no longer considered **Active** or actively enrolled in one of the Plan C coverage options. If you work enough to have “excess funds” in your **Active Plan C** CAPP account, you will be entitled to use such excess funds for the **Active Plan C-MRP** plan in accordance with current Plan provisions as described on page 27 of the **Active Plan C** Summary Plan Description (SPD).

Once you no longer meet the definition of “**Active**” as described above then you can once again use your R-MRP account balance for medical reimbursements and any remaining **Active Plan C** CAPP account will irrevocably become part of your R-MRP account (unless you elect otherwise, as described below under “Can I Voluntarily Re-Enroll In **Active Plan C**?”). However, you cannot be reimbursed from the R-MRP for claims incurred during any quarter that you were deemed **Active**. As long as you remain **Inactive**, the amount of any employer contributions received on your behalf for each **Employer Contribution Period** will be added to your R-MRP balance

unless, as described below, you affirmatively enroll in **Active Plan C** coverage or elect in writing to stay in **Active Plan C**.

Can I Voluntarily Re-Enroll in **Active Plan C**?

Even if you do not meet the definition of “**Active**,” you are eligible to enroll in one of the **Active Plan C** options (C-1, C-2, C-3 or C-4) if your **Active Plan C** CAPP account balance (excluding any amounts credited to the R-MRP) qualifies you for optional enrollment, meaning that your **Active Plan C** CAPP account balance equals at least the cost of one month of Plan C-3 single coverage plus the \$150 administrative charge (or one month of Plan C-2 single coverage plus \$150 if you were never enrolled in **Active Plan C**). If you are eligible for optional enrollment you will receive a quarterly enrollment form from the Fund. However, you must enroll in an **Active Plan C** option and make any necessary co-payment by the deadline described on the enrollment form, or make a timely written election as described below. Otherwise, since you do not meet the definition of “**Active**,” the amounts contributed to your **Active** CAPP account will be permanently credited to your R- MRP account.

If you have an R-MRP account and the total contributions received by the Fund on your behalf are less than the cost of one month of Plan C-3 single coverage (plus the \$150 administrative fee), you will **not** receive a quarterly enrollment form, as you have not met the requirements for optional enrollment under the **Active Plan C** rules. However, if you wish to have those contributions remain in your **Active Plan C** CAPP account and accumulate toward future **Active** coverage under the **Active Plan C** rules (rather than becoming part of your R-MRP account) you must elect that in writing by the deadline for electing coverage (generally the 15th of the month prior to the start of the **Coverage Quarter**). Please contact the Fund Office for an election form. If you do not make this election to keep your CAPP balance in **Active C Plan**, your future employer contributions will be permanently included in your R-MRP account as long as you are **Inactive**, and the contributions will not be available for **Active Plan C** coverage, as explained above.

How Long Is My R-MRP Account Balance Available?

Your R-MRP account balance will remain available to you as long as you remain **Inactive** and until it is exhausted (through reimbursement of claims and payment of administrative expenses). The balance is not subject to the **Active Plan C** forfeiture rules. As noted above, if your R-MRP account balance is frozen for any quarter because you are **Active**, it will become unfrozen and available to you as of the first of the **Coverage Quarter** that you are no longer **Active** (as long as you do not enroll in **Active Plan C** coverage).

What Happens to My Account Balance After My Death?

If you are still enrolled and have a balance in the R-MRP at the time of your death, it can be used to reimburse any medical expenses incurred before your death. In addition, any of your dependents who were enrolled at the time of your death may continue to submit, and be

reimbursed for, expenses until your account is exhausted. As noted on page 2, the balance can never be paid out as a cash benefit to anyone. If you have no dependents enrolled at the time of your death, your account balance will forfeit twelve months after the date of your death.

OTHER PLAN RULES

Who Is an Eligible Dependent?

If you are eligible for benefits from the R-MRP, then you may enroll your dependents and receive reimbursement for their qualified medical expenses in addition to your own. The following individuals may be enrolled as your dependent:

- Your spouse.
- Your children, through the end of the calendar year in which they turn 26. Your “children” means your natural children, stepchildren, children recognized under a Qualified Medical Child Support Order (“QMCSO”), defined below, and adopted children (including a proposed adopted child during a waiting period before finalization of the child’s adoption).
- An unmarried dependent child after the year in which they turn 26 if they are totally disabled as supported by a Social Security Disability award and became disabled before age 26.

