I.A.T.S.E. LOCAL 16

HEALTH AND WELFARE TRUST FUND

HEALTH REIMBURSEMENT ARRANGEMENT

SUMMARY PLAN DESCRIPTION

JANUARY 2021
HEALTH REIMBURSEMENT ARRANGEMENT
INTRODUCTION

We are pleased to establish this Health Reimbursement Arrangement ("HRA" or the "Plan") for eligible retirees and eligible spouses of the I.A.T.S.E. Local 16 Health and Welfare Trust Fund (the "Trust") to provide you with additional health coverage benefits by reimbursing you for out-of-pocket expenses that you or your eligible spouse incur for eligible medical expenses. The benefits available under this Plan are outlined in this summary plan description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you become eligible and the laws that protect your rights.

(Note: The HRA is an individual account but is not vested – it is an account established for bookkeeping purposes only.)

Only the Board of Trustees is authorized to interpret the Plan of benefits described in this booklet. No individual Trustee, union representative, or employer representative is authorized to interpret this Plan or Plan documents on behalf of the Board or to act as an agent of the Board. The Board of Trustees has authorized BeneSys (the Fund’s Third-Party Administrator) to respond in writing to written inquiries from Plan Participants. As a convenience to you, BeneSys will provide oral answers regarding coverage on an informal basis. However, no such oral communication is binding on the Board of Trustees.

This booklet contains a summary of the Plan's HRA benefits. In the event a discrepancy exists, the provisions included herein, and any insurance contracts issued to the Board of Trustees shall prevail. Again, we strongly suggest that you read the entire contents of this booklet so that you will be familiar with the HRA. Any questions you may have should be directed to BeneSys, at (925) 398-7043 within the state of California or (855) 704-5273 for out of state, where the staff will be pleased to assist you. The address for BeneSys is 7180 Koll Center Parkway, Suite 200, Pleasanton, California 94566.

This document is a component of the Trust’s summary plan description. Together with the Trust’s General Information booklet, this document constitutes your summary plan description for the Trust’s HRA. Read this document carefully so that you understand the provisions of the HRA and the benefits you will receive.

Foreign Language Notice
This booklet contains a summary in English of your rights and benefits under the I.A.T.S.E. Local #16 Health and Welfare Trust Fund. If you have any difficulty in understanding any part of this booklet, you may contact BeneSys, 7180 Koll Center Parkway, Suite 200, Pleasanton, California 94566, telephone number (925) 398-7043.

Aviso En Español
Este folleto contiene un resumen en inglés de sus derechos y beneficios bajo el I.A.T.S.E. Local #16 Health and Welfare Trust Fund. Si tiene alguna dificultad en comprender cualquier parte de este folleto, puede comunicarse con BeneSys, 7180 Koll Center Parkway, Suite 200, Pleasanton, California 94566, o llamar a los teléfonos (925) 398-7043.

Sincerely,

THE BOARD OF TRUSTEES
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I – ELIGIBILITY

1. What Are the Eligibility Requirements for the HRA?
Medicare eligible retirees (and surviving spouses of retirees) with 35 years of continuous service under the I.A.T.S.E. Pension Plan and Medicare disability retirees are eligible for the HRA. Retirees must have been a participant in the I.A.T.S.E. Health and Welfare Trust Fund as of either:

(a) December 31, 2020 or

(b) For those retiring on or after January 1, 2021, the first day of the month preceding the date the retiree becomes eligible for the HRA described herein

Medicare disability retirees must have been covered under the I.A.T.S.E. Pension Plan for a continuous ten-year period immediately preceding the onset of the disability to be eligible. Medicare eligible spouses of eligible retirees as defined above are also eligible, provided they were married at the time of retirement.
II – BENEFITS

1. What Benefits Are Available?

Benefit plan design:

**Eligible Expenses:** All expenses under IRC Sec 213(d) and premiums are eligible for reimbursement by the HRA. Only expenses incurred by eligible retirees or Medicare eligible spouse are eligible for reimbursement.

**HRA Benefit:** Your HRA has been set up for bookkeeping purposes only – it is NOT a vested account and is subject to amendment or termination at any time and at the sole discretion of the Board of Trustees of the Trust. You may submit claims for reimbursement for one or more of the following—co-payments, co-insurance, deductibles, and health insurance premiums as well as medical care (as defined under Code § 213(d)). Your HRA will be funded $275 per month. An additional $275 per month will be funded for Medicare eligible spouses. Spouses must be married to the retiree prior to the retiree’s HRA eligibility in order to be eligible. HRA contributions commence on the first of the month of the date that your or your spouse’s coverage for the HRA begins.

**Unpaid Claims Rollover:** If your claims exceed your balance at the end of the calendar year the excess claims will rollover to the following calendar year once the new plan year has begun. You may request reimbursement for any unpaid claims with the HRA funds accumulated during the new plan year. However, all claims must be submitted no later than 180 days after the expense was incurred.

**Balance Rollover:** If you do not claim your full balance by the end of the calendar year it will rollover to the following calendar year once the new plan year has begun. However, your HRA funds will be forfeited to the Fund after 24 months of balance inactivity.

**Joint Account:** If you have an eligible spouse, you and your spouse will have a joint HRA account. Both you and your spouse may claim eligible expenses from the total amount in the account.

**Coordination of Benefits**

Only medical care expenses that have not been reimbursed or those for which you will not seek reimbursement from any other source may qualify as Eligible Expenses (to the extent all other conditions for Eligible Expenses have been satisfied). As such, this HRA does not coordinate benefits with any other group or individual health coverage except as provided herein.

