PROFESSIONAL MUSICIANS, LOCAL 47
AND EMPLOYERS' HEALTH AND WELFARE FUND

GENERAL INFORMATION BOOKLET

YOUR WELFARE PROGRAM

SUMMARY PLAN DESCRIPTION
OF
BENEFITS

JANUARY 2020

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TRUST ADMINISTRATOR'S OFFICE:

Professional Musicians, Local 47 and Employers' Health and Welfare Fund
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TRUST WEBSITE: www.pacfed-musicians.com

FOREWORD

This Summary Plan Description ("SPD") provides Participants (defined below) information about the benefits offered by the insurance plans (collectively "the Plan") available through the Professional Musicians, Local 47, and Employers' Health & Welfare Fund (the "Fund"). In this SPD, we summarize the eligibility requirements which you must satisfy before qualifying for benefits, how to enroll in the benefit plan(s) sponsored by the Fund, what benefits are available and the process used to file, review, or appeal claims. The SPD also provides information about the administration of the Plan and your rights under the Employee Retirement Income Security Act of 1974 ("ERISA").

This SPD, the Statement of Benefits and Coverage ("SBC"), and the Evidence of Coverage ("EOC") for the insurance you selected govern the filing, review and approval of claims for benefits, and appeals from claims denials, by the Fund's current insurance providers, and any other provider with whom the Fund may contract in the future to provide benefits. If you lose, or do not have, a copy of this SPD or any other Plan documents, you may call the Trust Administrator to request copies. See previous page (iii) for the Fund Administrator's contact information.

Currently the Fund has contracted with the following Benefit Providers: Blue Shield, Kaiser Permanente, Landmark Healthplan, Delta Dental, Gerber Life, and The Prudential Insurance Company of America ("Prudential Life").

Basic information about the Life and Accidental Death and Dismemberment benefits (provided through Prudential Life), Medical benefits (provided through Blue Shield and Kaiser Permanente), Dental benefits (provided through Delta Dental of California and DeltaCare USA), Chiropractic/Acupuncture benefits (provided through Landmark Healthplan) and Vision benefits (provided through Gerber Life and administered by MES Vision) are described in this SPD. A more thorough description of your benefits will be provided in the EOC. Appendix A, at the end of this SPD, sets forth the SBC for each Benefit Provider including summaries for all ancillary benefits. The EOCs and SBCs are on the Fund's website, www.pacfed-musicians.com. Together these benefits/insurance coverages, plus any other coverage the Trustees may implement, constitute the Plan.

The group master contracts, issued by each contracted Benefit Provider to the Fund, will determine whether a specific benefit will be provided by the Plan and will establish the claims and appeals procedures applicable to that Benefit Provider. The Benefit Providers are required by law, and public policy, to extend benefits to all Participants and Dependents (defined below) who otherwise qualify for coverage through the Fund.

This SPD is distributed to all eligible Participants and Dependents of the Fund. However, receipt of a SPD does not guarantee nor determine whether you are currently eligible to receive benefits.

You are cautioned that no Employer (defined below), Union (defined below), or any representative of any Employer or Union, is authorized to (i) interpret the various

insurance policies, agreements, or the coverage provided by these documents, (ii) act as an agent of the Trustees in any matter relating to insurance policies, agreements, or the coverage provided by these documents; or (iii) act as an agent of the Trust or Trustees regarding any other matter related to the administration of the Trust or any benefit plan administered or sponsored by the Trust. The Trustees have discretionary authority, and are responsible for interpreting the Plan's provisions through the rules and regulations, deemed necessary and appropriate, to assist them in administer and interpret the Plan. The Trustees are also responsible for determining the Plan's schedule of benefits.

The Trustees have also created appeals procedures for Participants with eligibility or other related matters which may be properly before them. When deciding such appeals, the Trustees have full discretion to interpret, construe, and apply the terms of the Fund's Trust Agreement, and, as applicable, the Fund's SPD, including any and all rules and regulations, as well as the coverage options offered by the Fund.

On the other hand, the Benefit Providers will determine whether claims and appeals for specific benefits, provided by those Benefit Providers, will be approved or denied. Please review your EOC or SBC documents for the Benefit Provider(s) you have selected to determine how to properly file a claim and, if necessary, an appeal. The Benefit Providers have discretion to interpret their insurance policies. The final decisions on insurance policies are determined by the appropriate Benefit Provider. A list of all current Benefit Providers is contained on pages 60 and 62.

Accordingly, any questions regarding a Participant or Dependent's eligibility should be directed to the Fund Administrator. The Fund Administrator will provide you with a response. However, any questions regarding Insurance Policies, the benefits and coverages provided in those Insurance Policies, claims for benefits, appeals from a claim denial, should be directed to your Benefit Provider(s).

If there is any conflict between this SPD and the Plan, the Plan shall govern. The Plan and the Plan Document are comprised of and shall include the Benefit Providers' policies under which Participants and Qualified Beneficiaries are entitled to medical, dental, vision and life insurance coverage, as applicable.

Participants and/or Dependents have no vested or accrued rights to any benefits provided or sponsored by the Fund.

Insured benefits are provided to the extent that Employer contributions are actually received or collected by the Fund. For the Fund to fulfill its obligation, within its limited resources, to provide benefits for all Participants, the Board of Trustees expressly reserves the right, in its sole discretion at any time and from time to time to:

- terminate or amend the eligibility requirements for any benefit, or to terminate or change any benefit or self-payment or Premium requirements even though such changes may affect claims that have already been submitted;
- terminate the Plan even though such changes may affect claims which have already been submitted;

- change Benefit Providers, and/or;
- amend or rescind any other provision of the Plan, and; to revoke or suspend the status of an Employer, payroll company or payroll agent as an entity or individual from which/whom the Fund will accept and process contributions.

The existence and continuation of the provision of benefits by the Fund requires that Employers continue to pay contributions to the Fund pursuant to various collective bargaining agreements between the Unions (e.g. the American Federation of Musicians as well as AFM, Local 47) and participating Employers. If, in the future, these agreements terminate or if contributions are eliminated or significantly reduced for any reason, the right to benefits for all Participants and Dependents will be determined by the Board of Trustees in their sole and exclusive discretion. If the Board of Trustees contemplate reducing benefits, they shall first consider the Fund's purpose and financial status before altering the Plan.

DEFINITIONS

ACA means the Patient Protection and Affordable Care Act of 2010, PL 111-148 (commonly referred to as the Affordable Care Act), as well as its implementing regulations.

AFM means and refers to the American Federation of Musicians of the United States and Canada, AFL-CIO, an International Labor Organization.

AFM Local 47 and/or Local 47 means and refers to American Federation of Musicians, Local 47, (formerly known as Professional Musicians, Local 47), a local union created by the AFM.

Agreement means any written agreement, including a Collective Bargaining Agreement or Participation Agreement; any written amendments, supplements, extensions or renewals thereof, by and between AFM, Local 47 and any Employer, or the AFM and any Employer which, by their terms, require monetary contributions to the Fund, and which agreements are approved and accepted by the Trustees, in their sole discretion.

Benefit Provider or Healthcare Providers means one or more entities with which the Fund contracts to provide medical, dental, vision and life insurance (e.g., Blue Shield, Kaiser Permanente, Delta Dental Plan, Landmark Healthplan, Gerber Life and Prudential Life).

Certificate of Creditable Coverage means a document provided by your previous insurance carrier (including one under which you were covered as a dependent) that proves that your insurance has ended. This includes the name of the member to whom it applies as well as the coverage effective date and cancelation date.

Child(ren) mean(s) Participant's child(ren), adopted child(ren), stepchild(ren), Domestic Partner's child(ren) who is/are under the age of 26.

Claimant means a Participant or Dependent who has filed a claim for benefits with a Benefit Provider.

Coverage Period or Coverage Year means the annual period – generally January 1 through December 31 – during which Participants and their enrolled Dependents receive benefits under the Plan. The Trustees reserve the right to modify the Coverage Period or Coverage Year.

Covered Services means those medically necessary health care services, supplies and benefits which are required by a Participant pursuant to the coverage provisions of the Plan.

Dependent(s) are the (1) Participant's Spouse, (2) Participant's Domestic Partner, (3) the Participants' Children, and (4) the children of a Spouse or Domestic Partner.

Domestic Partner is a person who maintains a common residence with the Participant and otherwise meets the definition of and is a registered domestic partner under California law.

Employee means a person performing work under a Collective Bargaining Agreement or Participation Agreement, and employed by an Employer; or Employee of the Fund; or other persons as the Trustees, in their sole discretion, may designate as Employees, to the extent permitted by law.

Employer means an employer, or an employers' payroll designee, who is required to make contributions to the Professional Musicians, Local 47 and Employers' Health and Welfare Fund and who is bound to the Fund's Trust Agreement, the Fund's rules and regulations and the Fund's Collection Policy.

Open Enrollment is the period in which you initially select, or subsequently change, an insurance provider (e.g. medical, dental, or vision). You may also add or delete Dependent coverage at this time. Except for qualifying special enrollments, these changes may occur only once in any twelve (12) month period. ("Special Enrollment" is defined below.) Open Enrollment begins on November 20th and ends on December 20th of each year.

Participant means an Employee or former Employee who is or may become eligible for benefits under the Plan and their Dependents who are enrolled in the Plan.

Plan or Plan Document means collectively, the Fund's Trust Agreement, this Summary Plan Description, EOC and SBC issued by each Benefit Provider, as well as the medical, dental, vision and other group insurance policies through which the Fund provides benefits.

Plan Sponsor means the Fund's Board of Trustees.

Premium means the Participant or any Dependent's portion of the monthly premium that must be paid by a Participant or any enrolled Dependent to maintain coverage.

Qualified Beneficiary(ies) (for purposes of COBRA coverage) means a person(s) covered by the group health plan on the day before a qualifying event who is either a Participant, the Participant's Spouse or Domestic Partner, or the Participant's dependent child.

Qualifying Period means each annual period of time – generally October 3 of the present calendar year through October 2 of the following calendar year – during which employer contributions are remitted to the Fund, for covered employment rendered during that period, for the purpose of determining Participant eligibility to enroll in the Fund's benefit programs for next succeeding Coverage Period.

Special Enrollment occurs when an individual loses eligibility for coverage under a group health plan or other health insurance coverage (such as an employee and his/her dependents' loss of coverage under the Spouse's plan) or when an employer terminates contributions toward health coverage; an individual becomes a new dependent through marriage, birth, adoption, or being placed for adoption; an individual loses coverage under a State Children's Health Insurance Program (CHIP) or Medicaid, or becomes eligible to receive premium assistance under those programs for group health plan coverage;notifies the Plan Administrator within thirty (30) days of such event, and complies with all other Plan rules and regulations.

Spouse means the individual of any gender or sexual orientation who is lawfully married to the Plan Participant under applicable state law. The term “marriage” includes a marriage between two individuals of the same or opposite sex for purposes of the provision of the Dependent benefits provided herein and those rights accorded, under Federal and State law, to those persons holding lawful status as another person’s spouse.

Trust Administrator's Office or **Fund Administrator’s Office** means the administrator’s office of the Professional Musicians, Local 47 and Employers' Health and Welfare Fund, located at: 1000 North Central Ave., Suite 400, Glendale, CA 91202.

Trust or **Fund** means the Professional Musicians, Local 47 and Employers' Health and Welfare Trust Fund.

Trust Administrator or **Fund Administrator** means PacFed Benefit Administrators.

Trustees or **Board of Trustees** mean the group of individuals consisting of an equal number of Union and Employer representatives to oversee the Trust Fund.

Union means and refers collectively to the AFM and AFM Local 47.

Waiver of Coverage means that although you qualify for enrollment and coverage with the Fund’s benefits, you decide not to enroll. The most common reason Participants voluntarily waive coverage is that they, their Spouse, or domestic partner are already covered by another group health plan. Since you may be covered by another health plan, the law allows you to decline coverage from the Fund while, under certain circumstances (e.g., the loss of your other group coverage), retaining your right to enroll with the Fund at a later date.

THE FUND AND THE ACA

The Fund has determined that it does not have, nor is it claiming, "grandfathered status" under the ACA (defined above). However, the Fund has determined that the benefits it offers fully comply with the ACA's affordability, cost sharing, and coverage requirements. Please note that under the ACA, if you become eligible for enrollment in a benefit plan offered by the Fund, you will likely be disqualified from receiving any subsidies, under the ACA, that may have otherwise been available if you independently purchased health insurance through a federal or state exchange. This means that even though you may decline to enroll in the Plan, after you become eligible to do so, you may still purchase health insurance through a federal or state exchange, but you will not be entitled to claim, or accept, any federal subsidy.

Additionally, since the Fund complies with the ACA, any Employer which contributes to the Fund and is subject to the ACA's health insurance mandate – i.e., those employers with fifty (50) or more full time employees – also complies with the ACA's affordability, essential benefits, enrollment, and coverage requirements.

IMPORTANT NOTE

In compliance with the ACA, none of the medical Benefit Providers nor the medical plans offered by the Fund maintain or enforce any annual or lifetime caps on the total cost of care provided for Participants.

CERTIFICATION OF COMPLIANCE WITH ACA

Pursuant to an actuarial review of the Fund's benefits, the Fund certifies that the Benefit Providers selected by the Fund as well as benefit plan(s) administered by those Benefit Providers comply with the ACA. As such, the actuarial review commissioned by the Fund demonstrates that the Fund: (A) provide(s) the minimum actuarial value required by the ACA; (B) provide(s) "affordable benefits" as defined by the ACA; (C) provide(s) coverage in accordance with the ACA; (D) provide(s) "Minimum Essential Health Benefits" as defined in, and required by, the ACA, and; (D) does not require a waiting period that exceeds more than ninety (90) days after a Participant qualifies for coverage.

RELATIONSHIP BETWEEN FUND AND HEALTHCARE BENEFIT PROVIDERS

The Benefit Providers selected by the Trustees, and the actual healthcare providers with whom they contract, are not agents or representatives of the Fund. The Fund does not control or direct the Covered Services provided to Participants or Dependents by any of the insurance providers. The Fund makes no representation(s) or guarantee(s) of any kind concerning the skill or competency of any Benefit Provider. The Fund makes no representation or guarantee of any kind that any Benefit Provider will furnish Covered Services that are free of the risk of resulting in malpractice.

The foregoing statement applies to any and all Benefit Providers, Health Care Providers and all entities (and their agents, and representatives) who offer Covered Services to Participants and their Dependents.

ELIGIBILITY FOR COVERAGE & ENROLLMENT

A Participant qualifies for coverage with the Fund when s/he attains at least $700 in Employer contributions during the applicable Qualifying Period (discussed below). The Fund maintains three (3) levels of coverage, depending upon the amount of Employer contributions that have been remitted on behalf of a Participant during the applicable Qualifying Period. These levels are (A) $1,500 and above per Qualifying Period; (B) $1,200-$1,499 per Qualifying Period, and; (C) $ 700 - $1,199 per Qualifying Period. Thus, the level and cost of any benefit plan(s) you may be eligible to enroll in will be governed and dictated by the amount of Employer contributions remitted on your behalf during the applicable Qualifying Period.

EXAMPLE NO.1: I joined Local 47 after three (3) months of preforming live music engagements in Local 47's jurisdiction. Am I eligible for enrollment and coverage in the Fund?

ANSWER: No: eligibility to enroll in and participate in the Fund is conditioned upon having a sufficient amount of Employer contributions remitted to the Fund during the Qualifying Period; *eligibility is not an automatic function of Local 47 membership*.

EXAMPLE NO. 2: I'm a brand new musician but lucky enough to have worked under an Agreement for the last year or so. I have more than seven hundred dollars ($700.00) in Employer contributions that have been made to the Fund, during the Qualifying Period, what now?

ANSWER: Excellent! You are now eligible to enroll in the benefits offered by the Fund. Your level of coverage and the benefits you will be allowed to enroll in are dependent upon the amount of Employer contributions the Fund received on your behalf during the Qualifying Period: here, the "C" level of coverage. You will receive an enrollment package from the Fund, during the month of November, from which you can make your enrolment

choices and which will contain additional information about the cost and availability of benefits. If you decide to enroll, your coverage will start January 1st and end December 31st of the following calendar year.

Qualifying and Coverage Periods are as follows:

Qualifying Period:	Coverage Period:
Contributions for work performed during these months: OCTOBER 3rd of the present calendar year through OCTOBER 2nd of the following calendar year.	Will qualify you for eligibility to enroll in coverage during these months: JANUARY 1ST through DECEMBER 31ST effective the JANUARY 1ST immediately after the close of the Qualifying Period

The amount of Employer contributions received by the Fund, on behalf of a Participant, shall determine the level of coverages/benefits available to a Participant.

