

**THEATRICAL STAGE EMPLOYEES HEALTH AND WELFARE TRUST  
HEALTH REIMBURSEMENT ARRANGEMENT  
SUMMARY PLAN DESCRIPTION**

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## Introduction

We are pleased to establish this Health Reimbursement Arrangement to provide you with health coverage benefits. 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.

Read this summary plan description carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a plan document on file, which you may review if you desire. In the event there is a conflict between this summary plan description and the plan document, the plan document will control.

## I - Eligibility

### 1. What Are the Eligibility Requirements for Our Plan?

You will be eligible to join the Plan once you have enrolled in the Core Medical Plan.

### 2. When is My Entry Date?

Once you have met the eligibility requirements, your entry date will be the same day you enter our group medical plan.

### 3. Are There Any Employees Who Are Not Eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

- Employees who are not eligible to participate or waive coverage under our Core Medical Plan.

## II - Benefits

### 1. What Benefits Are Available?

Benefit plan design:

Eligible Expenses: Deductible expenses associated with the Trust sponsored medical plan.

Benefit: Reimbursements will be issued as indicated below.

Prescription	Deductible, Coinsurance, & Copayment
0% of the first \$2000; 100% of the last \$2,000	0% of the first \$2,000; 100% of the last \$2,000
Max Reimbursement:	Max Reimbursement:
Employee and Dependents: \$2,000	Employee and Dependents: \$2,000

How it Works:

You are permitted to permanently opt out of and waive future reimbursements from the HRA at least annually. Any balance in your HRA will be forfeited to the Trust. This opt-out feature is required because the benefits provided by the HRA generally will constitute minimum essential coverage under Code § 5000A and will therefore preclude the participant from claiming a Code § 36B premium tax credit.

Your HRA is integrated with a Trust's group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements. The Trust's group health plan meets minimum value. Integrated means (1) the Trust's group health plan does not consist solely of excepted benefits; (2) the employee receiving the HRA is actually enrolled in a group health plan (of the Trust or spouse); (3) the HRA is available only to employees who are enrolled in the group health plan of the Trust or spouse; (4) the HRA is limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care (as defined under Code § 213(d)); and (5) under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA. This opt-out feature is required because the benefits provided by the HRA

generally will constitute minimum essential coverage under Code § 5000A and will therefore preclude the individual from claiming a Code § 36B premium tax credit.

### **Changes to Coverage**

If you change your level of coverage under the corresponding medical plan during the Plan Year (e.g. single to family/family to single or part-time to full-time/full-time to part-time) there is no change to your annual HRA dollar allocation.

### **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 Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). As such, this HRA does not coordinate benefits with any other group or individual health coverage except as provided herein.

### **Women's Health and Cancer Rights Act**

This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

#### **2. When Must Expenses Be Incurred?**

You may submit expenses that you incur each "Plan Year." A new "Plan Year" begins each year on January 1st.

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. When Will I Receive Payments From the Plan?**

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than 90 days after the end of the Plan Year. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

#### **4. What Happens If I Terminate Employment?**

If your employment is terminated during the Plan Year for any reason, your participation in the Plan will cease and any unused amounts are forfeited. You will have 90 days from when you terminated or retired to turn in claims for expenses that were incurred prior to your date of termination.

You are permitted to permanently opt out of and waive future reimbursements from the HRA upon termination of employment. Any balance in your HRA will be forfeited to the employer. This opt-out feature is required because the benefits provided by the HRA generally will constitute minimum essential coverage under Code § 5000A and will therefore preclude the participant from claiming a Code § 36B premium tax credit.

You may be eligible to maintain coverage under COBRA, see subsection V for more information.

#### **5. Family and Medical Leave Act (FMLA)**

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA) then to the extent required by FMLA, the Trust will continue to maintain HRA benefits on the same terms and conditions as if you were still an active Eligible Employee.

#### **6. Uniformed Services Employment and Reemployment Rights Act (USERRA)**

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Reimbursement Arrangement under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

**7. Newborns' and Mothers' Health Protection Act**

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**8. Overpayments and Fraud**

If it is later determined that you and/or your covered dependent(s) 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 HRA.