Qualified Medical Child Support Orders (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute. Orders must be submitted to the Fund Office, which will determine whether the order is a QMCSO as required under federal law. You or your beneficiary can receive a copy of the Plan’s procedures for handling QMCSOs at no cost by contacting the Fund Office. The Plan will provide benefits according to the requirements of a QMCSO, to the extent consistent with the Plan’s rules. The Fund Office will notify affected participants and alternate recipients if a QMCSO is received.

What Are Qualified Medical Expenses?

Medical expenses that can be reimbursed under R-MRP can be either:

- expenses that are not paid in full under Medicare or other employer or union sponsored group medical coverage, or
- your cost of post- tax premiums for qualified medical coverage other than an individual policy obtained through the Health Insurance Marketplace or directly from an insurer (for example, you can be reimbursed for your Medicare premiums or other employer or union sponsored group medical coverage).

In order to qualify for reimbursement under the R-MRP, a health care expense must meet all of the following requirements:

- It is incurred after the effective date of your enrollment in the R-MRP and during a period that you are still enrolled in the R-MRP. (You cannot be reimbursed for claims incurred while you were **Active** under Plan C or before you were enrolled in the R-MRP).
- It is on the list of qualifying expenses that appear later in this section. This includes all the expenses that meet the definition of a “medical expense” as set forth by the Internal Revenue Service (IRS) in IRS Publication 502 (other than premiums for individual health coverage). To see the full list of such expenses and any applicable limits and/or requirements, please go on the IRS website for Publication 502 at <https://www.irs.gov/uac/about-publication-502>.
- It has not been and will not be reimbursed by Medicare or any other coverage.
- It is submitted with appropriate documentation, including:
 - a detailed statement or bill that includes the name, address, phone number and tax ID number of the provider; the patient’s name, address, birth date and relationship to the member; and an itemization and description of the service(s) provided
 - a copy of an Explanation of Benefits (EOB) or other statement from an insurance company (such as your Medicare carrier) or other provider showing denial of reimbursement or proof that the expense is not reimbursable.
- It must be rendered by a licensed provider, in accordance with applicable law.

As noted above, there are two types of qualifying expenses under the R-MRP: qualifying medical coverage premiums and qualifying unreimbursed medical expenses.

Qualifying medical coverage premiums. To qualify for reimbursement, post-tax medical premiums must satisfy all of the following requirements:

- The medical policy or plan must provide you or you and your dependents (who are also enrolled in an employer or union sponsored group health coverage plan or Medicare) with coverage for medical services such as hospitalization, surgery, x-rays, prescription drugs, etc.
- The premium must have been paid after you became enrolled in R-MRP.
- The premium must cover a policy that is in effect at the time reimbursement is to be paid

- The claim must be documented with proof of payment and a description of the medical coverage provided (for example, a premium billing statement and canceled check). In the case of coverage through your spouse's employer, you will be asked to provide proof that an additional premium was paid for your coverage.
- Premiums for life insurance, accidental death and dismemberment insurance, loss of income insurance or automobile insurance are not eligible for reimbursement.

To be eligible for reimbursement under the R-MRP, your expense must be a qualifying medical coverage premium or appear on the list of qualifying unreimbursed medical expenses.

Qualifying unreimbursed medical expenses. Unreimbursed medical expenses that qualify for reimbursement include:

- Abortion
- Acupuncture
- Alcoholism treatment
- Ambulance/Ambulette
- Annual Physical Exam
- Artificial Limb
- Artificial Teeth
- Bandages – You can include in medical expenses the cost of medical supplies such as bandages
- Birth Control Pills
- Body Scan
- Braille Books and Magazines – If you or your eligible spouse and/or dependent is visually impaired, reimbursable expenses include the additional cost of Braille books and magazines in excess of the cost of regular printed editions.
- Breast Pumps and Supplies – Reimbursable expenses include breast pumps and supplies that assist lactation after the birth of a child
- Breast Reconstruction Surgery, breast prostheses and surgical bras following mastectomy or other medically necessary breast surgery.
- Capital Expenses – Reimbursable expenses include special equipment that is installed in your home or any improvements or changes to your house if the main purpose is for medical care for you, your spouse, or your dependent. If the cost of the improvement increases the value of your home, the medical expense will only be the amount in excess of the additional property value. If the value of your property is not increased by the improvement, the entire cost of the special equipment or improvement is a reimbursable medical expense. There are many detailed rules included in IRS Publication 502. You should review those rules carefully and you must complete Worksheet A, the Capital Expense Worksheet, and include it with your claim form for Capital Expenses.