The Employer Contribution amount necessary to enroll in each medical plan is listed below:

Level	Eligibility Contribution Level	Medical Plan	Dental/Vision Chiro/Acupuncture
A	**$1,500 +**	**Blue Shield HD PPO Blue Shield HMO $30 Co-Pay Kaiser Traditional Kaiser High Deductible Kaiser High Deductible/HSA Qualified**	**Yes**
B	**$1,200 to $1,499**	**Blue Shield HD PPO Blue Shield HMO $30 Co-Pay Kaiser Traditional Kaiser High Deductible Kaiser High Deductible/HSA Qualified**	**Yes**
C	**$700 to $1,199**	**Kaiser High Deductible/HSA Qualified**	**No**

For dental/vision coverage only (requires written waiver of medical coverage on file with Fund):

Level	Eligibility Contribution Level	Medical Plan	Dental/Vision
A	**$1,500 +**	**Waive Medical Coverage**	**Yes**
B	**$1,200 to $1,499**	**Waive Medical Coverage**	**Yes**
C	**$700 to $1,199**	**Waive Medical Coverage**	**Yes**

Thus, to be eligible for enrollment in one of the three levels of medical insurance offered by the Fund, the minimum Employer contribution necessary for Participant qualification is $700 for Level C enrollment/coverage, $1,200 for Level B enrollment/coverage, and $1,500 for Level A enrollment/coverage. As we review later in this SPD, each level of eligibility provides different benefits and coverage.

The Trustees reserve the right in their sole and exclusive discretion to amend, change, or modify the benefits offered or change Benefit Providers offered at each Level of eligibility (A,B,C).

Carry-Forward Contribution Bank

If a Participant fails to have sufficient Employer contributions during a Qualifying Period, a Participant may apply a maximum of $600 of Unused Employer Contributions from the prior Qualifying Period to make that Participant eligible for the next Coverage Year.

"Unused Employer Contributions" are defined as either (a) the excess of the amount of $1,500 of Employer Contributions, that were actually contributed on the participant's behalf and that were accepted by the Fund, or (b) the amount of Employer Contributions in the preceding qualifying period, that were actually contributed on the participant's behalf and that were accepted by the Fund, when a participant did not qualify. In either event, the maximum look-back period is the prior 12-month contribution period (October 3rd though October 2nd of the previous year), and no more than $600 in Employer contributions may carry-forward. The carry-forward contributions may qualify a musician for Level C eligibility. Contributions that carry-forward may not be used to achieve Levels A or B.

Please note, however, that Unused Employer Contributions from the immediately preceding Qualifying Period may be carried forward ***only*** to obtain Level C coverage.

Carried forward Unused Employer Contributions may ***never*** be used to obtain a higher coverage/benefit level.

EXAMPLE NO.1: Joe's Employer contributed $1,600 for him for the Qualifying Period October 2, 2017, through October 3, 2018. He is eligible for Level A benefits January 1 through December 31, 2019.

ANSWER: Joe will also have $100 in Unused Employer Contributions ($1,600 minus $1,500 = $100) to carry-forward to the ***next*** Qualifying Period should he fall short of the required Employer contributions during the next Qualifying Period, but only to achieve Level C eligibility.

EXAMPLE NO. 2: Sally's Employers contributed $900 for Sally in the Qualifying Period.

ANSWER: Because Sally's Employer(s) did not contribute more than $1,500 on her behalf during the present Qualifying Period, she has no Unused Employer Contributions to carry forward to the next Qualifying Period.

EXAMPLE NO. 3: Bob's Employer contributed $550 for him in the current Qualifying Period.

ANSWER: Bob does not have sufficient Employer Contibutions to qualify (he needs a minimum of $600), so he will have $550 in Unused Employer Contributions to carry-forward to the ***next*** Qualifying Period that may be used to become eligible for Level C benefits.

Combining Spouse Credits

If Spouse's perform under one, or more, Agreement(s) that require the Employer to contribute to the Fund, they may elect to have their Employer contributions, remitted during the current Qualifying Period, combined, but only to achieve Level C coverage. This means that if Husband and Wife, ***when their Employer contributions are combined together***, have a minimum of $700 of Employer contributions, the Spouse with the higher contribution amount will be deemed the eligible Participant. The non-eligible Spouse will be the Dependent of the eligible Spouse. The Musicians must notify the Fund Administrator, in writing, of their desire to combine Employer contributions before December 20th of each year and which Spouse will be deemed the "eligible Spouse." The Fund Administrator will process the designation and provide written approval that the designated Employer contributions may be combined. Please note that once the Open Enrollment closes (i.e., approx. December 20th, a Spouse cannot combine their Employer's contributions to obtain eligibility for the next succeeding Coverage Period.)

Please note that if each Spouse's Employer contributions are sufficient to qualify them, on their own, for coverage, they may not use their Spouse's Employer contributions to attain a higher level of benefits.

EXAMPLE: Bob and Mary are married. They are both musicians working under Local 47 or AFM Agreements. Bob has $650 in Employer contributions in the current Qualifying Period, and is ineligible for any coverage during the next Coverage Period. Mary has $675 in Employer contributions in the current Qualifying Period, and is ineligible for any coverage during the next Coverage Period.

ANSWER: Mary and/or Bob may request in writing, by December 20th of that year, that the Administrator combine the Employer contributions remitted for her and Bob. Assuming that the Administrator approves Mary's request, Mary may borrow $25 from

Bob's account to make her eligible for Level C coverage in the next succeeding Coverage Year.

The Trustees reserve the right in their sole and exclusive discretion to modify the amount of Employer contributions required during any Qualifying Period to obtain coverage and to modify the dates that set forth an applicable Qualifying Period.

SPECIAL ELIGIBILITY PERIOD" FOR FULL-TIME EMPLOYEES WORKING FOR A SINGLE LARGE EMPLOYER

If a new Employee is reasonably expected, at the Employee's start date, to be a full-time Employee, then the Employer may determine the Employee's status based on the hours of service for each calendar month. If the number of hours worked, for the calendar month, equal or exceeds an average of 30 hours of service per week, then the Employee is a full-time Employee for that calendar month for purposes of the ACA and eligibility for coverage with the Fund. After determining an Employee's ongoing employment status, the Employer may determine each ongoing Employee's full-time Employee status by looking back at the "standard measurement period." The Employer can decide the month when the standard measurement period starts and ends. The Employer is required to determine a formula which will be applied uniformly and consistently for all full-time Employees in the same category. If the Employer determines that an Employee was employed on average at least 30 hours of service per week during the standard measurement period, then the Employer must treat that Employee as a full-time Employee as long as he or she remains a full time Employee. In this scenario, a "special eligibility period" commences and once the Employer contributes sufficient contributions for purposes of the Employee's eligibility for coverage with the Fund, the Employee must be offered the ability to enroll no later than the 90th day ***after*** such sufficient Employer contributions have been remitted for the Employee.

Example: Joe began working for an Employer on August 3, 2018. Joe works an average of 30 hours a week for his Employer through October 2, 2018. Joe's Employer submitted contributions for Joe to the Fund during Joe's special eligibility period. Joe's Employer has 50 or more full-time employees and is subject to the requirements of ACA.

Answer: Joe qualifies for coverage starting December 1, 2018, based upon his Employer's contributions to the Fund during the "special eligibility period."

Special Rules Governing the Receipt And Attribution of Contributions Remitted *Under AFM Collective Bargaining Agreements*

Some collective bargaining agreements, negotiated and enforced by the AFM, require Employer contributions to be made to the Fund. These contributions are usually recorded by the Fund, during the Qualifying Period, as of the date of the engagement or the date services were actually rendered.

However some AFM agreements – most notably the Commercial Announcement Agreement (or the "Jingles Agreement") – require Employer contributions also be remitted during what is known as the "broadcast cycle." Because the timing of these Employer contributions is different than the regular Employer contribution processes, the Trustees have adopted a special rule for Employer contributions required by the Jingles Agreement. This special rule is (A) Employer contributions required under the Jingles Agreement and that are received prior to October 2nd will be used to determine eligibility for the current Qualifying Period; (B) employer contributions made under the Jingles Agreement and received between October 3rd and December 31st will be applied retroactively to the immediately preceding Qualifying Period and; (C) employer contributions made under the Jingles Agreement and received after January 1st of each year will be applied to the then applicable Qualifying Period.

For example, if the Fund receives Employer contributions under the Jingles Agreement on December 20th for a broadcast cycle that occurred during the prior Qualifying Period, these contributions will be used to determine eligibility for the prior Qualifying Period. On the other hand, if the same contributions are received by the Fund on or ***after*** January 1st of the ***next*** year, then the contributions shall be attributed to the then current Qualifying Period and will be used to determine eligibility for the following Coverage Year (starting January 1st of the *next* year).

Example 1: What happens to Employer contributions that were earned for a broadcast cycle that aired prior to October 3, 2018, are not received by the Fund until January 3, 2019.

Answer: These Employer contributions will be applied to the October 3, 2018, through October 2, 2019, Qualifying Period for coverage commencing January 1, 2020.

EMPLOYEE SELF-REPORTING PROCEDURE

Failing to Timely Report Engagements Could Result in Loss of Eligibility.

In order to ensure that all Employer Contributions are properly and timely received and recorded by the Fund, each Participant is responsible for notifying the Fund of engagements they have performed and for which Employer contributions are due to the Fund. Employer contributions that are not received at the close of the Qualifying Period are not "timely," and will generally not be applied to that Qualifying Period. To ensure the timely collection and allocation of all Employer contributions and to avoid the potential of failing to qualify or re-qualify for benefits, the Employee must comply with the following procedures:

1. Immediately report ***all*** engagements to Local 47 or the Fund by completing a Member Self-Reporting Form (Member Self-Reporting forms are available at the Local 47 office, the Trust Fund office or www.pacfed.com/musicians);

2. Request from the Trust Administrator's Office, at the close of the applicable Qualifying Period, a list of Employer contributions for that period;
3. Review the list of Employer contributions for accuracy;
4. Notify the Fund, on or before November 20th if there are any discrepancies. Employees may also be required to provide additional information concerning unreported Employer contributions. This information should, at a minimum, include the (i) dates of the employment for which the Employee claims the Fund should have received Employer contributions; (ii) the name of the Employer(s); and (iii) the amount which the Employee claims the Fund should have received on his/her behalf; and
5. Provide the Fund with any additional information to aid in its collection efforts.

   Participants who fail to follow the above procedures, may fail to qualify or re-qualify for benefits because they cannot substantiate any claim that additional Employer contributions should appear in that Particpant's Employer contribution records.

EXAMPLE 1: An engagement was performed on July 1, 2018, and the Employee ***DID NOT*** file an Engagement Reporting Form. The contributions were received at the Fund Administrator's Office on March 2, 2019 (8 months late and 6 months past the close of the Qualifying Period).

ANSWER: The late Employer contribution is applied as of the date of receipt, March 2, 2019, to determine the Employee's eligibility during the current Qualifying Period (here, October 2, 2018 through October 3, 2019).

EXAMPLE 2: An engagement was performed on July 1, 2018. The Employee ***timely filed*** an Engagement Reporting Form and provided all additional information requested by the Fund. The Employer contributions were received at the Fund Administrator's Office on January 2, 2019. The Employer contributions are delinquent but, if counted, the Employer contributions places the member at or over the $700 level, for Level C coverage, for the relevant Qualifying Period.

ANSWER: The Employer contribution will be applied, as of the date it was earned (July 1, 2018), and the Employee will be eligible January 2019 to enroll in Level C benefits.

IMPORTANT NOTE:

Failing to timely report an engagement could result in not qualifying or re-qualifying for benefits. It is the Employee's responsibility to verify the accuracy of their Employers' contributions by requesting a copy of their Employer Contribution Statement from the Fund Administrator.

ANNUAL ELIGIBILITY REVIEW PROCEDURES

At the close of the each Qualifying Period the Fund Administrator will determine who is eligible to enroll for benefits during the next Coverage Period. A notice of eligibility or loss of eligibility will be sent to all newly qualified and re-qualified Participants at their last known mailing address via the US Postal Service. If you have not previously been determinded as an eligibile Particpant and if you do have sufficient Employer contributions to become eligible, you will not receive any notice whatsoever from the Fund.

The Fund may also send a separate notice to any Employee (the "Employer Contribution Statement"), who has not qualified, but who could potentially qualify for benefits (e.g., Employees who need approximately $25 or less in Employer contributions to qualify), based on the Employer contributions the Fund has received, on their behalf, during the Qualifying Period. This notice will usually be sent each November after the Qualifying Period closes. In the event an Employee receives an adverse Employer Contribution Statement from the Fund Administrator (i.e., a notice the Employee did not have sufficient Employer contributions to qualify for coverage), s/he must provide – no later than November 20th - all information concerning any Employer contributions the Employee claims should, but may not, have been recorded by the Fund during the Qualifying Period. This information should, at a minimum, include the (i) dates of the employment for which the Employee claims the Trust should have received Employer contributions; (ii) the name of the Employer(s), and; (iii) the amount of Employer contributions which the Employee claims the Trust should have received on his/her behalf. If you do not receive an Employer Contribution Statement or eligibility notice by November 15th, contact the Fund Administrator.

After an Employee submits all records and supplemental information, on or before November 20th, the Trustees will determine – by December 15th of each calendar year – whether an Employee is eligible as a re-qualified Participant or a newly qualified Participant. Employees will receive a final written determination from the Trustees about whether they are eligible for benefits prior to January 1st.

Employees may appeal a denial of eligibility to the Trustees by submitting a timely written appeal to the Fund Administrator. See page 55 for Appeal rights.

ENROLLMENT IN THE BENEFIT PLAN

All Employees who become eligible to enroll – either as a re-qualified Participant or as a newly qualified Participant – in the Fund's benefit programs, based on Employer contributions remitted to the Fund for covered employment during the Qualifying Period, shall be offered the opportunity to enroll in the Fund's benefits, for which such Employees qualify, no later than the ninetieth (90th) day after the Fund has validated that the Employee has, in fact, qualified for enrollment.

How an Employee Enrolls In Coverage and Becomes a Participant

Once an Employee is eligible to enroll in the Fund, the following steps must be completed to obtain coverage and attain Participant status:

1. Submit a complete and timely enrollment application for all coverages desired (e.g., medical, dental, vision and life insurance);
2. Submit a complete and timely applicable Premium;
3. Comply with all other regulations and requirements of the Trust Fund, and applicable Benefit Provider.

The above forms along with the applicable Premium payment, must be completed and filed with the Fund Administrator no later than December 20th. Failure to timely submit the completed Enrollment Form and/or applicable Premium may result in the Participant *not* receiving coverage/benefits during the next Coverage Year: *You must enrolled to be covered by the Fund's medical plan benefit(s)*.

Currently the Fund, through the Plan, offers medical, dental, vision, chiropractic/acupuncture and life and accidental death & dismemberment benefits. Blue Shield, Kaiser Permanente, Landmark Healthplan, Delta Dental Plans of California, Delta Care USA, Gerber Life and Prudential Life are the Benefit Providers for these benefits. (Gerber Life underwrites the vision benefit, which is administered by MES Vision). It is through the above Benefit Providers that the Fund makes available the benefits in which you can enroll. **The Trustees reserve the right in their sole and exclusive discretion to amend, change, or modify the benefits offered or change Benefit Providers who currently contract with the Fund.**

Once you are eligible to enroll as a Participant, you **MUST** complete the applicable ENROLLMENT APPLICATION FORMS in full and timely remit to the Fund Administrative Office with the applicable co-premium.

If you wish to enroll in Blue Shield, you ***must*** also select a Participating Medical Group or Independent Physician Association from the HMO provider directory. You have the right to designate any primary care provider who participates in the Blue Shield Plan network and who is available to accept you or your family members. If you do not designate a primary care provider, one will be assigned to you, until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, you may visit the Fund's website at www.pacfed-musician.com, select the "PROVIDER" tab, select the link to take you to the carrier's Provider Find page, or you may call the carrier's member services at the number provided on page 59 of this booklet.

TERMINATION OF PARTICIPANT COVERAGE

Participant coverage will generally terminate on the earliest of:

1. The last day of a Coverage Period, (i.e., December 31) if eligibility for the following Coverage Period was not established, through the remittance of sufficient Employer contributions, during the applicable eligibility period; or
2. The date your absence begins and you enter into full-time military service lasting more than the lesser of 24 months or the date the Participant fails to reapply for enrollment after completion of military service; or
3. The type or level of coverage for which you are eligible is eliminated from the Plan; or
4. Failure to timely remit, in full, any required Premium as may be established by the Trustees and the Participant fails to timely request any available "Safe Harbor" to reinstate coverage; or
5. Failure to comply with any rule, regulation or requirement of the Fund (i.e. failure to timely return a completed enrollment form, achieving eligibility through fraudulent means, etc.); or
6. Federal law no longer mandates that the Fund provide the coverage at issue and the Trustees of the Fund, in their sole and exclusive discretion, determine to discontinue such coverage.