2. When Must Expenses Be Incurred?

You may submit expenses that you incur each “Calendar Year.” A new “Calendar Year” begins each year on January 1st. This Plan also permits reimbursements for claims incurred in previous Calendar Years in which you were actively enrolled in the Plan. However, all claims must be submitted no later than 180 days after the expense was incurred.

Expenses are considered “incurred” when the service is performed, not necessarily when it is paid for. Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage.
3. **How do I use the Benefit Card?**
   You will be provided with a prepaid benefit card once you have accumulated an HRA balance of $275. This benefit card will be continuously loaded with the value of your HRA as it becomes available. No claims forms or mailed reimbursement checks will be needed if a benefit card is used, in most cases.

   Each time you incur a qualified health care expense, you may use the benefit card and the amount of the purchase will be deducted from your HRA balance. HRA balances and account details can be viewed online and questions can be directed to the administrative office.

   The IRS requires the benefit card be used only for eligible medical care expenses. The card will only work at health care related providers or stores. In certain situations, you may receive a letter asking you to furnish an itemized receipt to verify the expense. When such a request is received, you must submit the receipts as soon as possible to avoid having your benefit card suspended until receipts are submitted and approved.

   You may check your account balance by visiting [www.iatse16benefits.org](http://www.iatse16benefits.org) or calling the phone number listed on the back of the benefit card.

4. **When Will I Receive Payments From the Plan?**
   During the course of the Calendar Year, you may submit requests for reimbursement of expenses you have incurred to the third-party administrator, BeneSys Administrators. You must make your requests for reimbursements no later than 180 days after the expenses were incurred. BeneSys Administrators will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to BeneSys Administrators proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the timely request qualifies as a benefit or expense that is covered by the HRA, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the HRA are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

5. **What Happens to the HRA Funds in the Case of a Deceased Retiree?**
   HRA funds are transferred to the surviving spouse provided that the spouse is eligible and currently receiving an HRA benefit. If there is no surviving spouse, the balance is forfeited to the Trust.

6. **Forfeiture**
   HRA funds will be forfeited to the Trust after balance inactivity of 24 months.

7. **Overpayments and Fraud**
   If it is determined that you and/or your covered spouse received an overpayment or a payment was made in error (e.g., you were reimbursed for an expense under the HRA that is later paid for by the corresponding medical plan or some other medical plan), you will be required to refund the overpayment or erroneous reimbursement to the Plan. You will receive a First and Second Substantiation notice. If a response is not received, you will be sent a Final Substantiation Letter requesting your repayment and your account suspension until the overpayment is satisfied.

   If you do not refund the overpayment or erroneous payment, the Trust reserves the right to offset future reimbursement equal to the overpayment or erroneous payment. The Plan reserves the right to recover the overpayment plus interest and cost, through whatever means are necessary, including without limitation, legal action or by offsetting future benefit payments to you, your dependent, or you or your dependent’s heirs, assigns, or estates.
The Plan Administrator, the Board of Trustees of the Trust, may audit the Plan to detect fraud or material misrepresentations of fact for health care operations and plan administration functions. Fraudulent claims are not protected health information because they do not relate to the health condition of an individual. Examples of fraudulent claims include claims for services not rendered or claims for services rendered by a provider that does not exist. In the event fraudulent claims are discovered the participant will be required to refund the payment to the HRA. If the participant fails to refund the overpayment, the Trust reserves the right to offset future reimbursements. In addition, if the Trust determines that you have submitted a fraudulent claim, the Trust may terminate, deny suspend, or discontinue your coverage at any time and for any length of time under this HRA, even if you would otherwise be eligible. The Trust may also take any and all action permitted by state and federal law.
III – GENERAL INFORMATION ABOUT THE RETIREE HRA

This Section contains certain general information which you may need to know about the HRA. Refer to the Trust’s General Information Summary Plan Description for additional information about Trust benefits and the Trust.

1. **Plan Administrator Information**
   The name, address and business telephone number of your Plan’s Administrator are:

   **Board of Trustees of the I.A.T.S.E. Local #16 Health and Welfare Trust Fund**
   c/o BeneSys
   7180 Koll Center Parkway, Suite 200
   Pleasanton, California 94566
   Telephone: (925) 398-7043 or (855) 704-5273
   Fax: (925) 462-0108
   Hours of Operation: 8:00 a.m. – 4:00 p.m. PST

   The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. The Plan Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Plan Administrator are conclusive and binding. You may contact the Administrator for any further information about the Plan.

2. **Type of Administration and Funding**
   The HRA is self-funded and administered by the Board of Trustees. The Board of Trustees has delegated day-to-day administration of the HRA and claims administration responsibilities to BeneSys Administrators. Benefits are paid from the assets of the Trust.

3. **How to Submit a Claim**
   When you have a Claim to submit for payment, you must:

   1. Obtain a claim form from the Trust Claim forms may be obtained online at [https://www.ourbenefitoffice.com/IATSE16/Benefits/](https://www.ourbenefitoffice.com/IATSE16/Benefits/)
   2. Complete the Retiree portion of the form. Each reimbursement request must total at least $25 per submission. Recurring claims (e.g. monthly premiums) and high dollar claims (claims over $10,000) can be submitted once to cover a period of twelve months.
   3. Attach copies of all bills and/or Explanation of Benefits (EOB) for which you are requesting reimbursement.
   4. Completed HRA form and required documentation can be faxed, emailed or mailed as follows:

      Fax forms to (925) 297-6655 OR
      Email forms to flexclaims@benesys.com OR providers@iatse16benefits.org
      Mail forms to: I.A.T.S.E. Local 16 Health & Welfare Trust Fund
      P.O. Box 1607
      San Ramon, CA 94583
CLAIMS PROCEDURE

A. Notice of Adverse Benefit Determination and Payment of Claims

Your claim will be paid to you according to the rules of the Plan unless your claim has been properly assigned to your health care provider. If your claim is denied, you will be provided with a written notice of the decision and the procedure for filing an appeal of an adverse claim determination. Any reference to "you" in this section includes you and your Authorized Representative. An Authorized Representative is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. An "Adverse Benefit Determination" is any denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service, supply or benefit under the Plan, or any other rescission of coverage. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retroactive termination of coverage whether or not there is an adverse effect on any particular benefit;
- Coverage determinations, including Plan limitations or exclusions;
- Results of any Utilization Review decision;
- Decision that a service or supply is experimental or investigational;
- Decision that a service or supply is not medically necessary.