- Car (for persons with disabilities) – Reimbursable expenses include special hand controls and other special equipment installed in a car for the use of a person with a disability. Reimbursable expenses also include the difference in cost between a regular car and a car specifically designed to hold a wheelchair.
- Chiropractor
- Christian Science Practitioner
- Contact lenses
- Crutches
- Dental Treatment
- Diaper Service (must be for a person 3 years of age or older and required to relieve the effects of a particular disease)
- Diagnostic Devices
- Disabled Dependent Care Expenses – Some disabled dependent care expenses may qualify as reimbursable medical expenses if you are not claiming a credit for dependent care on your taxes.
- Drug Addiction treatment
- Drugs – Prescription drugs/medicine only, except for insulin.
- Eye Exam
- Eyeglasses
- Eye Surgery
- Fertility Enhancement
- Guide Dog or Other Service Animal – Reimbursable expenses include the cost of buying, training and maintaining a guide dog or other service animal to assist the visually impaired or hearing disabled person, or a person with other physical disabilities.
- Health Institute – Reimbursable expenses include medical expense fees you pay for treatment at a health Institute only if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness of the individual receiving the treatment.
- Hearing Aids
- Home Care
- Hospital Services
- Insurance Premiums – Reimbursable expenses only include those premiums paid on a post-tax basis. In addition to plans that cover hospital, medical, prescription drugs and dental care, you can also receive reimbursement for premiums for long-term care insurance, Medicare Part B premiums and Medicare Part D premiums. Premiums for individual health policies, including those purchased on Federal or State Health Care Exchanges, may not be reimbursed from the Retiree MRP Plan.
- Laboratory Fees
- Lactation Expenses
- Lead-Based Paint Removal – If you have a child who has or had lead poisoning, reimbursable expenses include the cost of removing lead-based paints from surfaces in your home.

- Legal Fees – Reimbursable expenses include legal fees you have paid that are necessary to authorize treatment for mental illness or those directly related to medical care.
- Lifetime Care – Advanced Payments – Reimbursable expenses include a lump sum fee you pay to a retirement home or institution for future medical care.
- Lodging – Reimbursable expenses include the cost of meals and lodging at a hospital or similar institution if the reason for being there is for medical care. For specific rules and limits on this, please see IRS Publication 502.
- Long Term Care – Reimbursable expenses include amounts paid for qualified long-term care services and premiums paid for qualified long-term care insurance contracts. Reimbursement for premiums are limited based on your age, please see Publication 502 for those limits.
- Medical Conferences – Reimbursable expenses include amounts paid for admission and transportation to a medical conference if the medical conference concerns the chronic illness of yourself, your spouse or your dependent.
- Medicines
- Nursing Home
- Nursing Services
- Operations
- Optometrist
- Organ Donors
- Osteopath
- Oxygen – oxygen and oxygen equipment to relieve breathing problems caused by a medical condition.
- Physical Examination
- Pregnancy Test Kit – Reimbursable expenses include the amount you paid to purchase a pregnancy test kit to determine if you are pregnant.
- Prosthesis
- Psychiatric care
- Psychoanalysis
- Psychologist
- Special Education – Reimbursable expenses include fees you pay on a doctor’s recommendation for a child’s tutoring by a teacher who is specially trained and qualified to work with children who have learning disabilities caused by mental or physical impairments. For more information, please see IRS Publication 502.
- Special Home Costs for intellectually and Developmentally Disabled – reimbursable expenses include the cost of keeping a person who is intellectually and developmentally disabled in a special home on the recommendation of a psychiatrist to help the person adjust from life in a mental hospital to community living, as long as this is not the home of a relative.
- Sterilization
- Stop Smoking Programs
- Surgery