DEPENDENT COVERAGE AND DEPENDENT ENROLLMENT

Once an Employee becomes a Participant, the Participant's Dependents are also entitled to enroll in and be covered by the benefits provided by the Plan. Enrollment and coverage of any Dependent is conditioned upon (A) the Participant's timely payment of the required Premium as set forth herein, and; (B) enrollment of the Dependents through the completion and filing of all required forms. A Participant may enroll her/his Dependents only if the Participant is also eligible for ***and*** enrolled in coverage with the Fund. Additionally, all Dependents will be covered under the same medical, dental and vision benefits selected by the Participant.

Proof of the Dependent's eligibility is required for claims administration of services by the Fund and/or its Benefit Providers (e.g., certified copy or original of marriage certificate, state certification (or other documentation) of domestic partnership, birth certificates, a Dependent certification form, etc.).

NOTE: A Dependent will be eligible for coverage only if his/her full name, date of birth, Social Security Number and relationship to the Participant is registered with the Fund Administrator's Office. This requires Participants to file an enrollment application, provide proof of Dependent status (certified copy or original of marriage certificate or California certificate of domestic partnership, birth certificate, etc.), and timely remit the Premium.

Premiums Required for Dependent Coverage

For active Participants, the cost for covering your eligible Dependents is 100% of the Premium for Dependent coverage, plus an administration fee (not to exceed 5% of premium). During Open Enrollment (see below) a Participant will receive written notification of the applicable Premium. If you have further questions on this topic, please contact the Fund Administrator to obtain information on the current Premiums and administrative fees.

DEPENDENTS COVERED UNTIL AGE 26: By law, a group health plan and a health insurance issuer offering group health insurance coverage which provides Dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age.
In the event your Child, up to age 26, is also enrolled and covered under her/his employer's group medical plan, the Fund shall coordinate benefits with that other plan

OPEN ENROLLMENT

Open Enrollment is November 20th through December 20th. During this time, and if you are enrolling with the Fund for the first time, you will make an initial selection of your Benefit Provider(s), complete and file your enrollment packet and pay your Premium(s). During subsequent Open Enrollment(s), and assuming you remain eligible for coverage (enrollment), you may change your coverage (i.e. medical, dental, vision) or enroll your Dependents. Open Enrollment is also the time to add or remove any Dependents from the coverage you enroll in. Any changes to your coverages must be received by the Trust Administrator no later than December 31.

Cost to Participant

Payment of the required premium must occur *before* the Fund will recognize and treat anyone as a Participant or Dependent and as a condition to enrollment in and for the continuation of coverage. Eligible Members who do not pay the required Premium will not be enrolled and will not become Participants. Premiums are calculated annually for each level of coverage. Participants will be notified, of their Premiums, by the Fund Administrator no later than December 1st. For more information, see the premium schedule at: www.pacfed-musicians.com.

IMPORTANT NOTE:

Participants will be notified, in writing, of the Participant and Dependent Premium schedules by the first business day of December each year. The Trustees reserve the right to change, modify or eliminate the Premium. Please note that the Premiums are subject to change each Coverage Year.

The Premium Payment Policy

Your monthly premium payment will be due no later than the twentieth (20th) day of the month preceding the next month of coverage. If a Premium payment is not received by the 20th of the month prior to the month of coverage, the Participant will be delinquent. A Participant in delinquent status will have their coverage terminated and benefits cancelled if coverage is not reinstated. Please see information under "The Late Premium Reinstatement Period" (pages 19 through 20) of this SPD for information on reinstatement after a Premium delinquency.

IMPORTANT NOTICE:

The Fund sends out only one (1) monthly billing statement. The statement will notify a Participant of the amount of their Premium via the US Postal Service. **The timely remittance of monthly Premium payments is the sole responsibility of the Participant.**

EXAMPLE: Participant Bob's initial Premium payment is due no later than December 20th, prior to the January 1st effective date of the new coverage year.

ANSWER: Participant Bob's subsequent Premium payments will now be due one month in advance (the 1st of the month prior to the month of coverage), but he will have a grace period until the ***twentieth (20th) day*** of each month to remit the premium for the next month's coverage.

The Enrollment Grace Period

The Fund offers an enrollment grace period, which is between December 21st and December 31st. Applications and/or Premiums received during the grace period will be accepted. However, if the Fund Administrator receives your application and/or Premium(s) during the grace period there is no guarantee that your enrollment will be recorded with the Benefit Providers by January 1. This means that if Covered Services are required in early January, you may appear to be ineligible for benefits in the Benefit Provider's records.

The Late Premium Reinstatement Period

Applications and/or Premiums received during the month of January – from eligible Participants – will be accepted, subject to a processing fee for late payments. However, the Fund shall require the remittance of an additional administrative processing fee (described below) for either (1) the submission of a late enrollment (i.e., receipt of an enrollment application form) or (2) late payment of the required Premium (i.e. where the required Premium was not timely remitted along with the Participant's enrollment form.)

A “Safe Harbor” has been established to allow late enrollment or reinstatement if coverage is terminated due to late Premium payments. The “Safe Harbor” requirements are:

1) Reinstatement requests must be made in writing, to the Funds’ Administrator (***not*** Local 47), and be post-marked no later than 30 days from the date of cancellation listed on the termination notice.
2) The Fund Administrator may reinstate the Participant(s) and, if applicable, Dependents, provided that (a) the delinquent Premium is received in ***addition to*** (b) the next month’s Premium and (c) the applicable administrative fee, are all received within 30-days of the notice of benefit termination date.
3) Administrative fees are calculated and imposed as follows:

   - First time delinquent – the greater of $25 or 10% of the delinquent Premium.
   - Second time delinquent **-** the greater of $25 or 25% of the delinquent Premium.
   - Third time delinquent **-** the greater of $25 or 50% of the delinquent Premium.
   - Fourth delinquency will result in loss of coverage with no right to reinstate. A Participant seeking reinstatement for themselves or a Dependent may, however, file a written appeal with the Fund’s Trustees in the event of a complete loss of coverage.

If a timely request for reinstatement is made, the Fund Administrator shall advise you, in writing, of the decision and inform you of any required administrative fee which must be paid before your reinstatement will be processed.

Enrollment applications and/or Premium payments submitted during the month of **January are subject to a late enrollment processing fee**. Any applications submitted on or **after February 1st will be returned and will not be processed**. In the event your late enrollment application and/or Premium payment is denied, you may appeal the decision to the Funds’ Board of Trustees. (See page 54 of this SPD for information about filing an appeal).

The Trustees reserve the right, in their sole and exclusive discretion, to grant or deny, in whole or in part, any application or appeal for late enrollment or reinstatement. Any decision by the Trustees, to allow late enrollment or reinstatement, shall be conditioned upon the acceptance of such late enrollment by the applicable carrier(s) and payment of the applicable Premium and Administrative Fee. Retroactive coverage may not be available in all circumstances even if an application for reinstatement/late enrollment is granted.

EXAMPLE: Participant Bob has selected a twelve (12) month Premium payment installment program. Participant Bob fails to send in his Premium payment by June 20th, 2019. Participant Bob is delinquent and his coverage may be cancelled on the first day of the next month (July).

ANSWER: Participant Bob may take advantage of the "Safe Harbor" rule to maintain coverage and have his late Premium accepted. However, Bob must follow the "Safe Harbor" rules and timely submit his request for the "Safe Harbor."

Termination of Dependent Eligibility

Dependent Eligibility will terminate upon the earlier of the following dates:

1. The Participant ceases to be eligible due to a lack of sufficient Employer contributions; or
2. The date the Dependent no longer qualifies as an eligible Dependent by operation of law (e.g. age 26); or
3. The date the Dependent enters into full-time military, naval, or air service; or
4. The date the Premiums are not paid on time or in full and has become delinquent; or
5. Failure by the Participant, or Dependent, to comply with any rule, regulation or requirement of the Trust, or Benefit Provider (i.e. failure to timely return a completed enrollment form, achieving eligibility through fraudulent means, etc.).; or
6. A Participant fails to timely enroll his/her Dependent with the Plan; or
7. Federal law no longer mandates that the Fund provide coverage and the Trustees of the Fund, in their sole and exclusive discretion, determine to discontinue such coverage.

IMPORTANT NOTE:

Termination of Dependent(s) coverage due to non-payment of Premiums or withdrawal from coverage for reasons other than a change in eligibility status will require the Dependent(s) to wait at least 12 consecutive months before they may re-enroll in the Fund. Enrollment may occur during Open Enrollment only if the Participant is eligible and enrolled.

Example: An enrolled Participant owes Premiums for his/her Dependent. The Premium is due March 1, 2018. The Participant does not pay the Premium until April 1, 2018.

Answer: Dependent coverage will be terminated effective March 1, 2018. The Dependent must wait 12 months from March 1st 2018 and may not re-enroll until the next Open Enrollment (for 2020 calendar year coverage), as long as the Participant is eligible and also enrolled.

Disabled Child Coverage

Children, who are age 26, or older, are eligible to continue coverage with the Fund if all of the following conditions apply:

- The Child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, (as determined by a physician);
- The disability arose at or prior to age 19;
- The Child depends upon the Participant for support and maintenance, and is not married; and
- The Participant becomes or re-qualifies for coverage with the Fund.

If a Participant enrolls a disabled Child for coverage, the Participant must provide the Fund Administrator, proof of incapacity and dependency within 30 days prior to enrolling in the Plan. The Child must have been continuously covered, as a Dependent of the Participant, under a group health plan, which can include the Fund, at the time the Child reached the age limit.

The Fund Administrator's Office will provide Participants notice at least 90 days prior to the date their enrolled Child reaches the age limit (26) and prior to the termination of the Dependent Child's coverage. Participants who wish to continue their Child's coverage due to a qualifying disability, must provide the Fund Administrator with proof of their Child's incapacity and dependency within 30 days of the date of receipt of notice from the Fund Administrator in order to extend coverage for a disabled Child past age 26.
A disabled Child may remain covered by this Plan, as long as he/she remains disabled, and continues to meet the eligibility criteria described above, and the member is a Participant.

IMPORTANT NOTICE

The insurance carrier possesses the discretion to approve or deny enrollment based upon the proof of disability and dependency provided by the Participant. Please review the EOC for each carrier to determine the specific rules and procedures for your carrier's disability enrollment process. The EOCs for all of the Fund's carriers may be located on the website.

WAIVER OF COVERAGE, HIPAA & ENROLLMENT

"Waiving coverage" means that although you qualify for enrollment and coverage with the Fund, but you decide not to enroll in any of the coverages offered by the Fund. The most common reason Participants voluntarily waive coverage is that they, their Spouse, or domestic partner are already covered by another employer-sponsored group health plan. Since you may be covered by another health plan, the law allows you to decline coverage from the Fund while, under certain circumstances (e.g., the loss of your other group coverage), retaining your right to enroll with the Fund at a later date.

HIPAA allows you and your Dependents to enroll with the Fund at the time you are notified of your eligibility for coverage with your prior carrier has been terminated due to loss of employment, reduction in hours, etc.

Thus,and if you previously declined coverage for yourself or a Dependent because you or your Dependent had another health plan and subsequently lost coverage from the other health plan, you may enroll for benefits, during a special enrollment period, if the following criteria are met:

- You are no longer eligible for health benefits through the other source;
- You are currently eligible for coverage under the rules of the Fund, (you have been credited with Employer contributions for the coverage period);
- The required HIPAA paperwork,enrollment form and Premium are submitted within thirty (30) days after you lost coverage from another plan;
- You must also submit a Certificate of Creditable Coverage (see page 40 for explanation of Certificate of Creditable Coverage), and;
- You must provide the appropriate enrollment applications and Premiums required by the Fund.

If you satisfy the above criteria – and subject to the rules of the applicable carrier – you will be enrolled in benefits effective the first day you lose your health benefits with the other plan.

Please note that coverage obtained through an Exchange such as Covered California, is not considered group coverage for purposes of late/HIPAA enrollment rights.

HIPAA Special Enrollment:

In addition to the Special Enrollment Rights discussed above, HIPAA also has special rules for new Dependents of Participants who are added by marriage, birth, adoption or placement of adoption. The Trust Administrator must be notified within thirty (30) days of the qualifying event.

Special Enrollment occurs when a Participant: (1) is eligible for benefits through the Fund (2) has voluntarily declined coverage with the Fund; (3) then marries and/or adds a Child through birth or adoption during the Coverage Period. Remember, Spouses, newborns and adopted Dependents are ***not*** eligible to enroll ***unless*** the member is a Participant ***in the Fund***.

If a Participant is late enrolling in the Fund, HIPAA may subject Participants and Dependents to a twelve (12) or eighteen (18) month waiting period if the Certificate of Creditable Coverage is not provided timely to the Fund.

If you need more information about Special Enrollement please contact the Fund immediately through PacFed Benefit Administrators at (818) 243-0222.

IMPORTANT NOTE:

Certified Birth Certificates are required to add dependent children. Certified Marriage Certificates are required to add a spouse.

BENEFITS APPLICABLE TO CALIFORNIA DOMICILED PARTICIPANTS

Medical and Prescription Drug Coverage

The Fund contracts with Blue Shield and Kaiser Permanente to provide PPO and HMO benefits for the Fund's Participants who reside in California. Complete versions of the SBCs for these plans may be found on the Fund's website www.pacfed-musicians.com. In addition to the Blue Shield and Kaiser health plans, the Fund sponsors ACA-compliant prescription drug benefit plans. Please see attached SBCs at Appendix "A" to this SPD.

Medicare Part D Notification

(The Following Section Applies Only To Those Fund Participants and/or Covered Dependents Who Are Eligible for or Actually Enrolled In Medicare Coverage)

Under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "MMA"), new prescription drug benefits were added to Medicare. The Trustees have determined, based on current Federal law, that the prescription drug benefits currently sponsored by the Fund meet the MMA's creditable coverage requirements. This means that the anticipated financial value of the prescription drug benefits offered by the Fund would equal or exceed the amount of paid claims under the standard Medicare Part D prescription benefit. This also means Medicare eligible Participants, or soon to become Medicare eligible Participants, may maintain enrollment in the Fund's benefit plans and will not be required to pay an extra enrollment fee when, or if, you later enroll for both Medicare and Medicare Part D.

Eligible Participants may enroll in a Medicare Part D prescription drug plan. Generally, the annual Open Enrollment Period for Medicare Part D is October 15th – December 7th Participants in union/employer medical plans, such as the Fund, may also be eligible for special enrollment in Medicare Part D.

If a Medicare eligible Participant drops his/her prescription drug coverage through the Fund, and opts for a Medicare Part D plan, then the Participant's Dependents, to the extent they are enrolled in and covered by the Fund, may lose their prescription drug coverage. These Dependents may not be able to reinstate prescription coverage with the Fund.

Furthermore, the ACA imposed various modifications to Medicare Part D. Most significantly, these changes are in the area of the "doughnut hole" and related out-of-pocket costs. Please consult the Medicare website (www.medicare.gov) for more information about how the ACA impacts your costs and coverage if you are enrolled in, or eligible for, enrollment in Medicare Part D.

If a Participant, who is Medicare eligible, drops or loses coverage with the Fund, and that Participant does not enroll with a Medicare Part D plan within the allowable time, then that Participant must pay a penalty before being allowed to enroll in a Medicare Part D prescription drug plan. Under the MMA, if a Participant, loses his/her coverage with the Fund and then goes 63 days, or longer, without prescription drug coverage that meets or exceeds Medicare Part D prescription drug plan, then that Participant's monthly premium will rise 1% for each month that Participant does not have the required coverage. Additionally, if a Medicare eligible Participant fails to timely enroll in an approved Medicare Part D prescription drug plan after dropping or losing coverage with the Fund, he/she may also have to wait until the next Open Enrollment to re-enroll with the Fund.

For more information about potential options under, and questions about, Medicare Part D coverage and enrollment, please contact:

1. The Fund's Administrator;
2. www.medicare.gov
3. 1-800-MEDICARE

For those Participants who have limited resources and income, help for paying Medicare Part D prescription drug plan premiums is potentially available. Please contact the Social Security Administration at www.socialsecurity.gov or 1-800-772-1213 for more information.