B. Claims

The term "claim" means a request for a benefit made by a Participant or Dependent in accordance with the Plan’s procedures. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, if a Participant files a Claim for a specific benefit and the Claim is denied because the individual is not eligible under the terms of the Plan, that coverage determination is considered a Claim.

A Claim made for HRA reimbursement will generally be categorized as a "Post-Service Claim."

Post-Service Claim. The term will generally be a claim for reimbursement for services already rendered.

C. Time Limits for Claims Procedure

Post-Service Claims. You will be notified of the decision not later than 30 days after the Plan’s receipt of the Post-Service Claim. This time period may be extended up to an additional 15 days due to circumstances beyond the control of the Plan. If such an extension is necessary, you will be notified before the end of the initial 30-day period. If the extension is necessary because you failed to submit the information needed to decide the claim, you will have 45 days from receipt of the notice to supply the additional information and will be notified of the claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

Further, in addition to the information described above, the notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. If additional information is needed, you will be afforded at least 45 days to provide the specified information. The deadline for the Board of Trustees to render its decision is tolled from the date on which the notification of the extension is sent to you until the date a response from you is received.
D. **If Your Claim Is Denied**

If all or part of your claim is denied, you will receive a written notice that provides:

- The specific reason(s) for the denial, including references to specific Plan provision(s), as applicable, the denial code and its corresponding meaning, a description of the plan’s standards (as applicable), upon which the denial was based;

- A description of the additional materials or information needed to support your claim and why such information or materials are necessary if the claim was denied because you did not furnish complete information or documentation;

- A statement of your right to bring a civil action under Section 502(a) of ERISA after an adverse benefit determination on appeal;

- Information sufficient to identify the claim involved, including the date of the service, the health care provider, and the claim amount (if applicable);

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;

- For an adverse benefit determination, a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable (the Plan will not consider a request for such diagnosis or treatment information, in itself, to be a request for an internal appeal or an external review);

- A description of the Internal Appeals Procedure and External Review processes, including information regarding how to initiate an appeal and the applicable time limits; and

- A description of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793.

If the claim is denied on the basis of an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion; or include a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

If the claim is denied on the basis of a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request.

Common reasons for denial are:

1. The expenses were incurred during a month that the Employee and/or Dependent was not eligible.

2. The expenses were incurred as the result of any injury which occurred on the job.

3. The expenses were submitted after the 90-day filing limitation following the completion of treatment, or one year after this 90-day period.

4. The expenses were for a non-covered procedure or service.
INTERNAL APPEALS PROCEDURE

If a claim is denied in whole or in part or if the Pharmaceutical Benefit Manager denies your prescription drug claim in whole or in part, you or your authorized representative may appeal the denial. You will have 180 days from the date you receive your written Notice of an Adverse Benefit Determination to appeal the determination to the Plan or its Designee. You may submit written comments, documents, records, and other information relating to your claim in connection with your appeal, whether or not the comments, documents, or other information were submitted in connection with the initial claim. You may also request to receive, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to your claim for benefits.

A. Procedure on Internal Appeal
The review of your appeal will take into account all comments, documents, records, and other information submitted by you that relate to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. In addition, the decision maker on appeal will be different from the decision maker at the initial claim level, as will any health care professional who is consulted at the appeal level. Further, the decision maker on appeal will not be a subordinate of the individual who made the adverse benefit determination that is subject of the appeal.

In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Plan will consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted will not be the individual who was consulted in connection with the denial of the claim that is the subject of the appeal (nor the subordinate of such individual).

Upon request, the Plan will provide the identification of any medical or vocational experts whose advice was obtained on its behalf, as applicable, in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

You are also entitled to the following appeal rights:

- Review your claim file, submit comments, documents, records and other information, evidence, and present testimony in support of your appeal;

- During the course of the determination of your appeal, you will be provided (free of charge) with any new or additional evidence considered, relied upon, or generated in connection with the claim, as well as any new or additional rationale for a denial at the appeals stage as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided and a reasonable opportunity for you to respond to such new evidence or rationale prior to that date; and

- Your coverage will be continued pending the outcome of an appeal that is pursued (this means that benefits for an ongoing course of treatment (concurrent care) will not be reduced or terminated).
B. **Time Limits For Processing Internal Appeals**

**Post-Service Claims.** A decision will be rendered by the Board of Trustees no later than the date of the first Board of Trustees meeting following the Plan’s receipt of the request for review, unless the request for review is filed within 30 days prior to the date of such meeting. In such case, a benefit determination may be made no later than the second Board of Trustees meeting following the Plan’s receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be rendered no later than the third meeting of the Board of Trustees following the Plan’s receipt of the request for review. The Trust Fund Office shall provide you with a written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Trust Fund Office will notify you of the Board of Trustees’ determination of your request for review as soon as possible, but not later than 5 days after the benefit determination is made.