If you do not refund the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, withhold such funds from your pay. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may include the amount on your W-2 as gross income.

The Plan Administrator 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 Plan Administrator reserves the right to offset future reimbursements or withhold such funds from the participant's income. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under this HRA. The Trust may also take any and all action permitted by state and federal law.

**III - General Information About Our Plan**

This Section contains certain general information which you may need to know about the Plan.

**1. General Plan Information**

Health Reimbursement Arrangement is the name of the Plan.

Your Trust has assigned Plan Number 501 to your Plan.

The provisions of your Plan become effective on May 1, 2011

The provisions of your Plan have been amended as of May 1, 2016

**2. Trust Information**

Your Trust's name, address, and identification number are:

Theatrical Stage Employees Health and Welfare Trust  
7525 SE 24<sup>th</sup> Street, Suite 200  
Mercer Island, Washington 98040  
91-0853746

3. **Plan Administrator Information**

The name, address and business telephone number of your Plan's Administrator are:

Theatrical Stage Employees Health and Welfare Trust  
7525 se 24<sup>th</sup> Street, Suite 200  
Mercer Island, Washington 98040  
(206)-441-7574

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 Administrator are conclusive and binding. You may contact the Administrator for any further information about the Plan.

4. **Third Party Claims Administrator Information**

The name, address and business telephone number of the Third Party Claims Administrator are:

Vickie Garner  
Theatrical Stage Employees Health and Welfare Trust  
PO Box 34203  
Seattle, Washington 98124

The Third Party Claims Administrator is responsible for the actual processing of claims on behalf of the Plan Administrator.

5. **Service of Legal Process**

The Trust is the Plan's agent for service of legal process.

6. **Type of Administration**

The Plan is a health reimbursement arrangement. The Plan is not funded or insured. Benefits are paid from the general assets of the Trust.

**IV - Additional Plan Information**

1. **Your Rights Under ERISA**

Plan Participants, eligible employees and all other employees of the Trust may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

- (a) Examine, without charge, at the Administrator's office, all Plan documents, 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.
- (b) Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies.
- (c) Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.
- (d) Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage 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.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Trust or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

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.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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.

## 2. How to Submit a Claim

When you have a Claim to submit for payment, you must:

- (1) Obtain a claim form from the Plan Administrator.
- (2) Complete the Employee portion of the form.
- (3) Attach copies of all bills and/or Explanation of Benefits (EOB) for which you are requesting reimbursement.

A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Notification of whether Claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Denial or insufficient information on the Claim:	
Notification of	15 days
Response by Participant	45 days
Review of Claim denial	30 days

You must file your appeal by submitting a written request by email, fax, or mail. Indicate either level one or two appeal on the email, fax, or letter.

Email: [vickieg@wpas-inc.com](mailto:vickieg@wpas-inc.com)

Fax: 206-441-9110

Mail: Attn: Vickie Garner Theatrical Stage Employees Health Welfare Trust PO Box 34203 Seattle WA 98124.

The Plan Administrator will provide written or electronic notification of any Claim denial. The notice will state:

- (1) The specific reason or reasons for the denial.
- (2) Reference to the specific Plan provisions on which the denial was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502 of ERISA following a denial on review, if applicable.
- (5) A statement that the claimant is 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; and
- (6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

A level one appeal must be submitted within 180 days of receipt of the denial. Any such request should be accompanied by documents or records in support of your appeal. You may review pertinent documents and submit issues and comments in writing. The claims administrator will review the claim and provide, within 30 days, a written response to the appeal (extended by reasonable time if necessary). In this response, the claims administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based.

If you disagree with the level one appeal decision you may submit a request for a level two appeal to be determined by the Trust. You must submit your request for level two appeal within 60 days of receipt of the level one notice. You will be notified within 30 days after the Trust receives the appeal (extended by reasonable time if necessary). The Trust has the exclusive right to interpret the appropriate plan provisions. Decisions of the Trust are conclusive and binding.