Chiropractic/Acupuncture Coverage

The Trustees have contracted with Landmark Healthplan (Landmark) for Chiropractic and Acupuncture benefits. However, the Participant must be enrolled in either the Level "A" or Level "B" medical plan coverage to receive these supplemental benefits. This supplemental benefit provides acupuncture coverage along with limited herbal therapy coverage. You must utilize an in-network provider listed in the Directory of Participating Chiropractors and Acupuncturists for these services to be covered.

Please see Appendix A attached at the end of this SPD for a summary of the Landmark Chiropractic/Acupuncture benefit and any applicable co-payment schedules. **You can also view the schedule of Accupuncture benefits and co-payments at: www.pacfed-musicians.com**

Note: Ancillary benefits (Chiropractic/Acupuncture, Vision, and Dental) are not available to those who qualify for Level C Benefits. However, if a Participant qualifying for Level C waives medical coverage they may opt to enroll in the Dental/Vision plan benefits.

Dental Coverage

The Fund has contracted with Delta Dental Plan (Delta) to provide dental benefits to Participants. Delta offers two options, a Dental Health Maintenance Organization (DHMO) through DeltaCare USA and Delta Dental PPO through Delta Dental Plans of California. When enrolling for benefits coverage through the Fund, Participants may enroll in one, but not both, of these options. Both options are described below.

PLAN 1 – Deltacare Dental Health Maintenance Organization (DHMO)
If you choose to enroll in the DHMO, you must select a provider from the directory supplied by DeltaCare USA. To obtain Covered Services you must receive care from the dentist you selected. Please read the EOC from Delta Dental to understand your benefits.

PLAN 2 - Delta Dental PPO
If you elect to enroll in the PPO plan, you may select a provider from the preferred list or choose any provider you like. When you utilize a PPO, your benefits will be different than if you select a dentist who is not on the list. The percentage of Covered Services is determined by whether the Dentist is in-network or out-of-network. Please refer to your Delta Dental EOC for information about benefits, co-payments, co-insurance and deductibles.

Please see Appendix A attached at the end of this SPD for a summary of the Delta Dental benefit and any applicable co-payments or co-insurance schedules.

Vision Plan Coverage

Gerber Life underwrites the Fund's vision benefits. Vision benefits are administered through MES Vision. If you want vision benefits, you *must separately enroll* in the Plans' vision benefit program. Enrolling in one of the health/medical coverage options *does not* automatically make you eligible for vision benefits.

Please see Appendix A attached at the end of this SPD for a complete summary of the MES Vision benefit and any applicable co-payments or co-insurance schedules.

IMPORTANT NOTE

All eligible participants are able to waive medical coverage and enroll in Dental/Vision and life insurance. A Dental/Vision enrollment form and life beneficiary form must be completed, signed and returned to the Administrative office within the Open Enrollment time period.

Life and Accidental Death and Dismemberment Insurance

The Prudential Insurance Company of America

All Eligible Employees (e.g., those who qualify to enroll in the Fund's benefit plans, regardless of level) are automatically enrolled in the Prudential Life and Accidental Death and Dismemberment plan regardless of whether the Participant has actually enrolled in a medical plan sponsored by the Fund. Dependents are not eligible for this benefit.

Please see Appendix A attached at the end of this SPD for a summary of the Prudential Life and Accidental Dismemberment benefit.

IMPORTANT NOTE

Remember to complete and return a Prudential Beneficiary form to the Fund Administrative office. Beneficiary Forms may be found on the Fund's website Forms Page – www.pacfed-musicians.com. This is important if you want your life insurance benefit to go to the correct beneficiaries.

Please see Appendix A attached at the end of this SPD for a summary of the Prudential Life and Accidental Dismemberment benefit.

IMPORTANT NOTE:

All plans or services may not be available in every geographic region. Please refer to your provider's EOC and/or SBC, or call the Fund Administrator, to determine if your Benefit Provider offers coverage where you reside. Services will not be provided if you do not reside within the service area covered by the plan you chose.
Provider's EOC and/or SBC are available at www.pacfed-musicians.com.
Vision, Dental and Chiropractic benefits are NOT offered nor provided to Participants and/or Dependents who do not live in California.

SUMMARY OF BENEFITS & COVERAGE

The Fund provides each enrolled Participant, and their Dependents with a copy of the applicable SBC for the applicable insurance plan. The SBC will contain descriptions of the benefits provided, including the applicable limitations and exclusions, if any, which relate to the selected insurance plan. If you do not receive an SBC, please contact the Fund Administrator.

The SBC for each Benefit Provider are posted on the Fund's website at www.pacfed-musicians.com . If you cannot download or print an SBC from the Fund's website, please contact the Fund Administrator and the relevant SBC will be mailed to you at no cost.

WOMEN'S CHOICE FOR HEALTHCARE PROVIDERS

Prior authorization is not required by the Fund, Blue Shield, Kaiser Permanente, or from any other person (including a primary care provider) before a Participant or Dependent receives obstetrical or gynecological care from an in-network health care professional specializing in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your provider's service center (these phone numbers are listed on page 62 of this SPD).

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NMHPA)

Group health plans, and health insurance issuers, may not, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child. This means that a mother and newborn may not have their hospital stay restricted to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. Additionally, the Fund or any Benefit Provider may not require prior authorization for prescribing the length of the hospital stay for child births. However, Federal law does not prohibit the attending provider, after consulting with the mother, from discharging the mother or her newborn prior to the minimum length of stay discussed above.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 ("WHCRA")

If your health plan provides medical and surgical benefits for mastectomies, and a Participant or a Dependent receives benefits in connection with a mastectomy and who later elects to have breast reconstruction surgery in connection with such mastectomy, then the following benefits must also be provided:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery/reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications, including lymphedema, in a manner determined in consultation with the attending physician and the patient.

COORDINATION OF BENEFIT RULES
(APPLICABLE TO ALL BENEFIT LEVELS AND PLANS)

The Benefit Providers the Fund contracts with will coordinate with any other applicable plan(s) to ensure that benefits you are eligible to receive through the Fund are provided. Coordination shall occur pursuant to the rules and regulations of the carrier which provides the benefit at issue. Contact the Fund Administrator and/or review the applicable EOC or SBC for further coordination of benefits information.

Under the Medicare, Medicaid, and CHIP Extension Act of 2007, the Fund – through its carriers – coordinates benefits with Medicare for those Participants who are Medicare eligible. Thus, for any Participant, who is Medicare eligible, the Fund's carrier shall be primary insurer and Medicare is secondary: this applies both for Medicare Parts A and B as well as Medicare Part D.

CONTRIBUTIONS REMITTED TO A "HOME LOCAL HEALTH & WELFARE FUND" PURSUANT TO AN AFM AGREEMENT OR RECIPROCITY LANGUAGE IN A LOCAL 47 CBA

As noted, some Agreements negotiated by the AFM require Employer contributions to be remitted to the Fund for certain covered work. These same Agreements provide that the required Employer contributions may be remitted to a health and welfare fund sponsored by an employee's "home local union." As a result, the Fund may maintain what are known as "reciprocity" arrangements with health and welfare funds sponsored by other AFM local unions. These reciprocity arrangements may allow transfers of Employer contributions that were erroneously made either to the Fund (for a non-Local 47 musician) or to a health and welfare fund sponsored by another AFM local union.

Although these Employer contributions should be received and credited to the health and welfare fund where the covered musician actually resides, transferring contributions is not automatic. A Participant must request, in writing, that the Fund (i) seek the transfer of Employer contributions from another health and welfare fund to the Fund (so long as the Fund maintains a reciprocity arrangement with the other health and welfare fund) or (ii) transfer Employer contributions the Fund has received on behalf of an employee to a health and welfare fund sponsored by another AFM local union (so long as the Fund maintains a reciprocity arrangement with the other health and welfare fund and your "home local union").

Any request for the transfer of Employer contributions ***must*** be made prior to October 2, in any Qualifying Period, to allow the Fund sufficient time to request/initiate the transfer of contributions prior to the Fund's annual eligibility determination. The Trustees retain the full, complete and unfettered discretion to approve, modify or deny an Employee's request to transfer Employer contributions to another health and welfare fund.

IMPORTANT NOTICE CONCERNING THE USE OF PAYROLL COMPANIES IN CONNECTION WITH CONTRIBUTIONS TO THE FUND

Under the Fund's rules and regulations, as well as governing law, a third party payroll company may only remit Employer contributions to the Fund, on behalf of a bona-fide Employer, where the Employer has properly documented that it appointed the payroll company as its agent to process payroll and that the end-user Employer is actually responsible for payment of the ***full and complete amount of Employer contributions*** due for the applicable engagement. This includes the end-user Employer being responsible for the required contributions to the Fund and requires the Employer to enter into an appropriate Agreement, requiring contributions to the Fund, with Local 47 or the AFM, as well as any additional Participation Agreement which may be required by the Fund. Moreover, any Employer contributions processed by a payroll company must be for covered employment (i.e., a musical engagement covered by a Local 47 or AFM Agreement). If the required documentation, e.g., a written agreement/designation between the Employer and the payroll company is not provided to the Fund, at the time of or in advance of the Fund's receipt of the Employer contributions, the Fund reserves the right, in its sole and exclusive discretion, to reject any and all Employer contributions remitted by a third party Payroll Company.

ELIGIBILITY RULE RELATING TO OWNERSHIP OF A CONTRIBUTING EMPLOYER ENTITY

When Employer contributions are remitted to the Fund on behalf of an Employee/Participant who, or whose relative(s), directly or indirectly own(s) ten percent (10%) or more of the equity of the contributing Employer entity, or where a contributing Employer is a non-profit entity, as defined under Internal Revenue Code, for which an Employee/Participant is an officer, board member, director (or serves in another similar capacity of such non-profit), such Employer contributions shall generally not count toward the Participant's qualification for eligibility to enroll in the Fund's benefit plans. However, if there is sufficient documentation to establish that the amount paid by one or more third parties to the Employer or revenue obtained from third parties by the Employer is sufficient to cover (a) the prevailing base scale, as set forth in the applicable Agreement and (b) the total amount of Employer contributions due to the Fund, then the Employer contributions will be treated as if made by an unrelated third party on behalf of a 10% owner and shall be counted towards the 10% owner's/employee's eligibility.

Through this rule, the Trustees' intent is to prohibit Employer contributions that cannot be substantiated by documentation showing that a third party actually contracted with, and paid, the Employer an amount adequate to cover all scale wages and benefits for all musicians who performed at the engagement in question. Provided, however, this rule shall not be applied to non-owner side-musicians whose employment with the Employer is a legitimate arm's length transaction and on whose behalf Employer contributions are properly remitted to the Fund.

This does NOT mean that if you are an owner you cannot have Employer contributions applied to your eligibility. It only means that additional documentation must be provided to show that there was a third party purchaser and the purchaser paid an amount sufficient to cover scale wages and benefits.

If you have any questions, call the Fund Administrator at (818) 243-0222.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

Any Child of a Participant who would otherwise be eligible to enroll per the Fund's rules and regulations (e.g., a Particpiant who has sufficient employer contributions made on her/his behalf during a qualifying year), must be enrolled if a Court or Agency issues a Qualified Medical Child Support Order ("QMCSO). This is required under the Omnibus Budget Reconciliation Act of 1993 ("OBRA-93"). A QMCSO is (1) any judgment, decree, or order (including approval of a settlement agreement) issued by a court or an administrative agency authorized to issue Child support orders under State law that (2) requires that the Child of a Participant be enrolled in health benefits under the Plan; **or** enforces State law relating to medical Child support pursuant to Section 1908 of the Social Security Act., Section 1908 provides, in part, that if the Participant parent does not enroll the Child, the non-Participant parent, or State agency, may enroll the Child.

QMCSO's must clearly specify:

1. The name and last known mailing address of the Participant and the name and mailing address of each Child covered by the QMCSO;
2. A reasonable description of the type of coverage to be provided by the Plan to each such Child, or the manner in which such type of coverage is to be determined;
3. The period to which each order applies; and
4. The Court or Agency that issued the QMCSO.

A QMCSO cannot require the Fund to provide any benefits or options not otherwise provided under the Plan, unless the benefit is necessary to comply with Section 1908 of the Social Security Act.

Once the Fund Administrator receives a QMCSO, the Fund Administrator must notify the Participant and each Child, named in, and covered by, the QMCSO, that the QMCSO was received and provide each party a copy of the procedures the Fund uses to determine whether the QMCSO is qualified. Each Child, named in the QMCSO, will also be notified of his or her right to designate a representative to receive copies of all notices sent to the Child with respect to the QMCSO.

The Fund Administrator must review the QMCSO to ensure that it is a properly issued QMCSO. The Fund Administrator will make such a determination within a reasonable period, and notify the Participant and each Child of the determination. If the Order is a QMCSO, the Child will be enrolled in the Plan.

Benefit payments made to the Plan by the Participant and pursuant to a QMCSO may be reimbursed to an alternate recipient or his/her custodial parent or legal guardian.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008
(APPLICABLE TO CALIFORNIA AND NON-CALIFORNIA HMO & PPO MEDICAL PLANS)

Under the Mental Health Parity and Addiction Equity Act of 2008 (the "MHPAEA"), group health plans that sponsor any form of mental health or substance abuse/addiction treatment coverages must (1) provide such coverage on the same economic basis as all other health/medical coverages (i.e., same co-pays for similar treatments; same co-insurance payments for similar treatments, etc.) and (2) honor claims for out-of-network mental health/substance abuse expenses on the same economic basis as they would cover out-of-network health/medical expenses.

Additionally, and under the MHPAEA, a group plan's treatment limitations (e.g., the amount of and frequency of doctor visitations, treatments, etc.) cannot be more restrictive for mental health/substance abuse matters than the predominant limitations that apply to substantially all of the medical/health benefits sponsored by the group plan.

MHPAEA also allows covered group plans to require that a Participant must have a medical necessity for any claim relating to medical health/substance abuse coverage. If a group plan cannot determine that a medical necessity exists for a mental health or substance abuse claim, a Participant, or her/his treating physician, will be provided, upon request, the criteria used to determine that the treatment was not medical necessary. The reason for a denial is required, under MHPAEA, to be provided in a written form when claims are denied and the reason for the denial.

Also, the ACA includes mental health and substance abuse services within the definition of “minimum essential health benefits.” This means that certain group plans must also cover mental health and substance abuse services as part of their benefits. Moreover, the ACA requires, starting in plans years that commence in 2014, that group insurers may no longer exclude Participants from mental health or substance abuse benefits because of a pre-existing condition.

As the Fund’s Benefit Providers determine and set mental health coverage (where applicable), any inquiry regarding MHPAEA compliance should be directed to the Benefit Providers who are providing health and medical coverages to the Fund. Please consult the applicable EOC and SBC to determine the level and type of mental health/substance abuse benefits that may be available through your Benefit Provider.

Pursuant to an actuarial review of the Fund’s benefit plans and their benefits structure, the Fund certifies that the benefit plan(s) sponsored and administered by the Fund comply with MHPAEA.

FAMILY MEDICAL LEAVE ACT (FMLA)

The Fund will accept contributions from an Employer on behalf of an Employee who has taken leave for a qualifying family or medical reason pursuant to the FAMILY AND MEDICAL LEAVE ACT OF 1993 ("FMLA"), as amended by The National Defense Authorization Act ("NDAA"). However, a Participant must satisfy the following requirements before he/she can obtain, or maintain, coverage:

1. Employer contributions must meet the minimum contribution level necessary for eligibility;
2. The Employer contributions must be made in compliance with the applicable Collective Bargaining Agreement, and if applicable the signed Participation Agreement.;
3. If already enrolled in, and receiving, benefits from the Fund, the Employee must remit the Premium, and if applicable the Dependent Premium, in a timely manner and as required by the Fund's rules and regulations;
4. The Participant must comply with all rules and regulations set forth by the Trustees.

Continued participation in the Fund during FMLA covered leave is optional: if you (a) are currently covered, based on Employer contributions remitted on your behalf, and (b) enrolled in Fund sponsored benefits, then you may continue your coverage during your FMLA covered leave so long as you timely remit all required Premium payments. If you elect not to continue coverage during your FMLA covered leave, you must notify the Fund, in writing, of your election. Your coverage will be reinstated upon return to active working status.

Please note that the Fund does not sponsor nor participate in any plan that provides paid family leave benefits to the Participants.

IMPORTANT NOTE:

You must contact your Employer to determine your eligibility for FMLA leave. It is not the role of the Trustees or the Fund Administrator to determine if you are entitled to leave under the FMLA and/or corresponding state law.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, but you think you or any of your Dependents might be eligible for assistance, contact your State's Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State Representative if a program exists that might help you pay the premiums for an employer-sponsored plan.