C. **Notice of Final Internal Adverse Benefit Determination on Appeal**

If the Board of Trustees determines that benefits should be paid, the Plan will take whatever action is necessary to pay them as soon as possible.

A “Final Adverse Benefit Determination” is an Adverse Benefit Determination that has been upheld by the Plan at completion of the Plan’s Internal Appeals Procedures or an adverse benefit determination for which the internal appeals procedures have been exhausted under the “deemed exhaustion rules” (explained below in Subsection D.).

If your Appeal is denied, the Notice of Final Internal Adverse Benefit Determination will explain:

- The reason(s) for the denial, including references to specific Plan provisions, denial code(s) and its corresponding meaning, and a description of the Plan’s standards, as applicable, upon which the denial was based, and a discussion of the decision;
- Your entitlement to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim for benefits;
- Your right to bring a civil action under section 502(a) of ERISA (if applicable);
- Information about your right to Independent External Review for certain types of claims (if applicable);
- Information sufficient to identify the claim involved, including the date of the service, the health care provider, and the claim amount (if applicable);

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will state the specific rule, guideline, protocol, or other similar criterion; or include a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request. For Appeal Denial Notice on a Disability-related claim, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist.

If the claim is denied based on a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan, as applicable, to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request.
Upon request, the Plan will provide you with the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any Final Adverse Benefit Determination as soon as practicable (the Plan will not consider a request for such diagnosis or treatment information, in itself, to be a for an external review).

D. Exhaustion of Internal Appeals Process

Generally, you are required to complete all claims and appeal procedures of the Plan before being able bring civil action. However, subject to an exception (explained below) if the Plan does not strictly adhere to all Internal Claims and Appeals requirements under applicable federal law, you are considered to have exhausted the Plan’s appeal requirements (“Deemed Exhaustion”) on the grounds that the Plan has failed to provide a reasonable Internal Claims and Appeals process that would result in a decision on the merits of the claim. If so, and you may pursue any available remedies under ERISA Section 502(a) or under State law, as applicable. You may also initiate an External Review (discussed in the External Review Section below).

There is an Exception to the Deemed Exhaustion rule. The Internal Claims and Appeals process will not be deemed exhausted if:

- Violation was minor and is not likely to cause, prejudice or harm to you; and
- Violation was for good cause or due to matters beyond the Plan or its Designee’s control; and
- Violation occurred in the context of an ongoing, good faith exchange between you and the Plan or its Designee.

This exception is not available if the violation is part of a pattern or practice of violations by the Plan or its Designee.

You may request a written explanation of the violation from the Plan or its Designee, and the Plan or its Designee must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

If a court rejects your request for immediate review on the basis that the Plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.
EXTERNAL REVIEW

A. Time Limits for Processing External Review

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<th>Type of Notice</th>
<th>Standard external Review</th>
<th>Expedited External Review</th>
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<tbody>
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<td>Request for Review</td>
<td>Four months after receipt of denial notice or, if not</td>
<td>First Day of the 5th month following receipt of</td>
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<td>applicable, First Day of the 5th month following receipt of</td>
<td>denial notice.</td>
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<td></td>
<td>denial notice.</td>
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<td>Preliminary Review</td>
<td>Within 5 business Days</td>
<td>Immediately</td>
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<td>Notification of Eligibility or</td>
<td>Within 1 business Day</td>
<td>Immediately</td>
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<tr>
<td>Incomplete Information</td>
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<tr>
<td>Referral to Independent Review</td>
<td>Immediately</td>
<td>Immediately</td>
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<tr>
<td>Organization (IRO)</td>
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<tr>
<td>IRO Notice of Final Review</td>
<td>Within 45 days following receipt of request for external</td>
<td>No later than 72 hours following written request.</td>
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<td>Determination</td>
<td>review.</td>
<td>If notice not in writing, written confirmation</td>
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<td>within 48 hours after date of notice.</td>
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B. Standard External Review of Claims for Benefits

1. **Request for External Review.** If you receive a notice of denial either at the claim level or any of the mandatory levels of appeal with respect to medical, dental or prescription drug benefits, you or your authorized representative have the option to file a written request for an external review by independent review organization ("IRO") selected by the Plan, provided the request is filed within four months after the date of receipt of the denial notice. You may file your request for External Review through the Trust Fund Office. (Note: For prescription drugs, the claims administrator is OptumRx.) If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date falls on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

External review is available only for those claims that involve (1) medical judgment (e.g., a claim that is denied on the basis of medical necessity or because a treatment is experimental or investigational), as determined by the external reviewer; or (2) rescissions of coverage (whether or not the rescission has any effect on any particular benefit at that time); or (3) Plan’s failure to adhere to its Internal Claims and Appeals Process without meeting an exception ("Deemed Exhaustion Rule").

2. **Preliminary External Review.** Within 5 business days of the Plan’s receipt of the request for external review, a preliminary review will be conducted to determine whether the request is suitable for external review. The following determinations will be made:

- Whether you were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- Whether the adverse benefit determination relates to your failure to meet the requirements for eligibility under the Plan (e.g., worker classification or similar determination);
• Whether you have exhausted the Plan’s internal appeal process; and
• Whether you have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, a written notification will be provided to you or your authorized representative as to whether your request is eligible for external review. If the request is complete but not eligible for external review, the notification will include the reason(s) for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification will describe the information or materials needed to make the request complete. The required information must be provided no later than the last day of the four month period after the date of the denial notice (for example, not later than March 1, 2021 for a denial notice dated October 30, 2020) or 48 hours after receipt of the preliminary review notification, whichever is later.

