Theatrical Stage Employees Health & Welfare Trust

HEALTH REIMBURSEMENT ARRANGEMENT

SUMMARY PLAN DESCRIPTION

Effective May 1, 2015

TABLE OF CONTENTS

I ELIGIBILITY

1. What Are the Eligibility Requirements of the Plan? Page 3

2. When is My Entry Date? Page 3

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

4. Does the HRA apply to Employees and Dependents? Or just Employees? Page 3

5. How long can I make reimbursements on the HRA? Page 3

II BENEFITS

1. What Benefits Are Available? Page 4

2. When Must Expenses Be Incurred? Page 4

3. When Will I Receive Payments From The Plan? Page 4

4. What Happens If I Terminate Employment? Page 4

5. Family and Medical Leave Act (FMLA) Page 5

6. Uniformed Services Employment and Reemployment Rights Act (USERRA) Page 5

III GENERAL INFORMATION ABOUT OUR PLAN

1. General Plan Information- Page 6

2. Plan Sponsor Information- Page 6

3. Plan Administrator Information- Page 6

4. Third Party Claims Administrator Information- Page 6

5. Service of Legal Process- Page 7

6. Type of Administration- Page 7

IV ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA- Page 8

2. How to Submit a Claim- Page 9

HEALTH REIMBURSEMENT ARRANGEMENT

INTRODUCTION

We are pleased to establish this Health Reimbursement Arrangement to provide you with additional 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 the 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 The Plan?

You will be eligible to join the Plan if you are enrolled in the Theatrical Stage Employees Health & Welfare Trust medical plan and work a minimum of 90 hours per month.

2. When is My Entry Date?

Once you have met the eligibility requirements, your entry date will be the first day of the month coinciding with or following the date, you met the eligibility requirements.

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 enrolled in a Theatrical Stage Employees Health & Welfare Trust medical plan.

Certain non-resident aliens whose income is not considered income earned within the United States under Federal tax laws.

Employees who are considered "self-employed individuals" under the Federal tax law. A sole proprietorship is a "self-employed individual" and therefore is not eligible to participate.

Employees who are considered "2-percent shareholders" under the Federal tax law. "2-percent shareholders" are treated as "self-employed individuals" and therefore are not eligible to participate.

4. Does the HRA apply to Employees and Dependents? Or just Employees?

The HRA will reimburse employees only up to a certain dollar amount. Please refer to ***Section II: Benefits*** for plan limitations.

5. How long can I seek reimbursements on the HRA?

You must incur the expenses within each calendar year while you were an eligible enrollee. You have 90 days after December 31 of the calendar year to submit a reimbursement claim to the Plan Administrator.

II
BENEFITS

1. What Benefits Are Available?

The plan allows you to be reimbursed for certain out-of-pocket medical expenses which are incurred by you, the employee. The expenses which qualify are those that are permitted by Section 213 of the Internal Revenue Code. The expenses are limited to the ***Maximum Out-of-Pocket*** amounts satisfied during the coverage period for the employee and their dependents. Theatrical Stage Employees Health & Welfare Trust will reimburse any member for the difference over the current $2,000 maximum at calendar year end. You will need to submit a Group Health Explanation of Benefits (EOB) statement to verify any reimbursable out-of-pocket expenses.

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.

2. When Must Expenses Be Incurred?

You may submit expenses that you incur each "Coverage Period." A new "Coverage Period" begins each Plan Year. A Plan Year runs from January thru December of every year.

3. When Will I Receive Payments From The Plan?

At the end of the Coverage Period, you may submit requests for reimbursement of the eligible expenses you have incurred. However, you must make your requests for reimbursements no later than 90 days after the end of the Coverage Period each 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. Typically this will be the Explanation of Benefits (EOB) from the insurance carrier. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment at plan year end. 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. The plan will only reimburse eligible expenses if the employee is an, eligible enrolled employee with Theatrical Stage Employees Health & Welfare Trust at the end of the Plan Year (December 31).

It is your responsibility to notify the Plan Administrator of a divorce, legal separation or other change in marital status, change in a spouse's address, or a child losing dependent status under the plan, within sixty (60) days of the event. It is your Employer’s responsibility to notify the Plan Administrator of your death, termination of employment or reduction in hours, the Employer’s bankruptcy, or Medicare eligibility.

Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

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.

Ill
GENERAL INFORMATION ABOUT OUR PLAN

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

1. General Plan Information

Theatrical Stage Employees Health & Welfare Trust Health Reimbursement Arrangement Plan is the name of the Plan.
The Plan Sponsor has assigned Plan Number 501 to the Plan.
The provisions of your Plan become effective on 05/1/2015.

2. Plan Sponsor Information

Plan Sponsor's name, address, and identification number are:

Theatrical Stage Employees Health & Welfare Trust
c/o Welfare & Pension Administration Service, Inc.
PO Box 34203
Seattle, Washington 98124-1203
Tax Id Number: 91-1363171

3. Plan Administrator Information

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

Theatrical Stage Employees Health & Welfare Trust
c/o Welfare & Pension Administration Service, Inc.
PO Box 34203
Seattle, Washington 98124-1203
Phone: (800) 732-1121

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 The Trustees of the Plan have the exclusive right to interpret the appropriate plan provisions. Decisions of the Trustees are conclusive and binding. You may contact the Administrator for any further information about the Plan.

4. Claims Administrator Information

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

Theatrical Stage Employees Health & Welfare Trust
c/o Welfare & Pension Administration Service, Inc.
PO Box 34203
Seattle, Washington 98124-1203
Phone: (800) 331-6158

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

5. Service of Legal Process

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

6. Type of Administration

The Plan is a health reimbursement arrangement and the administration is provided through a Claims Administrator. The Plan is not funded or insured. Benefits are paid from the general assets of the Plan Sponsor.

IV
ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants 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 Pension and Welfare Benefits 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 Plan Sponsor 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 Pension and Welfare Benefits 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 Pension and Welfare Benefits 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, if applicable

(2) Complete the Employee portion of the form.

(3) Attach copies of all bills from the service provider 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
Insufficient information on the Claim:
Notification of 15 days
Response by Participant 45 days
Review of Claim denial 60 days

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.

(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.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. 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.
The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.
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.