Participants or Dependents who qualify for Medicaid or CHIP premium assistance, are permitted to enroll in the plan – as long as you and your Dependents are eligible, but not already enrolled. This is called a "Special Enrollment" Period, and **you must request**

coverage within 60 days of being determined eligible for premium assistance by the applicable state agency.

California residents may contact the California Medicaid (Medi-Cal) office at 1-866-298-8443, or visit their website at: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx.

For more information regarding other States or your special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF COVERAGE UNDER FEDERAL LAW

COBRA requires most employers, who sponsor group health plans, to offer employees and their families the opportunity to temporarily extend their health coverage at group rates though their employment has terminated. Individuals covered by COBRA are referred to as Qualified Beneficiaries. COBRA applies to employer-sponsored group(s) or individual medical, dental, vision, prescription drug plans, certain health flexible spending accounts, and other arrangements. This notice is intended to inform you of your rights and obligations under COBRA. (Both you and your Spouse should take time to read this notice carefully.)

Eligibility for COBRA Coverage

Qualified Beneficiaries (see page five (5) for definition) are covered by COBRA if coverage is terminated following a Qualifying Event.

1. **The Participant/Qualified Beneficiary:** A Participant may lose group health coverage because of a reduction in hours of employment or the termination of their employment (for reasons other than gross misconduct), then they have an independent right to elect COBRA continuation coverage, for up to 18 months.

2. **Other Qualified Beneficiaries, other than the Employee, that are currently-enrolled in a group health plan:** Dependents may also elect COBRA coverage if any of the following qualifying events occur and proper notice is given:

a. The Participant dies;
b. Divorce or legal separation; or
c. The Participant is eligible for Medicare coverage. (A Participant is eligible for Medicare Part A if he or she is 65 years of age or older and receives (or has applied for) Social Security. A Participant may also be eligible for Medicare/Social Security before age 65 if they qualify for SSDI due to a disabling condition).

People who meet this criteria have an independent right to extend COBRA benefits for a maximum of 36 months.

3. **A Qualified Beneficiary who is a "child"** may be covered under his or her parent's group health plan (e.g., a child up to the age of 26 or a child who, could lose coverage after age 26, is disabled and cannot care for themselves) for a maximum of 36 months if proper notice is provided to the Fund Administrator's Office and:
    a. The Participant dies;
    b. The Participants' divorce or legally separate;
    c. The Participant is eligible for Medicare coverage. (A Participant is eligible for considered entitled to Medicare Part A if he or she is age 65 years of age or older and receives (or has applied for) Social Security. A Participant may also be eligible for or is entitled to Medicare/Social Security before age 65 if they qualify for SSDI at an earlier age due to a disabling condition); or
    d. The Qualified Beneficiary ceases to be a Dependent child, as defined in the group health plan and/or the ACA, whichever is applicable.

4. **Adopted/Newborn Child:** A newborn or child placed for adoption by a Qualified Beneficiary while the Qualified Beneficiary is insured under COBRA is also a Qualified Beneficiary. The newborn or adopted child must be added to COBRA coverage within the time required by the plan. The newborn or adopted child's continuation coverage period is measured from the original date that COBRA coverage began.

IMPORTANT NOTE:
You are not eligible for COBRA coverage unless (A) you were eligible for, and did enroll in, a benefit Plan offered by the Fund and (B) you lost coverage due to a COBRA qualifying event.
Failure of a Qualified Beneficiary to remit Premiums of any type or to follow the rules and regulations established by the Trustees is ***NOT*** a COBRA qualifying event.

Obtaining and Enrolling In COBRA Coverage

COBRA requires Qualified Beneficiaries to timely notify the Fund Administrator once a Qualifying Event or loss of coverage occurs.

The Employer must notify the Fund Administrator if a Qualified Beneficiary dies, is terminated, his/her hours are reduced, or elects to be covered under Medicare. (*See* Eligibility for COBRA Coverage Section, above, for Medicare eligibility requirements).

When the Fund Administrator is notified of a Qualifying Event, the Fund Administrator will then notify the Qualified Beneficiary, in writing at their last known address, of their right to continue coverage. This notice is known as the COBRA Continuation Coverage Election Form.

Under COBRA Qualified Beneficiaries have 60 days to inform the Fund Administrator, in writing, whether you have elected COBRA coverage. This election period begins on the later of: (1) the date you lose coverage due to one of the events described above, or (2) the date you are provided your COBRA Continuation Coverage Election Form.

The Fund reserves the right to decline COBRA coverage for any Qualified Beneficiary who fails to complete and timely file the "COBRA Continuation Coverage Election Form" with the Fund Administrator. Each Qualified Beneficiary has an independent election right. However, a covered employee or the Spouse of the covered employee may elect continuation coverage for all qualifying family members. If you are, or became, mentally or physically incapacitated during this election period, an appointed guardian or responsible party may elect and/or pay for COBRA continuation coverage on your behalf.

After a Qualified Beneficiary makes a COBRA election, they have 45 days to remit the initial Premium(s); a 30-day grace period shall apply to all subsequent COBRA Premiums.

EXAMPLE NO 1: Joe is notified that he will lose his insurance coverage with the Fund. Joe's health benefits will terminate December 31. Joe has 60 days from December 31st to elect COBRA. On February 26th Joe decided to submit his COBRA Continuation Coverage Election Form, enrollment application, and check.

ANSWER: Joe paid for three months of coverage (January, February and March) and his Premiums are retroactive to the first day that he lost coverage. Joe is now covered by COBRA for benefits retroactive to January 1 through March 31.

EXAMPLE NO 2: Mary was notified that she is no longer eligible for health benefits provided by the Fund. She made her COBRA election on February 10th. When she mailed her COBRA Continuation Coverage Election Form and application she DID NOT send a check to the Fund Administrator's Office.

ANSWER: Mary will be covered as long as she pays all applicable Premiums no later than 45 days from February 10.

IMPORTANT NOTE:

You will **not** be enrolled in, or covered by, COBRA for benefits until the Fund Administrator receives full payment for your COBRA Premium. You have the right to elect COBRA within 60-days and must pay 45 days after the election. Qualified Beneficiaries will not be covered by the insurance company until the **full** Premium is paid.

COBRA requires the Fund to offer Qualified Beneficiaries the opportunity to elect the same coverage and enrollment rights provided to active employees. Ordinarily, this will be the same coverage the Qualified Beneficiary had on the day before the qualifying event. Coverage is subject to change if the group Plan is modified for active employees.

If you choose COBRA coverage, your election (or Premium) is considered made on the date you send your election form (or Premium) to the Fund Administrator's Office. If you do not elect and pay for COBRA coverage, your group health coverage will end in accordance with the terms of the Plan.

Cost and Payment of COBRA Premiums

As mentioned above, COBRA coverage is available **at your own expense.** If you or your Qualified Beneficiaries elect COBRA coverage, the cost will be the full cost of the Premium plus a 2 percent administrative fee. This means that if the Premium is $100, the COBRA Premium would be $102.

Example:

Cost of Coverage	Your COBRA Premium
$100	$102

You may elect to continue the Medical (including prescription drug and chiropractic/acupuncture), coverage only or, Medical (including prescription drug and chiropractic/acupuncture), Dental and Vision coverage. However, Life and Accidental Death and Dismemberment Benefits **are not** available under COBRA.

Qualified Beneficiaries are responsible for submitting their COBRA Premiums in full. These Premiums must be received by the Premium due date, as established by the Trust Administrator. If the full amount of the required Premiums is not received within 30 days of the due date, COBRA will not be offered. Termination of COBRA coverage will occur, when a Qualified Beneficiary fails to timely remit the required Premium(s).

IMPORTANT NOTE:

The Fund will not send monthly billing statements or other reminders that monthly COBRA Premiums are due. The timely remittance of monthly COBRA Premiums are the sole responsibility of the Qualified Beneficiary. COBRA Premiums are due prior to the 20th day of the month before the month of coverage. (i.e. July coverage is due June 1st)

Disability Extension to COBRA Coverage

COBRA's standard continuation coverage period, 18 months, may be extended to 29 months if any Qualified Beneficiary is determined to have been disabled (under Title II or XVI of the Social Security Act) at any time during the first 60 days of coverage. In the case of a newborn or adopted child, the 60-day period is measured from the date of the child's birth or placement for adoption. The Qualified Beneficiary is responsible to notify the Fund Administrator, complete, sign and return the form to the Fund Administrator's Office. The Qualified Beneficiary must also provide the Social Security Administration disability determination letter (commonly referred to as a Notice of Award) within 60 days of receipt and it must be submitted ***before the end*** of the original 18-month coverage period.

If COBRA coverage is extended due to a disability and the disabled individual is part of the coverage group, the Fund may charge up to 150 percent of the applicable Premium during the disability extension period.

The Fund Administrator must be notified within 30 days of any final determination, by the Social Security Administration, that the individual is no longer disabled. A Qualified Beneficiary must contact the Fund Administrator and request a form titled COBRA Continuation Coverage Election Form. You must complete, sign and return the form to the Trust Administrator's Office within 30 days of any final determination of the loss of Social Security disability status.

Second Qualifying Event Extension

COBRA's coverage period, 18 or 29 months (in the case of Social Security disability status; *see*, Disability Extension to COBRA Coverage, described above), may be extended an additional 18 months. Coverage will be extended to 36 months for eligible Qualified Beneficiaries if a second qualifying event occurs during the initial period of coverage (such as employee death, divorce, legal separation, employee Medicare entitlement *see*, Eligibility For COBRA Coverage Section, above, for definition of Medicare entitlement or a child losing Dependent status) during the initial 18 or 29 month period. An extension may be granted if the Fund Administrator is notified, in writing, within 60 days of the second qualifying event that occurred within the original 18- or 29- month coverage period.

To qualify for a second extension, you must contact the Fund Administrator and request COBRA Continuation Coverage Election Form. The Qualified Beneficiary is responsible

to complete, sign, and return the form to the Fund Administrator within the 60-days of receipt before the extension is due. In no event will COBRA coverage last beyond three years from the date of the qualifying event that made the Qualified Beneficiary eligible for COBRA coverage. If the qualifying event occurs within 18 months after the Employee became entitled to Medicare, then the other Qualified Beneficiaries will be entitled to extend COBRA coverage for 36 months after the Qualified Beneficiary enrolled in Medicare.

The Plan reserves the right to retroactively terminate your COBRA coverage if it is later determined that you were ineligible or you violated the law, and/or any rules of the Fund, when you applied for and/or were found eligible for COBRA coverage.

Open Enrollment Under COBRA

Qualified Beneficiaries who used to be covered through the Fund and who have enrolled through COBRA may select any medical, dental, vision, and/or any other benefits available during Open Enrollment. The effective date of any change in COBRA coverage will be the first day of the month following Open Enrollment.

Qualified Beneficiaries may select a different Benefit Provider than they selected before the Qualifying Event as long as the benefit level (e.g., Level “A,” “B,” or “C”) remains the same.

Termination of COBRA Continuation Coverage

Eligibility for COBRA Coverage for Qualified Beneficiaries will terminate on the first day of the month following any of the events listed below:

a) Failure to remit the Premium, in full and on time; or
b) A Qualified Beneficiary receives coverage under another group health plan; or
c) A Qualified Beneficiary is eligible for Medicare after first qualifying for COBRA coverage through the Fund; or
d) The date the Fund ceases to provide group health coverage under this Plan or is no longer required to provide continuing coverage as a matter of law; or
e) A final determination is made by the Social Security Administration that a Qualified Beneficiary is no longer disabled; or
f) A Qualified Beneficiary exhausts their COBRA benefits; or
g) A Qualified Beneficiary requests, in writing, that COBRA coverage be terminated; or

   A Qualified Beneficiary fails to abide by and follow all applicable rules and regulations of the Fund. The Fund may cancel coverage retroactive to the date the Fund determines that a violation of its rules and regulations was committed; or
h) A Qualified Beneficiary obtains coverage through California Covered or another exchange and qualifies for government premium subsidies.

IMPORTANT NOTE:

If a Qualified Beneficiary relocates to an area that a Benefit Provider does not cover, alternative coverage may not be available. If coverage is not available, or cannot be extended to the Qualified Beneficiarys' new location, the Qualified Beneficiary must select coverage from a different Benefit Provider (restrictions may apply). COBRA coverage will not be provided to the affected Qualified Beneficiaries if none of the then current Benefit Providers offer coverage in the new area where they reside.

Conversion Rights Upon Expiration of COBRA Coverage

If COBRA benefits terminate, Qualified Beneficiaries may, if eligible, convert from a group health insurance (medical only) to an Individual Insurance plan. You must check your Benefit Provider's EOC Booklet to determine whether you are eligible to transfer to an Individual Insurance plan.

Additional COBRA Information

This notice provides you with a broad overview of a complex law. If the content in the SPD differs from federal law, federal law will prevail.

To protect your rights, you should notify the Fund Administrator in writing of any change in marital status, when a Qualified Beneficiary ceases to be eligible for coverage under the Plan, or if you, or you change addresses. The Fund Administrator's Office address is:

PacFed Benefit Administrators
1000 North Central Avenue, Suite 400
Glendale, CA 91202
818-243-0222

MILITARY SERVICE AND CONTINUATION OF COVERAGE UNDER USERRA

Participants who are members of the Uniformed Services may still be covered by the Plan even if they are called up for duty. "Uniformed Services" is defined as the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Services, and any other category of persons designated by the President in time of war or national emergency. Though every situation is unique, there are two federal laws which must be considered: COBRA (as discussed above) and the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA), which is discussed more fully below.

Participants, or their Dependents, covered by an Employer sponsored health plan may elect to continue to be covered by the Fund under USERRA if the Participant is absent by reason of service in the Uniformed Services. Participants may be covered for the lesser

of (1) the 24-month period beginning on the date on which the Participant's absence begins; or (2) the day after the date on which the person fails to apply for or return to a position of employment which was vacated to perform military service.

A Participant who elects to continue health-plan coverage under USERRA may not be required to pay more than 102 percent of the full Premium under the plan. Participants who perform service in the uniformed services for less than 31 days may not be required to pay more than the Participant's share, if any, for coverage.

Any liability under the plan for Employer contributions arising under this paragraph shall be allocated by the Fund as follows: (i) to the last Employer employing the person before the period served by the person in the Uniformed Services, or (ii) if such last employer is no longer functional, then to the Fund.

If you elect continuation coverage, the COBRA and USERRA continuation periods run concurrently.

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

HIPAA requires the Fund to provide Participants and/or Dependents with written certification of their coverage under the Plan when a "qualifying event" occurs. Generally, a "qualifying event" for purposes of HIPAA is the same as a qualifying event under COBRA: a loss of employment or a loss of coverage due to a reduction in hours.

When a qualifying event occurs - e.g. loss of coverage due to lack of Employer Contributions - the Participant and/or Dependent will be issued a "Certificate of Creditable Coverage" at their last known address. The Certificate of Credible Coverage states the period of time you were covered by the group plan and the date on which you lost coverage. Participants and/or Dependents may also request, up to 24 months after loss of coverage due to a qualifying event, a Certificate of Creditable Coverage by contacting the Fund Administrator at:

Professional Musicians, Local 47 and Employers' Health and Welfare Fund
C/o PacFed Benefit Administrators
1000 North Central Ave., Suite 400
Glendale, CA 91202

The Fund Administrator will provide Participants a Certificate of Creditable Coverage (as defined in HIPAA) as soon as legally required.

The Certificate of Creditable Coverage allows you to enroll in another group health plan if you lose your eligibility for benefits with the Fund. Under HIPAA, the premium rate you can be charged for by the new plan will also be impacted by whether you can provide the new plan with a Certificate of Credible Coverage.

REQUIRED HIPAA DISCLOSURE ABOUT THE FUNDS' PROTECTED HEALTH INFORMATION AND YOUR PRIVACY

THE FOLLOWING DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

General Information About Health Information Confidentiality

The Fund is committed to maintaining the confidentiality of your private medical information. The Fund will take great effort to safeguard your health information from a prohibited, improper or unnecessary use or disclosure of your personal health information ("PHI or PII"). This section only applies to health-related information that was created, or received, by, or on behalf of, the Fund. The safety of your PHI or PII is required by federal law, specifically privacy regulations issued under HIPAA and the Health Information Technology for Economic and Clinical Health ("HITECH") Act. This is a summary of the Plan's privacy practices and related legal duties, which include your rights in connection with the use and disclosure of your PHI.