3. **Referral of External Review to Independent Review Organization (IRO).** Requests that are eligible for external review will be reviewed by an accredited IRO selected by the Plan. The IRO will not provide any deference to any prior determination and will not be bound to any decisions or conclusions that were reached by the claims administrator but must follow the Plan document. The assigned IRO will provide you or your authorized representative with a notice inviting you to submit any additional information that you wish the IRO to consider within 10 business days after the date of the notice. (Note: The IRO may, but will not be required to, consider any additional information that is submitted after 10 business days.) Any additional information that the IRO receives from you or your authorized representative will be provided to the applicable claims administrator. Such claims administrator may reconsider its prior denial on the basis of such information. If the denial is reversed and coverage or payment is provided, you or your authorized representative will be notified in writing and the external review will be terminated.

The IRO will review any timely received additional information you or your authorized representative provides and the documents and information that the claims administrator reviewed in connection with its denial (for example, your medical records, attending health care professional’s recommendation, the terms of the Plan, appropriate practice guidelines, any applicable clinical review criteria developed and used by the Plan, the opinion of the IRO’s clinical reviewer(s), etc.). The IRO will provide you or your authorized representative and the Plan with its final external review decision in writing within 45 days after the IRO’s receipt of the request for external review. If the IRO’s decision reverses the claims administrator’s adverse benefit determination or final internal adverse benefit determination, the Plan will provide the coverage or payment for the claim without delay, regardless of whether the Plan intends to seek judicial review of the IRO’s decision and unless or until there is a judicial decision otherwise.

C. **Expedited External Review of Claims for Benefits**

1. **Request for Expedited External Review.** Under certain circumstances, you or your authorized representative have the option to file a written request for an expedited (faster than usual) external review with the Trust Fund Office at the time you receive:

   (1) an adverse benefit determination which involves a medical condition for which the time frame for completion of an expedited internal appeal (urgent care 72 hours) would seriously jeopardize your life, health, or your ability to regain maximum function, and you or your authorized representative submitted a request for an expedited internal appeal; or
(2) a denial of your internal claims appeal determination which involves a medical condition for which the time frame for completion of a standard external review (45 days) would seriously jeopardize your life, health, or your ability to regain maximum function, or your internal claims appeal determination involves an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a health care facility.

To proceed with an Expedited External Review, the following information should be provided: (1) Name, address, and phone number of claimant; (2) Date and description of medical service received; (3) Brief description of reason for disagreeing with Plan’s denial decision; and (4) Whether request is urgent.

2. **Preliminary Expedited External Review.** Immediately following the receipt of your request for an expedited external review, a preliminary review will be conducted. The following determinations will be made:

- Whether you were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

- Whether the adverse benefit determination relates to your failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

- Whether you have exhausted the Plan’s internal appeal process; and

- Whether you have provided all the information and forms required to process an expedited external review.

Immediately after completion of the preliminary review, a written notification will be provided to you or your authorized representative as to whether your request is eligible for an expedited external review. If your request is determined to be ineligible, the notification will include the reasons for your ineligibility. If your request is incomplete, the notification will describe information and other materials needed to complete your request. (Note: The required information must be provided no later than the last day of the 4-month period after the date of the denial notice or 48 hours after receipt of the preliminary review notification, whichever is later. If your request is determined to be eligible, the Plan will immediately notify you or your authorized representative and shall thereafter refer the request to an IRO.

3. **Referral of External Review to Independent Review Organization (IRO).** Requests that are eligible for an expedited external review will be reviewed by an IRO. The Plan will provide or transmit to the IRO, electronically, by telephone or facsimile, or by any other available expeditious method, all necessary documents and information considered in the internal claims for benefits determination. In completing its expedited external review, the assigned IRO will review all of the information and documents submitted to it, in a timely manner and will provide Notice of its final external review determination to you or your authorized representative, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after receiving the request for an expedited review. If this notice is not in writing, written confirmation of the IRO’s determination must be provided to you and the Plan within 48 hours.

To the extent not otherwise prescribed herein, the Plan will comply with the Affordable Care Act’s requirements and guidance.
D. **Waiver of Class, Collective, and Representative Actions**
   By participating in the Plan, to the fullest extent permitted by law, whether in court or otherwise, Participants (including Retirees) waive any right to commence, be a party to in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy, and Participants (including Retirees) agree that any dispute, claim or controversy may only be initiated or maintained and decided on an individual basis.

E. **Exhaustion of Administrative Remedies and One Year Time Limitation to Bring a Lawsuit for Plan Benefits Under ERISA**
   You may not file a lawsuit to claim Plan benefits under ERISA Section 502(a) until you have exhausted all of the Plan’s administrative remedies, including the Plan’s Claims Procedure and Internal Appeal (or, if applicable, a denial after review by an Independent Review Organization).

   A lawsuit under Section 502(a) of ERISA must be filed within one year of the later of the date of the Notice of Final Adverse Benefit Decision/notice of Internal Appeal decision, or, for eligible claims, the date of the notice of the External Review decision.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

Your Health Information and Privacy
The health benefits offered under the Plan use health information about you and your covered dependents only for the purposes of providing treatment, paying claims, and related functions. The Plan’s Privacy Notice is printed here.

To protect the privacy of health information, access to your health information is limited to such purposes. Effective April 14, 2003, the health benefits offered under the Plan will comply with the applicable health information privacy requirements in Title II of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the applicable Federal regulations issued by the Department of Health and Human Services. Specific procedures related to the security of electronically transmitted Protected Health Information (“ePHI”) effective April 20, 2005, are also described below.

Privacy Rule
The Plan has been amended to conform to the “Privacy Rule” as described as follows.