- Telephone – Reimbursable expenses include special telephone equipment that lets a person who is deaf, hard of hearing, or has a speech disability communicate over a regular telephone.
- Therapy
- Transplants
- Transportation – Reimbursable expenses include amounts you pay for transportation primarily for, and essential to, medical care, subject to the limitations described in IRS Publication 502. You will need to provide proof of medical care obtained on the day for which you sought transportation. Receipts or proof of mileage for mileage reimbursement must be included.
- Trips – Reimbursable expenses include amounts you pay for transportation to another city if the trip is primarily for, and essential to, receiving medical services. For additional rules and limits, see Publication 502.
- Vasectomy
- Vision Correction Surgery
- Weight-Loss Program – Reimbursable expenses include amounts you pay to lose weight if it is a treatment for a specific disease diagnosed by a physician. For additional rules and limits, see Publication 502.
- Wheelchair
- Wig – Reimbursable expenses include the cost of a wig purchased upon the advice of a physician for the mental health of a patient who has lost all of his or her hair from a disease.
- X-ray

After all the medical plans under which you're covered have considered a claim and you have received an Explanation of Benefits (EOB) from each of them, you may apply to the R-MRP for any unreimbursed balance of your expense. Reimbursement will be made only to you, not to an insurance company or a medical provider. Do not file a claim if your expense is covered in full by any combination of sources or if it is not a qualifying expense. (See the list of qualifying expenses, above.)

CLAIMS AND APPEALS

Claims

The claims process for submitting requests for reimbursement is described on page 5 (under "How and When Do I Submit Claims?"). You will normally be notified of the decision on your claim within 30 days of receipt of the claim by the Fund Office. The Fund Office may extend that period one time for up to 15 days if the extension is necessary due to matters beyond its control. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time.

If you wish to submit a claim for eligibility under R-MRP, you should submit such claim directly to the Fund Office, at the address below.

IATSE National Health & Welfare Fund
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204

A claim for eligibility is a specific request relating to a particular person for a specified time period. A general inquiry unrelated to a specific benefit claim will not be treated as a claim. You must provide the Fund Office with a written description of the circumstances surrounding your claim so that your claim can be adjudicated properly. The Fund Office will make a decision on the claim and notify you of the decision within 90 days. If the Fund Office requires an extension of time due to matters beyond its control, it will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 90-day period. A decision will be made within 90 days of the time the Fund Office notifies you of the delay. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. Until you supply this additional information, the normal period for making a decision on the claim will be suspended.

Notice of Decision on a Claim

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

- information sufficient to identify the claim involved (including, if applicable, the date of service, the health care provider, and the claim amount)
- the specific reason(s) for the determination, and, upon request, the denial code, if applicable
- a description of the Plan's standard, if any, that was used in denying the claim
- reference(s) to the specific Plan provision(s) on which the determination is based
- a description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary
- a description of the appeal procedures and applicable time limits
- a statement of your right to bring a civil action under **ERISA** Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

Request for Review of Denied Claim

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

All appeals should be sent to the Fund Office for review by the Board of Trustees of the Fund. You must appeal in writing within 180 days after receiving the notice of denial, except that an appeal of an eligibility claim must be made within 60 days after receiving the notice of denial.

Review Process

The review process works as follows:

- You have the right to review, free of charge, documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Fund (or its designee) in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon) in making the benefit determination; it demonstrates compliance with the Fund’s (or its designee’s) administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.
- Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund (or its designee) on your claim, without regard to whether their advice was relied upon in deciding your claim.
- Your claim will be reviewed by a person who is not subordinate to (and shall not afford any deference to) the one who originally made the adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.
- You will also be provided free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before a claim on review is denied based on a new or additional rationale, you will receive the rationale, free of charge.

Timing of Decision on Appeal

Eligibility and medical reimbursement claims appeals are directed to the Board of Trustees of the Fund, which will provide one level of appeal. Ordinarily, decisions on appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a

decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

Notice of Decision on Review

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

- information sufficient to identify the claim involved (including, if applicable, the date of service, the health care provider, and the claim amount)
- the specific reason(s) for the determination, and, upon request, the denial code, if applicable
- a description of the Plan's standard, if any, that was used in denying the claim (in the case of a notice of final internal adverse benefit determination, this description will include a discussion of the decision)
- reference(s) to the specific Plan provision(s) on which the determination is based
- a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- a statement describing the Plan's voluntary appeal procedures and your right to obtain the information about such procedures, if applicable
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of **ERISA** without exhausting these appeal procedures if the Plan has failed to follow them.