For purposes of this section on HIPAA and PHI/PII, the terms as: "Plan," "we," "us," and "our" all refer to, and are synonymous with, the Fund, the Plan and third parties to the extent they perform administrative services for the Plan. When a third party service provider performs administrative functions for the Plan, we, and the law, require them to appropriately safeguard the privacy of your information.

Please note: If you are enrolled in an HMO you will also receive a HIPAA notice from your HMO provider. The Plan's notice generally describes the HMO providers' specific use and disclosure of your personal health information to and with the Plan. The legal requirements safeguarding your medical records and information, and its use and disclosure are set forth in the HMO's notice.

If you have any questions regarding this Notice, please contact:
Privacy Officer
Professional Musicians, Local 47 and Employers' Health & Welfare Fund
1000 North Central Avenue, Suite 400, Glendale, California 91202-3627

What is Protected?

Federal law requires the Plan to have a special policy for safeguarding "protected health information," or "PHI," received or created in the course of administering the Plan. PHI is health information that can be used to personally identify you and that relates to: your physical or mental health condition, the health care services provided to you, or any payments made for your health care services.

Any medical or dental records, your claims for medical or dental benefits and the explanation of benefits ("EOB's") sent in connection with payment of your claims, are all examples of PHI.

Uses and Disclosures of Your PHI

In addition to protecting your privacy and your PHI, your PHI must be securely transferred and stored by the Fund Administrator or the Service Providers selected by the Fund Administrator. The Fund Administrator must limit the way your PHI is used or disclosed to others. We may, however, use or disclose your PHI in certain circumstances described below. To the extent required under federal health information privacy law, we limit the use of PHI required:

To determine proper payment of your Health Plan benefit claims.

To reimburse you, your doctors, or health care providers for covered treatments and services. For example, your diagnosis information may be used to determine whether a specific procedure is medically necessary or to reimburse your doctor for your medical care. However, the Plan may not provide PHI to an insurer, for purposes of seeking payment where (A) you or someone on your behalf has already paid for the treatment or other medical care; (B) you are not seeking reimbursement for the expense; and, (C) you have given written instructions to the Plan to not release your PHI as it relates to the treatment, medical expense, etc., in question.

For the administration and operation of the Plan. We may use and disclose your PHI for numerous administrative and quality control functions necessary for the Plans' proper operation. For example, we may use your claims information for fraud and abuse detection activities or to conduct data analyses for cost-control or planning-related purposes.

To inform you or your health care provider about treatment alternatives or other health-related benefits that may be offered under the Plan. For example, we may use your claims data to alert you to an available case management program if you are diagnosed with certain diseases or illnesses, such as diabetes.

By a health care provider, if needed, for your treatment.

By a health care provider or to another health plan to determine proper payment of your claim under the other plan. For example, we may exchange your PHI with your Spouse's health plan for coordination of benefits purposes.

By another health plan for certain administration and operations purposes. We may share your PHI with another health plan or health care provider who has a relationship with you for quality assessment and improvement activities, to review the qualifications of health care professionals who provide care to you, or for fraud and abuse detection and prevention purposes.

By a family member, friend, or other person involved in your health care if you are present and you do not object to the sharing of your PHI, or it can reasonably be inferred that you do not object, or in the event of an emergency. For example, a physician may discuss proper medicine dosage with a your spouse or adult child or the Plan may discuss a patient's payment options with an adult family member.

For Plan design activities or to collect Plan contributions The Plan may use summary or de-identified health information for Plan design activities. In addition, Plan employees may

use information about your enrollment or disenrollment in a Plan in order to collect contributions that pay for your Plan participation.

By the Plan Sponsor. The Plan may disclose PHI to the Plan sponsor or the Board of Trustees, to the extent provided by a rule of the Plan, provided that the sponsor protects the privacy of the PHI and it is only used for the permitted purposes described in this Notice.

By Business Associates. The Plan may disclose PHI to other people or businesses that provide services to the Plan and which need the PHI to perform those services. These people or businesses are called business associates ("Business Associates"), and the Plan will have a written agreement with each of them requiring each of them to protect the privacy of your PHI. For example, the Plan may have hired a consultant to evaluate claims or suggest changes to the Plan, for which he needs to see PHI.

To comply with an applicable federal, state, or local law, including workers' compensation or similar programs.

For public health reasons, including (1) to a public health authority for the prevention or control of disease, injury or disability; (2) to a proper government or health authority to report child abuse or neglect; (3) to report reactions to medications or problems with products regulated by the Food and Drug Administration; (4) to notify individuals of recalls of medication or products they may be using; or (5) to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition.

To report a suspected case of abuse, neglect or domestic violence, as permitted or required by applicable law.

To comply with health oversight activities, such as audits, investigations, inspections, licensure actions, and other government monitoring and activities related to health care provision or public benefits or services.

By the U.S. Department of Health and Human Services to demonstrate our compliance with federal health information privacy law.

To respond to an order of a court or administrative tribunal.

To respond to a subpoena, warrant, summons or other legal request if sufficient safeguards, such as a protective order, are in place to maintain your PHI privacy.

By a law enforcement official for a law enforcement purpose.

For purposes of public safety or national security.

To allow a coroner or medical examiner to make an identification or determine cause of death or to allow a funeral director to carry out his or her duties.

To respond to a request by military command authorities if you are or were a member of the armed forces.

For cadaveric organ, eye or tissue donation. The Plan may use and disclose protected health information to organ procurement organizations or other entities engaged in the

procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

For research. The Plan may use and disclose protected health information to assist in research activities, regardless of the source of the funding for the research, where a privacy board or an Institutional Review Board has approved an alteration to or waived entirely the authorization requirements of the law and the Plan receives certain specific representations and documentation.

To avert serious threat to health or safety. The Plan may use and disclose protected health information to prevent or lessen a serious threat to health or safety of any one person or the general public and the use or disclosure is (1) to a person or persons reasonably able to prevent or lessen the threat to health or safety or (2) necessary for law enforcement authorities to identify or apprehend an individual.

To report an Incident if it is a permitted use or disclosure. The Plan may use and disclose protected health information incident to any use or disclosure permitted or authorized by law.

As part of a limited data set. The Plan may use and disclose a limited data set that meets the technical requirements of 45 CFR, Section 164.514(e), if the Plan has entered into a data use agreement with the recipient of the limited data set.

For fundraising. The Plan may use and disclose certain types of protected health information to a business or to an institutionally related foundation for the purpose of raising funds. The types of information that may be disclosed under this exception to the authorization requirement are (1) demographic information relating to an individual and (2) dates of health care provided to an individual. The fundraising materials must also inform you of how you may elect to opt out of receiving further fundraising communications that are healthcare operations. The entity that sends you such communications must treat your request to opt out as a revocation of your authorization to receive any such communications.

Generally, Plan employees may only use or disclose Participant's/Dependents' PHI as described above. This means that Fund employees may not access PHI for reasons unrelated to Plan administration. There is an exception to this rule when a Participant/Dependent provides written authorization to the Plan Administrator. If state laws provide greater protection for your PHI than federal laws, the Plan will apply the stricter of the two laws.

Other Uses and Disclosures of Your PHI

You may revoke your authorization, in writing, at any time. If you revoke a prior authorization, the Plan Administrator will no longer use or disclose your PHI. However, the Plan Administrator cannot retrieve any PHI previously disclosed to a third party. The Plan Administrator may not use, or disclose, your "genetic information" for "underwriting" purposes. See the Genetic Information Nondiscrimination Act of 2008 ("GINA") for definitions.

The Plan Administrator cannot sell your PHI to any other entity without your express written consent. Denial of consent prevents the Plan's providers, and their sub-providers, from using PHI to market services to Participants.

The Plan Administrator may, however, disclose a deceased Participant's or Dependents' PHI, to the decedent's family involved in (A) the decedent's health care and/or (B) payment for the decedent's health care, so long as the disclosure is consistent with the family member's prior involvement and does not contravene the decedent's prior authorization.

Any use of PHI not discussed or covered in this Summary Plan Description or in the Plan's HIPAA Privacy & Security Policy, is prohibited without express written consent. This prohibition applies to the PHI of any, and all, Participants and/or Dependents of this Plan.

Your Rights

Federal law provides Participants and Dependents with certain rights. Dependents of Participants who are, parents of minor children, or who have legal authority to make health decisions, for a Participant may exercise these rights. Federal and State law are generally consistent with each other. Under HIPAA, when there is a conflict between federal and state law, the more restrictive law will apply.

Right to request restrictions

Participants have the right to restrict, or limit, the Plan's use or disclosure of PHI. For example, a Participant may ask the Plan Administrator to limit the scope of PHI disclosures to case managers monitoring a Participant's chronic condition. Since PHI may be used to the extent necessary to pay Plan benefits, administer the Plan, and comply with the federal and state laws, it may not be possible to agree to all requests. If a Participant provides, in writing, notice that their PHI cannot be disclosed, except as otherwise required by law (and excluding disclosures for treatment purposes), the Plan Administrator must comply. The Plan Administrator will not agree to any restriction which will cause it to violate, or be noncompliant with, any legal requirement. If the Plan Administrator does agree to the requested restriction or limitation, the request will be honored. The restriction will remain in place until the Participant agrees to terminate the restriction or the Plan Administrator notifies the Participant that the restriction is being terminated. The restriction of PHI is limited to the PHI held by the Plan at the time of the request. Future requests to restrict use of PHI will require a new written request.

Participants may restrict the use and disclosure of their PHI by completing, and submitting, the appropriate form. The form is available upon request from the Fund Administrator.

Right to receive confidential communications

Participants may require the Plan to communicate with them about the use of, or request of, their PHI. PHI may be sent to an alternative address or by alternative means if a Participant believes that communication through normal business practices could endanger them. For example, a Participant may request that the Plan contact them at work and not at home.

Participants may also request confidential communication of their PHI. Requesting confidential transmission of PHI requires completion of the appropriate form which is available from the Plan Administrator. The Plan will accommodate all reasonable requests that clearly state the Participant requests confidential communication because disclosure in another way could endanger your safety.

Right to inspect and obtain a copy of PHI

Participants have the right to inspect, and obtain a copy of, PHI contained in their records maintained by the Plan for enrollment, payment, claims determinations, or case/medical management activities. If the Plan uses, or maintains, an electronic health record of your PHI, you may request such PHI in an electronic format, and direct that such PHI be sent to another person or entity. If the request does not unduly burden the Plan, a Participant may request that the Plan Administrator provide all of their PHI records in an electronic format.

However, this right does not extend to (1) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (2) any information, including PHI, which the law does not permit you to access. The Plan Administrator will deny requests to inspect and obtain a copy of a Participant's PHI if a licensed health care professional hired by the Plan has determined that providing the requested access is reasonably likely to endanger the life, physical safety, or cause substantial harm to the Participant or another individual. If a record references another person (other than a health care provider), and the requested access would likely cause substantial harm to the other person, this too shall be denied.

If a request to inspect or obtain a copy of PHI by a Participant is denied, the Participant may request to have the denial reviewed. A licensed health care professional, other than the professional who denied the request, will be chosen by the Plan Administrator to review your request and prior denial. The Plan and its Trustees will comply with the health care professional's decision.

Participants that request to inspect, or obtain copies of, their PHI must complete and then submit the appropriate form to the Plan Administrator's Office. The Plan may charge a fee to cover copying, mailing, or other costs directly associated with the request. Participants will be notified of any costs before incurring any expenses.

Right to amend PHI

Participants have the right to request that their PHI be amended if they believe the information is incorrect or incomplete. This right exists as long as the Plan maintains PHI in a designated record set. Any mistakes contained in a Participant's file, created by the Plan, including any person or entity, or if the person or entity is no longer available, will be corrected. However, the Plan cannot amend PHI that is believed to be accurate and complete.

Participants may have their PHI amended by completing, and submitting, the appropriate form. Participants may call the Plan Administrator to request the form.

Right to receive an accounting of disclosures of PHI

Participants have the right to request an accounting of certain disclosures of their PHI by the Plan. The accounting will not include disclosures (1) to carry out treatment, payment and health care operations, (2) to a Participant, (3) incident to a use or disclosure permitted or required by law, (4) pursuant to an authorization provided by the Participant, (5) for directories or to people involved in a Participant's care or other notification purposes as permitted by law, (6) for national security or intelligence purposes, (7) to correctional institutions or law enforcement officials, (8) that are part of a limited data set, (9) that occurred prior to April 14, 2003, or more than six years before it was requested by the Participant. The initial request for an accounting, within a 12-month period, will be free. The Plan may charge for costs associated with providing additional accountings. The Plan will notify the Participant in writing in advance before Participant incurs any costs. The Participant may elect to withdraw or modify their request before they are charged.

To receive an accounting, the Participant must complete, and submit, the appropriate form. The form is available upon request from the Plan Administrator.

Right to restrict or limit PHI disclosures to the Plan's insurance providers

Participants may restrict or limit disclosure of their PHI to the Plan's insurance providers. The right to limit the disclosure of PHI, to the Plan's insurance providers, must relate or pertain to any course of treatment or other medical services for which the Participant, or someone acting on the Participant's behalf, paid.

Right to Receive Notice

The Plan Administrator must notify a Participant within 30 days of discovery of a breach of their PHI. A breach occurs when "Unsecured" PHI is accessed, acquired, used or disclosed, in an impermissible manner under HIPAA. The disclosure must pose a significant risk of financial, reputational, or other harm to the Participant.

Right to file a complaint

If a Participant believes that their rights have been violated, they should notify the Plan immediately. The Plan shall remedy any violations of the Plans' privacy policy.

Participants may file a formal complaint with the Plan's Privacy Officer and/or with the United States Department of Health and Human Services ("HHS"). Participants should attach any documentary evidence that supports their belief that their privacy rights have been violated. We take your complaints very seriously. **The Plan is prohibited from retaliating against any person for filing a complaint.**

Complaints should be sent to:

Privacy Officer
Professional Musicians, Local 47 and Employers' Health and Welfare Fund
1000 North Central Avenue, Suite No. 400
Glendale, California 91202-3627

Region IX, Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: (415) 437-8310
FAX: (415) 437-8329
TDD: (415) 437-8311
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Additional Data About Your Personal Health Information

Changes to the Funds' Privacy Practices: Any change that may affect the use and disclosure of any PHI currently maintained by the Fund, as well as any PHI that may be received or created in the future, requires the Plan to notify Participants and Dependents. The Trustees reserve the right to change the Funds' privacy practices described in this notice. If there is a material change to the terms of this notice, you will receive a revised notice.

How to obtain a copy of the Funds' Privacy Practices*:* Participants may obtain a copy of the current Privacy Practices by contacting the Privacy Officer at the address listed above.

The Fund And The California Consumer Privacy Act ("CCPA"): Although the Fund itself is not subject to the CCPA, the Trustees have determined that the Fund's carriers and Administrator are subject to the CCPA. The Trustees have adopted procedures to verify that the Fund's carriers and Admininstrator comply, when applicable, with the CCPA.

REQUIRED DISCLOSURE CONCERNING THE FUNDS' COMPLIANCE WITH HIPAA ELECTRONIC DATA INTERCHANGE REGULATIONS

In accordance with the HIPAA, and the Electronic Data Interchange ("EDI") regulations, the Fund certifies that it, and the contracted Benefit Providers, complies with the standards governing the transmission of claims, payments, and the processing of information in acceptable EDI formats.

SUBROGATION OF CLAIMS AGAINST THIRD PARTIES

Medical expenses may be incurred due to the negligent or intentional acts of third parties. These acts may involve automobile accidents, slip and fall incidents, or dangerous property conditions that cause physical injuries. Since the Fund is responsible to pay medical Premiums, the Benefit Providers may seek recovery under a Subrogation Agreement.

Subrogation Agreements, once signed by the Participant, allow insurance carriers to recover monies, from the Participant, that the Benefit Provider(s) paid for the treatment of any injuries or medical emergencies that arise from the negligent or intentional conduct of a third party. This includes any cost for benefits provided to the Participant, and/or Dependent. In essence, this contract allows the insurance carrier to take some of the proceeds from a Participant's meritorious lawsuit or settlement and apply that towards the benefits it has paid out on account of the third party's conduct.

Each Benefit Provider has different rules concerning subrogation. Participants should carefully review their EOCs and SBCs to determine if any subrogation rules apply and advise their counsel of any such requirement.