Use and Disclosure of Health Information
The Plan may use your health information, that is, information that constitutes Protected Health Information (“PHI”) as defined in the Privacy Rule of the Administrative Simplification provision of HIPAA, for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment. The Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

The Plan may also disclose health information over the telephone to your spouse, another family member, or a personal representative (such as a Union business agent or Employer representative), for purposes of making or obtaining information about treatment or claims if you provide your oral authorization to the Plan to speak to this person on your behalf. If you do not wish the Plan to release your health information to your spouse, family member or personal representative without prior written authorization, please follow the instructions under the Right to Make Restrictions found in this notice.

To Conduct Health Care Operations. The Plan may use or disclose health information for its own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all Plan Participants. For example, the Plan may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment. The Plan does not provide treatment. However, the Plan may use or disclose your health information to support treatment and the management of your care. For example, the plan may disclose that you are eligible for benefits to a health care provider who contacts the Plan to verify your eligibility.

For Treatment Alternatives. The Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. The Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.
Public Health Risks. The Plan may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if the Plan believes a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

For Disclosure to the Plan Sponsor. The plan sponsor represents that adequate separation exists between the Plan and plan sponsor so that PHI will be used only for Plan administration. As a jointly trusteed multiemployer trust fund which contracts with a third-party administrator, the plan sponsor has no employees. No person under the control of the plan sponsor has access to your PHI. The Plan may disclose your health information to the plan sponsor for Plan administration functions performed by the plan sponsor on behalf of the Plan. Such administration shall include, but is not limited to, the following purposes: appeals of adverse benefit determinations, financial oversight, data analysis, COBRA administration, coordination of benefits, and Plan design. The Plan also may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from other health plans or modify, amend or terminate the Plan.

As a condition for obtaining PHI from the Plan and other insurers that may participate in the Plan, the plan sponsor agrees to:

- Use or disclose any PHI received from the Plan only as permitted by the Privacy Rule or as required by law.
- Require each of its subcontractors or agents to whom the plan sponsor may provide PHI to agree to the same restrictions and conditions that apply to the plan sponsor with respect to PHI.
- Bar the use or disclosure of PHI for employment-related actions or decisions or in connection with any other employee benefit plans sponsored by the plan sponsor.
- Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures authorized by the Privacy Rule of which it becomes aware.
- Make your PHI available for purposes of your request for inspection or copying.
- Make PHI available to the Plan to permit you to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and incorporate such amendments as is allowed under the Privacy Rule.
• Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule.

• Make its internal practices, books and records relating to the use and disclosure of PHI available to the Plan and to the Secretary of the U.S. Department of Health and Human Services ("DHHS") for the purpose of determining the Plan’s compliance with the Privacy Rule.

• If feasible, return to the Plan or destroy all PHI received from the Plan in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the plan sponsor agrees to restrict, and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

• Use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

When Legally Required. The Plan will disclose your health information when it is required to do so by any Federal, state or local law.

Organ and Tissue Donation. If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

To Conduct Health Oversight Activities. The Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection with Judicial and Administrative Proceedings. As permitted or required by state law, the Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by state law, the Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Coroners, Medical Examiners and Funeral Directors. The Plan may release your health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release your health information to funeral directors as necessary to carry out their duties.

In the Event of a Serious Threat to Health or Safety. The Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. Any disclosure would be to someone able to help prevent the threat.

For Specified Government Functions. In certain circumstances, Federal regulations require the Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.
For Workers’ Compensation. The Plan may release your health information to the extent necessary to comply with laws related to Workers’ Compensation or similar programs.

Authorization to Use or Disclose Health Information
Other than as stated above, the Plan will not disclose your health information without your written authorization. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

Your Rights With Respect to Your Health Information
You have the following rights regarding your health information that the Plan maintains:

- **Right to Request Restrictions.** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Plan’s disclosure of your health information to someone involved in the payment of your care. However, the Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the Privacy Officer at BeneSys.

- **Right to Receive Confidential Communications.** You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. You may be required to provide a statement that disclosure of your health information could endanger you. For example, you may ask that the Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Privacy Officer at BeneSys. The Plan will attempt to honor your reasonable requests for confidential communications.

- **Right to Inspect and Copy Your Health Information.** You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Privacy Officer at BeneSys. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. The Plan may deny your request in limited situations.

- **Right to Amend Your Health Information.** If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made as long as the Plan maintains the information. A request for an amendment of records must be made in writing to the Privacy Officer at BeneSys. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Plan, if the health information you are requesting to amend is not part of the Plan’s records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Plan determines the records containing your health information are accurate and complete.

- **Right to an Accounting.** You have the right to request a list of disclosures of your health information made by the Plan for any reason other than for treatment, payment or health operations. The request must be made in writing to the Privacy Officer at BeneSys. The request should specify the time period for which you are requesting the information but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

- **Right to a Paper Copy of this Notice.** You have a right to request and receive a paper copy of this Privacy Notice at any time, even if you have received this Privacy Notice previously or agreed to receive the Privacy Notice electronically. To obtain a paper copy, please contact the Privacy Officer at BeneSys.
Duties of the Plan
The Plan is required by law to maintain the privacy of your health information and to provide to you this Privacy Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Privacy Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Privacy Notice and to make the new privacy practice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Privacy Notice and will provide a copy of the revised notice to you within sixty (60) days of the change. You have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing to the Privacy Officer at BeneSys. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person
The Privacy Officer is the contact person for all issues regarding patient privacy and your privacy rights. You may contact:

Ms. Melanie Flowers  
I.A.T.S.E. Local #16 Health & Welfare Trust Fund c/o BeneSys Administrators  
700 Tower Drive, Suite 300  
Troy, Michigan 48098  
(248) 813-9800

Effective Date
The Plan’s privacy policies and procedures became effective April 14, 2003.