Under certain circumstances you may have a right to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Contact the claims administrator for more information.

If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

A document, record, or other information shall be considered relevant to a Claim if it:

- (1) was relied upon in making the Claim determination;
- (2) was submitted, considered, or generated in the course of making the Claim determination, without regard to whether it was relied upon in making the Claim determination;
- (3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants;
- (4) or constituted a statement of policy or guidance with respect to the Plan concerning the denied Claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Claim determination. The review will not afford deference to the initial denial and will be conducted by a

fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

## V - CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under this Arrangement will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Arrangement would otherwise end. This notice is intended to inform Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Participants who become Qualified Beneficiaries under COBRA. The Arrangement itself can provide group health benefits and may also be used to provide health benefits through insurance. Whenever "Arrangement" is used in this section, it means any of the health benefits under this Plan.

### 1. What is COBRA Continuation Coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Arrangement (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event).

### 2. Who Can Become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under the Arrangement by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Arrangement under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Arrangement as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Arrangement under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Arrangement due to his or her performance of services for the Trust sponsoring the Arrangement. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Trust no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

3. **What is a Qualifying Event?**

A Qualifying Event is any of the following if the Arrangement provided that the participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent child's ceasing to satisfy the Arrangement's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Arrangement).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Arrangement under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Trust, any substantial elimination of coverage under the Arrangement occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Arrangement that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Arrangement provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Arrangement during the FMLA leave.

4. **What Factors Should Be Considered When Determining to Elect COBRA Continuation Coverage?**

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's Trust) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

5. **What is the Procedure for Obtaining COBRA Continuation Coverage?**

The Arrangement has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

6. **What is the Election Period and How Long Must It Last?**

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Arrangement. The election period must begin no later than the date the Qualified

Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of a percentage of the premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact/2002act\\_index.asp](http://www.doleta.gov/tradeact/2002act_index.asp).

**7. Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?**

The Arrangement will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Trust will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the employee,
- (3) commencement of a proceeding in bankruptcy with respect to the Trust, or
- (4) enrollment of the employee in any part of Medicare,

**IMPORTANT:**

**For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.**

**NOTICE PROCEDURES:**

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

*Theatrical Stage Employees Health and Welfare Trust  
Attn: Vickie Garner  
PO Box 34203  
Seattle WA 98124*

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,

- the name(s) and address(es) of the Qualified Beneficiary(ies), and
- the Qualifying Event and the date it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include a **copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage would otherwise have been lost (if under your coverage the COBRA period begins on the date of the Qualifying Event, even though coverage actually ends later (e.g., at the end of the month) substitute the appropriate language, e.g. "on the date of the Qualifying Event"). If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

**8. Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?**

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

**9. Is COBRA Coverage Available If a Qualified Beneficiary Has Other Group Health Plan Coverage or Medicare?**

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

**10. When May a Qualified Beneficiary's COBRA Continuation Coverage Be Terminated?**

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Arrangement with respect to the Qualified Beneficiary.
- (3) The date upon which the Trust ceases to provide any group health plan (including a successor plan) to any employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

- (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
- (b) The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Arrangement can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Arrangement terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Arrangement solely because of the individual's relationship to a Qualified Beneficiary, if the Arrangement's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Arrangement is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

#### 11. **What Are the Maximum Coverage Periods for COBRA Continuation Coverage?**

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
  - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
  - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

#### 12. **Under What Circumstances Can the Maximum Coverage Period Be Expanded?**

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36-months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36-months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

#### 13. **How Does a Qualified Beneficiary Become Entitled to a Disability Extension?**

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the

Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

**14. Does the Arrangement Require Payment for COBRA Continuation Coverage?**

For any period of COBRA continuation coverage under the Arrangement, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of any costs. The Arrangement will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

**15. Must the Arrangement Allow Payment for COBRA Continuation Coverage to Be Made in Monthly Installments?**

Yes. The health coverage is also permitted to allow for payment at other intervals.