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

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you certain rights with respect to your health information, and requires that employee welfare plans, like the IATSE National Health & Welfare Fund, that provide health benefits, protect the privacy of your personal health information. A complete description of your rights under HIPAA can be found in the Fund's Notice of Privacy Practices, which is distributed to new Plan

enrollees and is available from the Fund Office. The statement that follows is not intended and cannot be considered to be the Fund's Notice of Privacy Practices. Your "protected health information" is information about you, including demographic information, that:

- is created or received by the Plan, your health care provider or a health care clearinghouse (and is not related to your non-health benefits under the Fund, e.g., disability)
- relates to your past, present or future physical or mental condition
- relates to the provision of health care to you
- relates to the past, present or future payment for the provision of health care to you
- identifies you in some manner.

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

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

- The Board of Trustees will keep a written record of certain types of disclosures it may make of PHI, so that it may make available the information required for the Plan to provide an accounting of certain types of disclosures of PHI.
- The following categories of employees under the control of the Board of Trustees are the only employees who may obtain PHI in the course of performing the duties of their job with or for the Board of Trustees who obtained such health information:
 - Executive Director
 - all department directors
 - Health & Welfare Fund staff
 - other staff as needed for their jobs.

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

- The employees listed above will be subject to disciplinary action and sanctions for any use or disclosure of PHI that violates the rules set forth in this Summary Plan Description. If the Board of Trustees becomes aware of any such violations, the Board of Trustees will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions and to mitigate any harmful effects to the participants whose privacy has been violated.
- The Board of Trustees will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of PHI received from the Plan in order to allow the Secretary to determine the Plan's compliance with HIPAA.
- The Board of Trustees will return to the Plan or destroy all your PHI received from the Plan when there is no longer a need for the information. If it is not feasible for the Board of Trustees to return or destroy the PHI, then the Trustees will limit their further use or disclosures of any of your PHI that it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

There are also some special rules under HIPAA related to "electronic health information." Electronic health information is generally protected health information that is transmitted by, or maintained in, electronic media. "Electronic media" includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as the internet, an extranet (which uses internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

The Board of Trustees has taken additional steps with respect to the implementation of security measures for electronic protected health information, as follows:

- The Board of Trustees has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.
- The Board of Trustees has ensured that the adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, is supported by reasonable and appropriate security measures.
- The Board of Trustees has ensured that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI.
- The Board of Trustees will report to the Plan any security incident of which it becomes aware concerning electronic PHI.

The Board of Trustees will comply with any other requirements that the Secretary of the U.S. Department of Health and Human Services may require from time to time with respect to electronic PHI by the issuance of additional regulations or guidance pursuant to HIPAA.

Genetic Information Non-Discrimination Act (GINA)

GINA prohibits discrimination by group health plans such as the Plan against an individual based on the individual's genetic information. Group health plans and health insurance issuers generally may not request, require or purchase genetic information for underwriting purposes, and may not collect genetic information about an individual before the individual is enrolled or covered. Pursuant to the applicable requirements of GINA, the Plan is also prohibited from setting premium and contribution rates for the group on the basis of genetic information of an individual enrolled in the Plan.

OTHER INFORMATION YOU SHOULD KNOW

Board of Trustees

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

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

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

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

Collective Bargaining Agreement and Contributing Employers

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

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

RECOVERY OF OVERPAYMENTS

If for any reason benefit payments are made to any person from the Fund in excess of the amount which is due and payable for any reason (including, without limitation, mistake of fact or law, reliance on any false or fraudulent statements, information or proof submitted by a participant, or a participant's failure to timely inform the Fund of relevant information, such as a divorce), the Trustees (or the Plan Administrator or any other designee duly authorized by the Trustees) shall have full authority, in their sole and absolute discretion, to recover the amount of any overpayment (plus interest and costs). That authority shall include, but not be limited to:

- the right to reduce benefits payable in the future to the person who received the overpayment
- the right to reduce benefits payable to a surviving spouse or other beneficiary who is, or may become, entitled to receive payments under the Plan following the death of that person, and/or
- the right to initiate a lawsuit or take such other legal action as may be necessary to recover any overpayment (plus interest and costs) against the person who received the overpayment, or such person's estate.