Security Rule Effective Date
The following are the Plan’s security rules with regard to the creation, receipt, maintenance, storage and transmission of Protected Health Information (“PHI”) via electronic means (“ePHI”).

Use and Disclosure of ePHI. The Plan may use and disclose ePHI, including ePHI for treatment, payment and operations, and such other uses and disclosures as are permitted and required under the HIPAA Privacy Rule and Security Rule, and the representatives of the Plan shall have access to such PHI, including ePHI, as is necessary for them to perform their duties for the Plan.

Trustees’ Use and Disclosure of ePHI. To the extent permitted by law, the Trustees may receive, use and disclose ePHI, if, in the sole discretion of the Trustees, such ePHI is necessary for the Trustees to perform their fiduciary or administrative duties as Trustees. In all cases, the Trustees shall receive, use and disclose the minimum amount of ePHI necessary for the Trustees to perform their functions under the Fund, and shall safeguard such ePHI as required by the Privacy and Security Rules. Each Trustee who receives ePHI from the Fund shall keep such information in strict confidence and shall not use or further disclose the ePHI received from the Fund other than as permitted or required by law and this Agreement or upon the express written permission of the Participant who is the subject of the ePHI.

Procedures. The Fund will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Fund, and will ensure the “adequate separation” within the meaning of 45 C.F.R. Sec. 164.504(f)(2)(iii) of the data.
INFORMATION REQUIRED BY ERISA

NAME OF PLAN. The name of the Plan is:
I.A.T.S.E. Local 16 Health and Welfare Trust Fund Employer Identification Number: 94-6138741
Plan Identification Number: 501

TYPE OF PLAN. The following benefits are for Active and Retired Plan Participants and their eligible dependents:

- Hospital, Medical and Surgical Care
- Dental Care
- Orthodontic Care
- Vision Care
- Prescription Drugs
- Inpatient and Outpatient Mental Health Benefits
- Home Health Care
- Hospice Care
- Durable Medical Equipment
- Immunizations and Inoculations
- Hearing Aids

The following benefits are for **Active Plan Participants and their eligible dependents only**:

- Alcoholism and Drug Addiction Benefits

The following benefits are for **Active Plan Participants only**:

- Supplemental Disability Income Benefits
- Life Insurance Benefits
- Accidental Death and Dismemberment Benefits

PLAN ADMINISTRATOR. The Plan Administrator is the Board of Trustees of the I.A.T.S.E. Local 16 Health and Welfare Trust Fund. The Board of Trustees of the Fund is responsible for the operation of the Fund and is made up of an equal number of Trustees appointed by the participating Employers and by the Union.

BOARD OF TRUSTEES
The current members of the Board of Trustees are:

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<tr>
<th>UNION TRUSTEES</th>
<th>EMPLOYER TRUSTEES</th>
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<tr>
<td>Steve A. Lutge</td>
<td>Debra Bernard</td>
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<tr>
<td>I.A.T.S.E. Local 16</td>
<td>San Francisco Ballet</td>
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<td>240 Second Street</td>
<td>455 Franklin Street</td>
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<tr>
<td>San Francisco, CA 94105</td>
<td>San Francisco, CA 94102</td>
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<tr>
<td>James Beaumonte</td>
<td>Robert Sauter</td>
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<td>I.A.T.S.E. Local 16</td>
<td>Moscone Center</td>
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<tr>
<td>240 Second Street</td>
<td>747 Howard Street, 5th Floor</td>
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<tr>
<td>San Francisco, CA 94105</td>
<td>San Francisco, CA 94103</td>
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<tr>
<td>Scott A. Houghton</td>
<td>Greg Holland</td>
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<tr>
<td>I.A.T.S.E. Local 16</td>
<td>Broadway San Francisco</td>
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<tr>
<td>240 Second Street</td>
<td>1182 Market Street, Suite 200</td>
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<tr>
<td>San Francisco, CA 94105</td>
<td>San Francisco, CA 94102</td>
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<tr>
<td>Kenneth M. Ryan</td>
<td>Lance &quot;R.B.&quot; Hughston II</td>
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<tr>
<td>I.A.T.S.E. Local 16</td>
<td>Hughston Engineering Inc.</td>
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<tr>
<td>240 Second Street</td>
<td>150 Starlite Street</td>
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<tr>
<td>San Francisco, CA 94105</td>
<td>South San Francisco, CA 94080</td>
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TYPE OF ADMINISTRATION

Certain administrative services are provided to the Fund through a contract with a Third-Party Administrator who is retained by the Board of Trustees and compensated by the Fund under the direction of the Board of Trustees.

The Third-Party Administrator processes all claims for benefits (except for life insurance, accidental death and dismemberment benefits) covered under the Plan on behalf of the Plan Participant(s).

Records concerning eligibility to Participants in the Plan are maintained by the Fund. For purposes of receipt of employer contributions and determination of eligibility, the Plan is self-administered.

ADDRESS OF THE FUND AND THE THIRD-PARTY ADMINISTRATOR

I.A.T.S.E. Local 16 Health and Welfare Trust Fund
c/o BeneSys
7180 Koll Center Parkway, Suite 200
Pleasanton, California 94566
Telephone: (925) 398-7043 or (855) 704-5273
Fax: (925) 462-0108
E-mail: funds@local16.org

AGENT FOR SERVICE OF LEGAL PROCESS

Ms. Rachel Mora is designated by the Board of Trustees as the Agent of the Trust Fund for service of legal process. She can be reached at:

BeneSys
7180 Koll Center Parkway, Suite 200
Pleasanton, California 94566

Service of legal process may also be made upon any Fund Trustee.