AUDITS OF EMPLOYERS, PAYROLL AGENTS AND PARTICIPANTS

The Fund reserves the right, in its sole and exclusive discretion, to audit any participating Employer, any payroll agents of any Employer(s), any Participant/Member, or any employee. An audit may be done with cause or on a random basis. When the Fund decides to conduct an audit, the Employer, Participant, or Employee is required by law, and the Trust Agreement, to provide full cooperation to the Fund and its auditors. Any party that is audited must disclose to the Fund, and its auditors, all documents, records, computer files and other items necessary to conduct the audit. In the event the audited party refuses to cooperate with the Fund and/or its auditors, the Fund reserves the right to take all appropriate legal action to compel cooperation. If an audit reveals that an Employer or payroll agent hired by the Employer(s) failed to remit all required contributions under the governing contract and/or Trust Agreement, which violated the rules and regulations of the Fund and/or applicable law, the Fund reserves the right to seek all legal and equitable relief to collect the delinquent contributions.

If the Fund's auditor(s) finds an Employer or a payroll agent for any Employer(s) failed to remit all required contributions to the Fund, which resulted in damages to the Fund including but not limited to lost opportunity costs that result from these delinquent contributions, calculated by the terms of the Fund's Trust Agreement and/or applicable law, the Fund, through its Board of Trustees, reserves the right, in addition to collection of contributions, to terminate or suspend the contributory status of such Employer and/or payroll agent for these Employer(s).

If an audit reveals that a Participant obtained eligibility by fraud or improperly remitted Employer Contributions, the Fund reserves the right to take any or all of the following actions: (i) revoke his/her eligibility during the applicable coverage year; (ii) retroactively cancel coverage if, the Participant or a Dependent's, coverage was obtained by fraud, cancellation of coverage is retroactive to the date of the fraudulent conduct and the Fund may also include referring the matter to the proper governmental authorities to investigate and potentially prosecute; (iii) if an Employer or Employer's payroll agent is responsible for the improper or fraudulent eligibility, then the Fund, through its Board of Trustees,

reserves the right to terminate or suspend the contributory status of the Employer and/or the Employer's payroll agent; (iv) deduct, from the affected Participant(s) eligibility bank(s), all contributions relating to, or connected with, the improper or fraudulent contributions, and; (v) institute legal action to recover all Fund expenses (including any, and all, premium payments paid by the Employer to the Fund on behalf of a Participant. This shall extend to all costs of the audit, which include auditors' and attorneys' fees, and the cost of any litigation damages) incurred to recover the losses from any Participant who fraudulently obtained coverage.

ELECTRONIC DELIVERY OF REQUIRED NOTICES

Pursuant to regulations issued by the United States Department of Labor, the Fund makes available to its Participants the ability to have all required annual and other notices (except notices related to claims processing and appeals as well as eligibility determinations) delivered electronically as opposed to through the United States Postal Service. Please review the Fund's website for more information on how a Particpant may enroll for or discontinue electronic delivery of required notices.

Enrolling in the electronic notice delivery system is free and will save paper!

CLAIMS, APPEAL AND REVIEW PROCEDURES

Manner and Content of Notification of Benefit Determinations

The Fund, through the Fund Administrator or a Benefit Provider, shall give a Claimant written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by the Regulations. The notification shall set forth, in a manner calculated to be understood by the Claimant:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan provisions on which the determination is based;
3. A description of any additional material or information necessary for the Claimant;
4. A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
5. In the case of an adverse benefit determination by a group health plan:

    a. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a 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 to the Claimant upon request; or

b. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

6. In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

Timing and Notification of Benefit Determination

Urgent Care

If a Claimant submits a claim which requires urgent care, the Plan Administrator or applicable Benefit Provider shall notify the Claimant of the benefit determination (whether adverse or not) as soon as possible. An urgent care (or emergency) claim is defined as any claim submitted that, if not decided quickly, could seriously jeopardize the life or health of the Claimant, or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimants' medical condition, would subject the Claimant to severe pain that cannot be adequately managed without such care or treatment. The Plan Administrator or applicable Benefit Provider must take into account the medical exigencies, but in most cases, may not respond later than 72 hours after receipt of the claim by the Plan or applicable Benefit Provider.

If a Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan Administrator or applicable Benefit Provider may be allowed more time to review the claim. The Plan Administrator or applicable Benefit Provider shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan or applicable Benefit Provider, of the specific additional information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information.

Concurrent Care Decisions

This type of decision must be made when a Plan or applicable Benefit Provider has approved an ongoing course of treatment that is provided over a period of time or a number of treatments. An adverse determination includes a reduction or termination of services before the end of treatment. The Claimant must be notified in advance of the reduction or termination of the benefits to allow the Claimant to appeal the decision before the benefit is terminated or reduced. There are also situations where Claimants request that their benefits be extended beyond the approved time for treatment. In this situation, the Plan Administrator or applicable Benefit Provider must notify the Claimant within 24 hours, in advance of the expiration of treatment, whether adverse or not.

Pre-Service Claims

These claims require advanced approval from the Benefit Provider before medical care is provided. The Claimant must be notified of the Provider's decision, whether an approval or denial, within a reasonable time. A Benefit Provider must reply within 15 days from receipt of the claim. If additional time, meaning more than 15 days, is necessary to review the claim, the Benefit Provider must request, in writing, from the Claimant an additional 15 days. This means there is a total of 30 days before a decision must be made by the Benefit Provider.

If the extension is needed because the Claimant failed to provide sufficient information to resolve the claim, the insurer must provide written notice to the Claimant. The Claimant will have at least 45 days to respond and provide the required documentation.

Post-Service Claims

These claims are defined as any claim submitted after medical treatment is received by the Claimant. The Benefit Provider shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time. However notification must not exceed 30 days after receipt of the claim. If the Benefit Provider determines that additional time is necessary due to matters beyond the control of the Plan, the Claimant must be notified, in writing, before the initial 30-day period expires. The Benefit Provider may extend the time to review the claim by 15 days. This means that the Benefit Provider may extend the review period for no more than 45 days from its original receipt of the claim. If the Claimant failed to provide the required information, the notice provided must specify which information is required to render a decision. The Claimant shall be given at least 45 days from the receipt of the notice to provide the specified information.
The time required to render a decision shall be suspended while the Benefit Provider waits for the Claimant to respond.

If a Claimant submits a claim, in writing, which is paid by the Benefit Provider, then the Claimant does not need to take further action.

Filing An Appeal If A Claim Is Denied

If a Claimant submits a claim which is denied by the Benefit Provider, either in part or in whole, then the Claimant must appeal the decision if the Claimant does not wish to pay for the services out of pocket. The Benefit Provider must notify the Claimant, in writing, that the claim has been denied. The denial must specify why the claim was not paid and must inform a Claimant of the documentation required from a Claimant, or their representative, to overturn the Benefit Provider's decision.

Appeal Adverse Benefit Determinations

Every employee benefit plan shall establish and maintain procedures for Claimants to have a reasonable opportunity to appeal adverse benefit determinations to an appropriate named Fiduciary of the Plan. This also requires there to be a full and fair review of adverse benefit determinations. A full and fair review requires that: Claimants be provided the opportunity to submit written comments, documents, records, and other information relating to their claim for benefits; Claimants be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits; and provide for a review that takes 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 benefit determination.

In addition to the requirements listed in the prior paragraph, Claimants shall have up to 180 days after receipt of the denial of pre-service claim to file an appeal with the applicable carrier. The review must not afford deference to the initial adverse determination and must be conducted by a named Fiduciary of the Plan who is not the same party that made the initial adverse determination. The named Fiduciary who reviews the appeal must consult with a health care professional who has the appropriate medical training and experience to adjudicate the claim. Assuming that appropriate measures are taken during the review, the carrier shall be provided up to 30 days from the date of the appeal in which to issue its written approval or denial.

Appeals for Denials of Pre-Service Claims

A Fund Administrator or applicable Benefit Provider shall notify the Claimant of the Plan's or applicable Benefit Provider's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 30 days after receipt by the plan of the Claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the plan of the Claimant's request for review of the adverse determination.

Appeal from Denial of Post-Service Claim

In the case of a post-service claim the Fund Administrator or applicable Benefit Provider shall notify the Claimant of the Plan's or applicable Benefit Provider's benefit determination on review within a reasonable period of time. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided,

with respect to any one of such two appeals, not later than 30 days after receipt by the plan of the Claimant's request for review of the adverse determination.

Content of Appeal Determination Notice

A Plan Administrator or applicable Benefit Provider shall provide a Claimant with a written or electronic notification of a Plan's or applicable Benefit Provider's benefit determination on review. The adverse benefit notification shall be written in a manner which is understood by the Claimant and must: (i) specify the reason(s) for the adverse determination action taken; (ii) refer to the specific plan provision on which it is based; (iii) state 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 Claimant's claim for benefits; (iv) describe any voluntary appeals procedures offered by the Plan and the Claimant's right to obtain the information required to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal and a statement of the Claimants' right to bring an action, under Section 502(a) of ERISA.

When a Claimant's request for benefits is denied, the Plan Administrator or applicable Benefit Provider must do three things. First, if an internal rule, guideline, protocol, or other similar criteria was relied on in making the adverse determination and a copy of such a rule was relied on, upon request, a copy will be provided at no cost to the Claimant. However, if an adverse benefit determination was based on a medical necessity, experimental treatment, or another similar exclusion or limit, then the Plan Administrator or applicable Benefit Provider must explain the scientific or clinical judgment for the determination, apply the terms of the Plan Document to the Claimant's medical circumstances, or provide a statement that the information used to explain the rationale for the decision will be provided, upon request, to the Claimant free of charge. In addition to the considerations mentioned in this paragraph, the adverse determination letter must also state that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

See the list below to find the proper Benefit Provider in the event you need to file an appeal from a denial of a benefit:

Appeal for:	Name of Benefit Provider:
Life and Accidental Death and Dismemberment Benefits	The Prudential Insurance Company of America
Medical Benefits	Blue Shield of California Kaiser Permanente
Prescription Drug	Blue Shield of California Kaiser Permanente
Chiropractic / Acupuncture	Landmark Healthplan
Dental Benefits (PPO)	Delta Dental Plans of California
Dental Benefits (DHMO)	DeltaCare USA
Vision Benefits	Gerber Life, c/o MES Vision

APPEAL TO THE TRUSTEES IF YOUR ELIGIBILITY IS DENIED OR IF YOUR ELIGIBILITY IS CANCELLED OR RESCINDED OR REVOKED

A Claimant, or their duly authorized representative, has the right to appeal the denial of eligibility for participation in the Fund's benefits and coverages (i.e. failure to attain eligibility), denial of coverage of a Dependent, or rescission of coverage (i.e. revocation of benefits, which may or may not be retroactive) to the Fund's Board of Trustees. Claimants who wish to appeal denials or rescissions, of eligibility ***must*** submit a written appeal to the Fund Administrator's Office. The Fund Administrator's Office will provide the appeal documents to the Trustees.

The Trustees shall make a benefit determination no later than the date of the meeting of the Trustees which immediately follows the Fund's receipt of an appeal. Provided, however, that if the appeal is filed within 30 days preceding the date of such meeting, a final determination on the appeal may be made by no later than the date of the second Trustees' meeting following the Fund's receipt of the appeal.

The Fund Administrator's Office shall provide a Claimant with a written or electronic notification of the Trustee's determination on review. The decision of the Trustees, with respect to any appeal from a denial of eligibility, revocation of enrollment and/or rescission of coverage shall be final and binding and there shall be no other or further level of appeal.

Any adverse decision on an appeal shall be written in a manner which is understood by the Claimant and must (i) specify the reason(s) for the adverse determination action taken; (ii) refer to the specific plan provision on which it is based; (iii) state 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 Claimant's claim for benefits; (iv) describe any voluntary appeals procedures offered by the Plan and the Claimant's right to obtain the information required to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal and a statement of the Claimants' right to bring an action, under Section 502(a) of ERISA.

ADMINISTRATORS', BENEFIT PROVIDERS' AND TRUSTEES' DISCRETION TO INTERPRET AND APPLY PLAN PROVISIONS

The Fund Administrator, and the Fund's Benefit Providers, shall determine benefit coverage and are delegated and shall have the right and responsibility to interpret the provisions of the Plan which include, but are not limited to, the Trust Agreement, the Fund's SPD and all policies of group insurance issued to the Fund. The Trustees, including any sub-committee(s), retain full discretionary authority to interpret and apply the provisions of the Trust Agreement, the SPD, and all Fund rules and regulations including all revisions thereto. Further, the Trustees retain full discretion to interpret, apply, amend, and promulgate the Fund's rules and regulations, including those that govern eligibility for enrollment in the Plan. The right to interpret the Plan extends to, but is not limited to, the SPD, the Trust Agreement, the SBC's and the EOC's issued by the Benefit Providers, and all the Fund's rules and regulations – to adjudicate all issues and questions related to the Administration of the Fund's Benefit Plan(s).

In addition, the Fund's Rules and Regulations may be used to establish reasonable procedures, which are consistent with the express terms of the Plan. Some examples of these issues include filing claims with the Plan and/or its Benefit Providers and the processing appeals through the Plan and/or its Benefit Providers. The Trustees may assign the full discretion and responsibility to interpret, apply, and decide all questions arising under the insurance policies selected for the Plan to the Benefit Providers. All decisions rendered by the Trustees – with respect to the interpretation and application of the Rules and Regulations to the Trust Agreement– shall be final and binding.

TIME AND LOCATION LIMITATIONS GOVERNING THE COMMENCEMENT OF LEGAL ACTION AGAINST THE FUND, ITS TRUSTEES, ADMINISTRATOR(S), PROFESSIONALS AND BENEFIT PROVIDERS

Legal or equitable action may not be initiated against the Fund, its Trustees, Administrators, Professionals and/or Benefit Providers after two (2) years has elapsed from the date on which: (a) an initial claim for benefits is submitted to the applicable Benefit Provider; or (b) an appeal is filed with the Fund that relates to eligibility of a Claimant. Appeals may relate to enrollment in the Plan or rescission or cancellation of coverage for a Participant and/or Dependent, whichever is applicable.

Any legal claim or action brought against the Fund, its Trustees, Administrators, Professionals and/or Benefit Providers must be brought in the United States District Court for the Central District of California.

INFORMATION REQUIRED BY ERISA

Name of the Plan: Professional Musicians, Local 47 and Employers' Health and Welfare Fund

Plan Sponsor: Joint Board of Trustees, Professional Musicians, Local 47 and Employers' Health and Welfare Fund.

Participants and Dependents may receive from the Trust Administrator's Office, upon written request, information as to whether a particular Employer or Union is the Plan Sponsor.

Plan's Employer Identification Number (EIN): 95-2645284

Plan Number: 501

Type of Plan: Group health plan

Type of Administration:

The Plan is administered by the Board of Trustees with the help of the Fund Administrator and staff, consultants, attorneys, accountants, etc.

Benefits are provided by group insurance policies, pre-paid service plans, or Benefit Providers that have contracts with the Fund. The benefits provided through these policies and agreements are governed by the terms of those contracts. Copies of these documents are available for inspection at the Trust Administrator's Office. Benefits provided by the Plan are subject to the terms of the applicable Local 47 or AFM Agreements and Employer contributions received pursuant to the Agreement(s).

Name and Address of Plan Administrator:

Professional Musicians, Local 47 and Employers' Health and Welfare Fund
C/o PacFed Benefit Administrators
James Garrison
1000 North Central Ave., Suite 400
Glendale, CA 91202
Phone: (818) 243-0222

Name and Address of Agent for Service of Legal Process:

Mr. Jim Garrison
C/o PacFed Benefit Administrators
1000 North Central Ave., Suite 400
Glendale, CA 91202

The Fund Administrator has been designated by the Trustees as the agent for service of legal process. Service may also be made on any Trustee.

Names and Addresses of Trustees:

	John Acosta President AFM, Local 47 3220 Winona Ave. Burbank, California 91504
DeeDee Daniel Director, Music Operations Entertainment Partners 2835 N. Naomi Street Burbank, CA 91504	Judy Chilnick Musician AFM, Local 47 3220 Winona Ave. Burbank, California 91504
Robert W. Johnson Senior Vice President, Labor Relations Walt Disney Pictures 500 South Buena Vista Burbank, California 91521	Stephanie O'Keefe Musician AFM, Local 47 3220 Winona Ave. Burbank, California 91354

Applicable Collective Bargaining Agreements and Participation Agreements

The Plan is maintained in accordance with various Agreements between Employers and American Federation of Musicians, Local 47 and/or the AFM. The Agreements require contributions from the participating Employers, which provide the funding for the benefits described in this SPD. The basis for such contributions by the Employer(s) are set forth in the Agreements. Copies of the Agreements are available for inspection at the Trust Administrator's Office during regular business hours, and upon written request, will be furnished by mail. You will be charged for the cost of furnishing such a copy. You may also request information as to whether a particular Employer is a sponsor of the Professional Musicians, Local 47 and Employers' Health and Welfare Fund.