**16. What is Timely Payment for Payment for COBRA Continuation Coverage?**

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Arrangement by a later date is also considered Timely Payment if either under the terms of the Arrangement, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Trust and the entity that provides benefits on the Trust's behalf, the Trust is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Arrangement does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to those providing coverage.

If Timely Payment is made to the Arrangement in an amount that is not significantly less than the amount the Arrangement requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Arrangement's requirement for the amount to be paid, unless the Arrangement notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

**17. Must a Qualified Beneficiary Be Given the Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage?**

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Arrangement will, during the 180 day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Arrangement. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

**IF YOU HAVE QUESTIONS**

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

**APPENDIX I TO THE HEALTH REIMBURSEMENT ARRANGEMENT SUMMARY PLAN DESCRIPTION**

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PHI ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY

EFFECTIVE DATE: SEPTEMBER 23, 2013

This Notice of Privacy Practices ("Notice") describes the legal obligations of the Plan and your rights regarding your protected health information ("PHI") held by the Health Reimbursement Arrangement (the "Plan"). PHI is defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). PHI generally means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. PHI includes information of persons living or deceased.

This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes permitted or required by law.

We are required by law to:

- maintain the privacy of your PHI;
- provide you with the notice of our legal duties and privacy practices with respect to your PHI; and
- follow the terms of the Notice that is currently in effect.

Your PHI will be disclosed to certain employees of the Trust who assist in administration of the Plan. These individuals may only use your PHI for Plan administration functions including those described below, provided they do not violate the provisions set forth herein. Any employee of the Trust who violates the rules for handling PHI established herein will be subject to adverse disciplinary action. The Trust will establish a mechanism for resolving privacy issues and will take prompt corrective action to cure any violations.

**The Trust may not use or disclose your PHI other than as summarized herein or as required by law. Your PHI may not be used by the Trust for any employment-related actions or decisions or in connection with any other benefit or employee benefit plan the Trust. The Trust must report to the Plan any uses or disclosures of your PHI of which the Trust becomes aware that are inconsistent with the provisions set forth herein.**

### **HOW WE MAY USE AND DISCLOSE YOUR PHI**

The following categories describe different ways that we use and disclose PHI for purposes of Plan administration. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment (as described in applicable regulations) We may use and disclose PHI about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.

For Health Care Operations (as described in applicable regulations) We may use and disclose PHI about you for other Plan operations. These uses and disclosures are necessary to administer the Plan.

To Business Associates, Subcontractors, Brokers, and Agents We may contract with entities known as Business Associates to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing to implement appropriate safeguards regarding your PHI in a Business Associate Agreement. Our Business Associates shall also require each of its subcontractors or agents to agree in writing to provisions that impose at least the same obligations to protect PHI as are imposed on Business Associate by the Business Associate Agreement or by HIPAA.

As Required By Law We will disclose PHI about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Disclosure to Health Plan Sponsor Information may be disclosed to another health plan maintained by the Trust for purposes of facilitating claims payments under that plan. In addition, PHI may be disclosed to the Trust personnel solely for purposes of administering benefits under the Plan.

### **SPECIAL SITUATIONS**

Organ and Tissue Donation If you are an organ donor, we may release PHI 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.

Military and Veterans If you are a member of the armed forces, we may release PHI about you as required by military command authorities.

Workers' Compensation We may release PHI about you for workers' compensation or similar programs.

Public Health Risks We may disclose PHI about you for public health activities (e.g., to prevent or control disease, injury, or disability).

Health Oversight Activities We may disclose PHI to a health oversight agency for activities authorized by law.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement We may release PHI if asked to do so by a law enforcement official for law enforcement purposes.

Coroners, Medical Examiners and Funeral Directors We may release PHI to a coroner or medical examiner. We may also release PHI about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official.

Research We may disclose your PHI for research if the individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

### **REQUIRED DISCLOSURES**

Government Audits We are required to disclose your PHI to Health and Human Services ("HHS") in the event of an audit in order to determine our compliance with HIPAA.