ASSIGNMENT OF PLAN BENEFITS

Except as otherwise specifically set forth elsewhere in this Plan, authorized by the Plan in writing or required by law, any attempt to assign benefits or rights (including, without limitation, rights to sue) under this Plan are prohibited, whether or not the Plan has made any benefits payments to any third parties.

PLAN FACTS

Official Plan Name	Retiree-Only Medical Reimbursement Program (R-MRP) of the IATSE National Health & Welfare Fund
Employer Identification Number (EIN)	13-3088695
Plan Number	502
Plan Year	January 1 – December 31
Type of Plan	An employee welfare benefit plan that reimburses eligible participants for qualified medical expenses.
Effective Date	The Plan became effective as of January 1, 2014. This Summary contains the rules in effect as of January 1, 2019.
Funding of Benefits	<p>The benefits described in this booklet are provided through employer contributions. The amount of employer contributions and the employees on whose behalf contributions are made are determined by the provisions of the applicable collective bargaining agreements. These agreements set forth the conditions under which the Employer is required to contribute to the Fund and the rate(s) of contribution. The Fund Office will provide to participants and beneficiaries, upon written request and as required by law, information as to whether a particular employer is contributing to the Fund on behalf of employees.</p> <p>Currently, benefits are self-funded, which means they are paid directly out of Fund assets, rather than through an insurance policy.</p>
Trust Fund	All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. The Fund's assets are invested according to guidelines and objectives adopted by the Board of Trustees.
Plan Sponsor & Administrator	The IATSE National Health & Welfare Fund is sponsored and administered by a joint Board of Trustees composed of Union trustees and employer trustees. Employer trustees are selected by the employer associations. Union trustees are designated by the Union. The names and addresses of the Trustees appear in this booklet. They may be contacted at:

	<p>IATSE National Health & Welfare Fund 417 Fifth Avenue, 3rd Floor New York, NY 10016-2204 1-212-580-9092 1-800-456-FUND (3863)</p>
Participating Employers	<p>The IATSE National Health & Welfare Fund will provide you, upon written request, with information as to whether a particular employer is contributing to the Plan on behalf of employees, as well as the address of such employer. Additionally, a complete list of employers and union locals sponsoring the Plan may be obtained upon written request to the Fund Office and is available for examination at the Fund Office.</p>
Agent for Service of Legal Process	<p>In the event of a legal dispute involving the Plan, legal documents may be served on:</p> <p>Anne J. Zeisler, Executive Director IATSE National Health & Welfare Fund 417 Fifth Avenue, 3rd Floor New York, NY 10016-2204</p> <p>Legal process may also be served on any individual Trustee at the Fund Office address.</p>

YOUR RIGHTS UNDER ERISA

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

As a participant in the R-MRP, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Office and at other specified locations, such as work locations and union halls, all documents governing the Plan, including summary plan descriptions, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series).
- Obtain, upon written request to the Fund Office, copies of documents governing the operation of the Plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Fund’s annual financial report. The Trustees are required by law to furnish each participant with a copy of this summary annual report.

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 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 Fund and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under **ERISA**, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington 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.
Toll-Free Publication Hotline: 1-866-444-3272

GLOSSARY TERMS

Active: “Active” means that the Health Fund has both received recent employer contributions on your behalf and you have enough in your **Active Plan C** CAPP to cover the cost of one quarter of single coverage under the Plan’s least expensive option (Plan C-4 as of January 1, 2015).

Active Plan C: The Fund’s Plan C, described in more detail in its Summary Plan Description, available from the Fund Office and on the website, www.iatsenbf.org.

Coverage Quarter: The three consecutive months of a calendar quarter (January-March, April-June, July-September, October-December) during which you are enrolled in by which R-MRP Plan C utilizes the same **Coverage Quarters**.

Employer Contribution Period: The three consecutive months during which contributions received by the Fund on your behalf for Plan C are applicable to a particular **Coverage Quarter**.

ERISA: The Employee Retirement Income Security Act of 1974, as amended, and all regulations issued pursuant thereto.

Inactive: Someone who does not meet the Plan’s definition of “Active”.