COLLECTIVE BARGAINING AGREEMENTS

The I.A.T.S.E. Local 16 Health and Welfare Trust Fund is maintained pursuant to collective bargaining agreements between I.A.T.S.E. Local 16 and the Employers who are parties to these bargaining agreements. A plan is maintained under a CBA if the CBA controls any duties, rights, or benefits under a plan. Copies of the bargaining agreements may be obtained upon written request to the Fund and are available for inspection during normal business hours.

As a Participant in this Plan you may obtain, upon written request to the Fund, information as to whether or not a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a Plan sponsor, the sponsor's address.

SOURCE OF CONTRIBUTIONS

Contributions to the Plan are made by Employers in accordance with collective bargaining agreements with I.A.T.S.E. Local 16, pursuant to the provisions of the Trust Agreement.

The collective bargaining agreements require contributions to the Plan based on a percentage of gross wages including vacation pay.

SOURCES OF PLAN BENEFITS

Hospital, medical, dental and vision benefits are paid in accordance with the Plan provisions out of Fund assets, which are used solely for that purpose and for defraying reasonable administrative expenses. Prescription drug benefits are administered by OptumRx, who is the Fund’s Pharmaceutical Benefit Manager, and paid by the Fund.
Life Insurance and Accidental Death and Dismemberment benefits are paid through an insurance policy between the Fund and Sun Life Financial. Medical benefits are insured for total covered medical claims covered by the Fund exceeding $200,000 per individual per Plan Year. Neither the Fund nor its Board of Trustees assume any liability to provide payment for claims over and beyond the amounts in the Fund available for the purpose of paying claims.

Addresses for the providers directly servicing participants are as follows:

Anthem Blue Cross of California  
21555 Oxnard Street, 5-D  
Woodland Hills, CA 91367

Teamsters Assistance Program of Northern California  
300 Pendleton Way  
Oakland, California 94621-2102

OptumRx  
5995 Plaza Drive  
Cypress, CA 90630

CIGNA Dental  
701 Fifth Avenue, Suite 4900  
Seattle, Washington 98104

Sun Life Assurance Company of Canada  
One Sun Life Executive Park  
Wellesley Hills, MA 02481

**PLAN YEAR.** The Plan Year starts each January 1 and ends each December 31.

**TRUST FUND RECORDS**  
The financial records of the Plan are kept on a Plan Year basis.

**TRUST FUND PROFESSIONALS**  
In accordance with prudent management standards, the following professionals are retained by the Fund to assist the Board of Trustees in the operation of the Plan:

1. A consulting actuary, who assists the Board of Trustees in technical matters relating to the operations of the Fund, such as the design of benefit programs and eligibility provisions, analysis of emerging loss experience, benefit expense, projections, specifications for competitive bids when necessary, and defining adequate reserve requirements.

2. Legal counsel, who assists and counsels the Board of Trustees on all legal matters, including interpretations of the many laws and regulations under which the Fund operates.

3. A Certified Public Accountant is responsible for auditing the records of the Fund and final preparation of financial statements in accordance with generally accepted auditing and reporting standards.

4. An investment consultant who assists the Board of Trustees in the investment of the Fund’s assets.
DISCRETIONARY AUTHORITY OF THE BOARD OF TRUSTEES
Nothing in this booklet is meant to extend or change in any way the provisions of the Plan or the insurance policies or service agreements. The Board of Trustees of the Fund reserves the right to amend, modify or discontinue all or part of the Plan whenever, in its judgment, conditions so warrant.

The Board of Trustees reserves the right to make any determination of fact necessary or proper to the administration of this Fund. Further, the Trustees shall have the power to construe and interpret the provisions of the Trust Agreement and Plans of Benefits relating to eligibility of Active Plan Participants, Retired Plan Participants, their dependents and beneficiaries to receive benefits. Such determinations shall be final and binding upon all parties, including Plan Participants, Retired Plan Participants, their dependents and beneficiaries.

FUTURE OF THE PLAN AND TRUST
The Board of Trustees anticipates that the Plan and the Trust will continue as long as collective bargaining agreements so provide or until the bargaining parties elect to discontinue the Plan or Trust. If the Plan or Trust is terminated, the remaining assets will be used to continue to provide benefits until there are no assets remaining. In no event will termination of the Plan or Fund result in the reversion of assets to any Employers.
STATEMENT OF ERISA RIGHTS

As a Plan Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that Plan Participants are entitled to:

Receive Information About Your Plan and Benefits

- You can examine, without charge, at BeneSys and at other specified locations (such as worksites and local unions) all documents governing the Plan, including insurance contracts, 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 Employee Benefits Security Administration.

- You can obtain, upon written request to the Board of Trustees or BeneSys, copies of all 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 an updated summary plan description. (A reasonable charge may be made for the copies.)

- You should receive a summary of the Plan’s annual financial report. The Fund is required by law to provide a copy of this summary annual report to each Plan Participant.

Continued Group Health Plan Coverage

You can continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review your summary plan description and the documents governing the Plan for 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. These people, called “fiduciaries” of the Plan, have a duty to operate your plan 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 covered 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 (within certain time schedules) to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial.

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 your copies 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, and you have exhausted the Plan’s claims and appeals procedures starting on page 46, 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 a federal court. In the event your claim is denied in the course of your exhaustion of the Plan's administrative remedies set forth in the Plan's Claims and Appeals procedures, you must commence any lawsuit under Section 502(a) of ERISA respecting such claim not later than the first anniversary of the date of the written notice of decision on the appeal denying such claim.

You may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court if Plan
fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights.

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 (e.g., if it finds your claim is frivolous.)

Assistance With Your Questions
If you have any questions about the Plan, you should contact BeneSys. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from BeneSys, 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 at (866) 444-3272.