Disclosures to you We are required to disclose your PHI to you. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for treatment, payment, or health care operations, and if the PHI was not disclosed pursuant to your authorization.

### **YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding your PHI:

Right to Inspect and Copy You have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to your Human Resources Department. If the information you request is in electronic copy, and you request an electronic copy, we will provide a copy in electronic format unless the information cannot be readily produced in that format then we will work with you to come to an agreement on a different format. If we cannot agree, we will provide you with a paper copy.

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

In certain very limited circumstances, we may deny your request to inspect and copy. If you are denied access to PHI, you may request that the denial be reviewed by your Human Resources Department.

Right to Amend If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to your Human Resources Department. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the PHI kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to Receive Notice of Breach You have a right to be notified upon a breach of your unsecured PHI.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures" of PHI made in the six years prior to the date on which the accounting is requested, except for disclosures:

- To carry out treatment, payment and health care operations as provided in §164.506;
- To individuals of PHI about them as provided in §164.502;
- Incident to a use or disclosure otherwise permitted;
- Pursuant to an authorization as provided in §164.508;
- to persons involved in the individual's care or other notification purposes as provided in §164.510;
- For national security or intelligence purposes as provided in §164.512(k)(2);
- To correctional institutions or law enforcement officials as provided in §164.512(k)(5);
- As part of a limited data set in accordance with §164.514(e); or
- That occurred prior to the compliance date for the Plan.

Please submit a written request of an accounting of disclosures to your Human Resources Department.

The Trust must act on your request for an accounting of the disclosures of your PHI no later than 60 days after receipt of the request. The Trust may extend the time for providing you an accounting by no more than 30 days, but it must provide you a written explanation for the delay. You may request one accounting in any 12-month period free of charge. The Trust will impose a fee for each subsequent request within the 12-month period.

Right to Request Restrictions You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular claim with your spouse. To request a restriction, you must make your request, in writing, to your Human Resources Department. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid the health care provider "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications You have the right to request that we communicate with you about your PHI a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to your Human Resources Department. We will not ask you the reason for your request. We will accommodate all requests we deem reasonable. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy You have a right to a paper copy of this Notice. You may ask for a copy at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. Contact the Human Resources Department for a paper copy of this Notice.

### **CHANGES TO THIS SUMMARY AND THE SEPARATE PRIVACY NOTICE**

We reserve the right to change this Notice of Privacy Practices that may be provided to you. We reserve the right to make the revised or changed Notice effective for PHI we already have about you as well as any information we receive in the future. The Notice will indicate the effective date on the front page.

### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of HHS. To file a complaint with the Plan, contact your Human Resources Department. All complaints must be submitted in writing.

**You will not be penalized for filing a complaint.**

### **OTHER USES OF PHI**

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us with an authorization to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization and that we are required to retain our records of the care that we provided to you.

Authorizations for Psychiatric Notes, Genetic Information, Marketing, & Sale In general, and subject to specific conditions, we will not use or disclose psychiatric notes without your authorization; we will not use or disclose PHI that is genetic information for underwriting purposes; we will not sell your PHI, i.e. receive direct or indirect payment in exchange for your PHI, without your authorization; we will not use your PHI for marketing purposes without your authorization; and we will not use or disclose your PHI for fundraising purposes unless we disclose that activity in this Notice.

Personal Representatives We may disclose your PHI to individuals authorized by you, or an individual designated as your personal representative, provided that we have received your authorization or some other Notice or documentation demonstrating the legal right of that individual to receive such information. Under HIPAA we do not have to disclose PHI to a personal representative if we have a reasonable belief that:

- 1) you have been or may be subjected to domestic violence, abuse, or neglect by such person; or
- 2) treating such person as your personal representative could endanger you; and
- 3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and other Family Members With only limited exceptions, we will send all mail to the employee. This may include information regarding a spouse or dependents also covered under the Plan. Information includes, but is not limited to, Plan statements, benefit denials, and benefit debit cards and accompanying information.