Eligibility Requirements: See page 8 of this SPD.

Description of Benefits: See applicable Benefit Provider's policy.

Cost Sharing Provisions: See applicable Benefit Provider's policy.

Annual Lifetime Caps/Other Limitations: See applicable Benefit Provider's policy.

Covered Preventative Services: See applicable Benefit Provider's policies for annual and lifetime caps and other limitations.

Prescription Drug Coverage: See applicable Benefit Provider's policies for annual and lifetime caps and other limitations.

Terms and Conditions for Coverage of Medical Tests, Devices, and Procedures: See applicable Benefit Provider's policy.

Provider Information: See applicable Benefit Provider's policy.

Emergency Medical Care Coverage Conditions and Limitations: See applicable Benefit Provider's policy.

Preauthorization or Utilization Review (if required as coverage precondition): See applicable Benefit Provider's policies for preauthorization or utilization review (if required as coverage precondition).

Qualified Medical Child Support Order: See page 31 of this SPD.

Maternity Length of Hospital Stay Notice: See page 28 of this SPD.

Source of Financing (and Funding Medium) of the Plan: The Plan is funded by Employer contributions remitted to the Fund pursuant to the terms of various Agreements to which the AFM and/or Local 47 are signatory.

Fund's Insurers and Providers of Services:

<table>
<tr><td>LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS</td><td colspan="2">HOSPITAL, MEDICAL, SURGICAL AND PRESCRIPTION DRUG BENEFITS</td></tr>
<tr><td>The Prudential Insurance Company of America
Prudential Group Life Claim Division
P.O. Box 8517
Philadelphia, Pennsylvania 19176
1-800-524-0542</td><td>Blue Shield Corporate
Blue Shield of California
50 Beale Street
San Francisco, CA 94105</td><td>Blue Shield Claims
Blue Shield of California
P.O. Box 272540
Chico, CA 95927-2540</td></tr>
<tr><td>DENTAL BENEFITS</td><td colspan="2" rowspan="2">Kaiser Permanente
Regional Administration, Southern California
3100 Thornton Avenue
Burbank, CA 95104</td></tr>
<tr><td>Delta Dental Plans of California
12898 Towne Center Drive
Cerritos, California 90703</td></tr>
<tr><td>Delta Dental Claims
Delta Dental Plans of California
Claims Office
P.O. Box 7736
San Francisco, California 94120</td><td colspan="2">VISION BENEFITS
Gerber Life
Administered By MES Vision
P.O. Box 25209
Santa Ana, California 92799</td></tr>
<tr><td>DeltaCare USA
12898 Towne Center Drive
Cerritos, California 90703</td><td colspan="2">CHIROPRACTIC/ACUPUNCTURE BENEFITS
Landmark Healthplan, Inc.
1750 Howe Avenue, Suite 30
Sacramento, California 95825</td></tr>
</table>

Plan Fiscal Year Ends: March 31

Plan Termination

The Board of Trustees may terminate the Plan pursuant to its authority under the Trust Agreement. Termination will not result in reversion of Trust Fund assets to the Union, Participants, Employers or Dependents. In the event of Plan Termination, the Fund's assets will be paid out in the form of benefits to its Participants and covered Dependents.

Statement of ERISA Rights

As a Participant covered under this Plan, you are entitled to certain rights and protections under the ERISA. ERISA provides that all Participants shall be entitled to:

- Examine, without charge, at the Trust Administrator's Office and at the Union's office all Plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plans' annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary financial report.
- File suit in a federal court if any materials requested are not received within 30 days of the Participants' request, unless the materials were not sent because of matters beyond the control of the Administrator. The court may require the Plan Administrator to pay up to $110 for each days' delay until the materials are received.

  In addition to creating rights for Participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Plans' benefits. These persons are referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of the Participants, and they must exercise prudence in the performance of their Plan duties. Fiduciaries that violate ERISA may be removed and required to make good any losses they have caused in the Trust Fund.

  If you are improperly denied a Plan benefit in full or in part, you have the right to file suit in a federal or a state court. If Plan fiduciaries are misusing the Plans' money, you have the right to file suit in a federal court, or request assistance from the U.S. Department of Labor. If you are successful in your lawsuit, the court may, if it so decides, require the other parties to pay your legal costs, including attorney's fees.

  If you have any questions about this statement or your rights under ERISA, you should contact the Plan Administrator or the nearest Office of EBSA listed in your telephone directory, or the Division of Technical Assistance and Inquiries, EBSA, 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 EBSA Administration **[https://www.dol.gov/agencies/ebsa]**.

Circumstances that May Trigger Disqualification: See page 30 of this SPD.

Fee-Based Provisions: See applicable Benefit Provider's policy.

COBRA Information: See page 34 of this SPD.

Claims and Appeals Procedures: See page 51 through 55 of this SPD.

Summary of Plan Provisions – Termination

The Plan may be changed, amended, or terminated at any time at the sole and absolute discretion of the Board of Trustees.

Summary of Plan Provisions - Allocation/Disposition of Assets Upon Termination

Upon dissolution or termination of this Fund, any remaining assets shall first be applied to satisfy any and all then outstanding claims for benefits; any assets remaining after the payment and satisfaction of such outstanding claims shall be irrevocably transferred to another collectively-bargained plan designed and intended to provide health, medical and related insurance benefits to musicians (including contractors and music preparation personnel) employees represented – for purposes of collective bargaining – by Local 47 and those musicians employed by the Employers who sponsor this Fund.

IMPORTANT PHONE NUMBERS

Blue Shield Member Service	(855) 256-9404
Kaiser Permanente	(800) 464-4000
Landmark Healthplan	(800) 298-4875
Delta Dental Plans (PPO)	(888) 335-8227
DeltaCare USA (Pre-Paid Plan)	(800) 422-4234
MES Vision	(800) 877-6372
The Prudential Insurance Company of America	(800) 524-0542
PacFed Benefit Administrators Member Service	(800) 753-0222

SCHEDULES OF BENEFITS - Appendix A

CALIFORNIA PLANS	***PAGE***
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Schedule 2 – Blue Shield HMO Trio Medical and Prescription Drug Benefit	9-A
Schedule 3 – Blue Shield PPO Medical and Prescription Drug Benefit (HSA Qualified Plan)	17-A
Blue Shield Nondiscrimination and Accessability Notice	28-A
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Schedule 4 – Kaiser Traditional HMO Medical and Prescription Drug Benefit	31-A
Schedule 5 – Kaiser High Deductible HMO Medical and Prescription Drug Benefit	33-A
Schedule 6 – Kaiser High Deductible HMO Medical and Prescription Drug Benefit (HSA Qualified Plan)	35-A
Schedule 7 – Landmark Chiropractic and Acupuncture Benefit	37-A
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This Summary Plan Description (SPD) has been prepared to give you basic information concerning the benefit plans (collectively the Plan) available to you through the Fund.

A summary of benefis provided is found in this booklet. A complete Evidence of Coverage ("EOC") and/or a Summary of Benefits and Coverages ("SBC") may be found on the Funds' website **www.pacfed-musicians.com**

blue of california

Group Plan
HMO Plan

Summary of Benefits

Access+ HMO® Facility Coinsurance 25-25%

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Medical Provider Network: **Access+ HMO Network**

This Plan uses a specific network of Health Care Providers, called the Access+ HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan.

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual
		$0: Family

Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

	When using a Participating Provider[3]
Individual coverage	$3,500
Family coverage	$3,500: individual
	$7,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Preventive Health Services[6]		
Preventive Health Services	$0	
California Prenatal Screening Program	$0	
Physician services		
Primary care office visit	$25/visit	
Access+ specialist care office visit (self-referral)	$40/visit	
Other specialist care office visit (referred by PCP)	$25/visit	
Physician home visit	$25/visit	
Physician or surgeon services in an outpatient facility	$0	
Physician or surgeon services in an inpatient facility	$0	
Other professional services		
Other practitioner office visit	$25/visit	
Includes nurse practitioners, physician assistants, and therapists.		
Teladoc consultation	$5/consult	
Family planning		
• Counseling, consulting, and education	$0	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0	
• Tubal ligation	$0	
• Vasectomy	$0	
Podiatric services	$25/visit	
Pregnancy and maternity care[6]		
Physician office visits: prenatal and postnatal	$0	
Physician services for pregnancy termination	$0	
Emergency services		
Emergency room services	$150/visit	
If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.		
Emergency room Physician services	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Urgent care center services	$25/visit	
Ambulance services *This payment is for emergency or authorized transport.*	$100/transport	
Outpatient facility services		
Ambulatory Surgery Center	15%	
Outpatient Department of a Hospital: surgery	30%	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	
Inpatient facility services		
Hospital services and stay	25%	
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*		
• Special transplant facility inpatient services	25%	
• Physician inpatient services	$0	
Diagnostic x-ray, imaging, pathology, and laboratory services *This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.*		
Laboratory services *Includes diagnostic Papanicolaou (Pap) test.*		
• Laboratory center	$0	
• Outpatient Department of a Hospital	$0	
X-ray and imaging services *Includes diagnostic mammography.*		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Other outpatient diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*		
• Office location	$0	
• Outpatient Department of a Hospital	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Radiological and nuclear imaging services		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Rehabilitative and Habilitative Services		
Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.		
Office location	$25/visit	
Outpatient Department of a Hospital	$25/visit	
Durable medical equipment (DME)		
DME	50%	
Breast pump	$0	
Orthotic equipment and devices	$0	
Prosthetic equipment and devices	$0	
Home health care services	$25/visit	
Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.		
Home infusion and home injectable therapy services		
Home infusion agency services	$0	
Includes home infusion drugs and medical supplies.		
Home visits by an infusion nurse	$25/visit	
Hemophilia home infusion services	$0	
Includes blood factor products.		
Skilled Nursing Facility (SNF) services		
Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.		
Freestanding SNF	25%	
Hospital-based SNF	25%	
Hospice program services	$0	
Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.		

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	20%	
• Self-management training	$25/visit	
Dialysis services	$0	
PKU product formulas and Special Food Products	$0	
Allergy serum billed separately from an office visit	50%	

Mental Health and Substance Use Disorder Benefits	Your payment	
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	When using a MHSA Participating Provider[3]	CYD[2] applies
Outpatient services		
Office visit, including Physician office visit	$25/visit	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0	
Partial Hospitalization Program	$0	
Psychological Testing	$0	
Inpatient services		
Physician inpatient services	$0	
Hospital services	25%	
Residential Care	25%	

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

Notes

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

4 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

5 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

Plans may be modified to ensure compliance with State and Federal requirements.

PENDING REGULATORY APPROVAL

blue of california

Outpatient Prescription Drug Rider

Group Rider
ACCESS + HMO

Enhanced Rx $15/30/45 with $0 Pharmacy Deductible Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:	**Rx Ultra**
Drug Formulary:	**Plus Formulary**

Calendar Year Pharmacy Deductible (CYPD)[1]

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

	When using a Participating[2] Pharmacy
Calendar Year Pharmacy Deductible	*Per Member* $0

Prescription Drug Benefits[3,4]	**Your payment**	
	When using a Participating Pharmacy[2]	**CYPD[1] applies**
Retail pharmacy prescription Drugs		
Per prescription, up to a 30-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$15/prescription	
Tier 2 Drugs	$30/prescription	
Tier 3 Drugs	$45/prescription	
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $200/prescription	
Mail service pharmacy prescription Drugs		
Per prescription, up to a 90-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$30/prescription	
Tier 2 Drugs	$60/prescription	
Tier 3 Drugs	$90/prescription	
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $400/prescription	
Network Specialty Pharmacy Drugs		
Per prescription, up to a 30-day supply.		
Tier 4 Specialty Drugs	20% up to $200/prescription	
Oral anticancer Drugs		
Per prescription, up to a 30-day supply.	20% up to $200/prescription	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✔) in the Benefits chart above.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✔) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting www.blueshieldca.com/wellness/drugs/formulary#heading2.

Non-Participating Pharmacies. Drugs from Non-Participating Pharmacies are not covered except in emergency situations.

3 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

4 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the Tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Benefit designs may be modified to ensure compliance with State and Federal requirements.

PENDING REGULATORY APPROVAL

SCHEDULE 2

blue of california

Group Plan
HMO Plan

Summary of Benefits

Trio HMO Facility Deductible 20-25%/1500

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Medical Provider Network: **Trio ACO HMO Network**

This Plan uses a specific network of Health Care Providers, called the Trio ACO HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$1,500
	Family coverage	$1,500: individual
		$3,000: Family

Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

	When using a Participating Provider[3]
Individual coverage	$3,000
Family coverage	$3,000: individual
	$6,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Preventive Health Services[6]		
Preventive Health Services	$0	
California Prenatal Screening Program	$0	
Physician services		
Primary care office visit	$20/visit	
Trio+ specialist care office visit (self-referral)	$20/visit	
Other specialist care office visit (referred by PCP)	$20/visit	
Physician home visit	$20/visit	
Physician or surgeon services in an outpatient facility	$0	
Physician or surgeon services in an inpatient facility	$0	
Other professional services		
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	$20/visit	
Teladoc consultation	$0	
Family planning		
• Counseling, consulting, and education	$0	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0	
• Tubal ligation	$0	
• Vasectomy	$0	
Podiatric services	$20/visit	
Pregnancy and maternity care[6]		
Physician office visits: prenatal and postnatal	$0	
Physician services for pregnancy termination	$0	
Emergency services		
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.*	$150/visit	
Emergency room Physician services	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Urgent care center services	$20/visit	
Ambulance services *This payment is for emergency or authorized transport.*	$100/transport	
Outpatient facility services		
Ambulatory Surgery Center	15%	✔
Outpatient Department of a Hospital: surgery	30%	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	
Inpatient facility services		
Hospital services and stay	25%	✔
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*		
• Special transplant facility inpatient services	25%	✔
• Physician inpatient services	$0	
Diagnostic x-ray, imaging, pathology, and laboratory services *This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.*		
Laboratory services *Includes diagnostic Papanicolaou (Pap) test.*		
• Laboratory center	$0	
• Outpatient Department of a Hospital	$0	
X-ray and imaging services *Includes diagnostic mammography.*		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Other outpatient diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*		
• Office location	$0	
• Outpatient Department of a Hospital	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Radiological and nuclear imaging services		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Rehabilitative and Habilitative Services		
Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.		
Office location	$20/visit	
Outpatient Department of a Hospital	$20/visit	
Durable medical equipment (DME)		
DME	50%	
Breast pump	$0	
Orthotic equipment and devices	$0	
Prosthetic equipment and devices	$0	
Home health care services	$20/visit	
Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.		
Home infusion and home injectable therapy services		
Home infusion agency services	$0	
Includes home infusion drugs and medical supplies.		
Home visits by an infusion nurse	$20/visit	
Hemophilia home infusion services	$0	
Includes blood factor products.		
Skilled Nursing Facility (SNF) services		
Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.		
Freestanding SNF	25%	✔
Hospital-based SNF	25%	✔
Hospice program services	$0	
Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.		

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	20%	
• Self-management training	$20/visit	
Dialysis services	$0	
PKU product formulas and Special Food Products	$0	
Allergy serum billed separately from an office visit	50%	

Mental Health and Substance Use Disorder Benefits	Your payment	
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	When using a MHSA Participating Provider[3]	CYD[2] applies
Outpatient services		
Office visit, including Physician office visit	$20/visit	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0	
Partial Hospitalization Program	$0	
Psychological Testing	$0	
Inpatient services		
Physician inpatient services	$0	
Hospital services	25%	✔
Residential Care	25%	✔

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Notes

Covered Services not subject to the Calendar Year medical Deductible. Some Covered Services received from Participating Providers are paid by Blue Shield before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

Family Coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

4 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

5 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

Plans may be modified to ensure compliance with State and Federal requirements.

PENDING REGULATORY APPROVAL

blue of california

Outpatient Prescription Drug Rider

Group Rider

TRIO HMO

Enhanced Rx $15/30/45 with $0 Pharmacy Deductible Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:	**Rx Ultra**
Drug Formulary:	**Plus Formulary**

Calendar Year Pharmacy Deductible (CYPD)[1]

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

	When using a Participating[2] Pharmacy
Calendar Year Pharmacy Deductible	*Per Member* $0

Prescription Drug Benefits[3,4]	**Your payment**	
	When using a Participating Pharmacy[2]	**CYPD[1] applies**
Retail pharmacy prescription Drugs		
Per prescription, up to a 30-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$15/prescription	
Tier 2 Drugs	$30/prescription	
Tier 3 Drugs	$45/prescription	
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $200/prescription	
Mail service pharmacy prescription Drugs		
Per prescription, up to a 90-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$30/prescription	
Tier 2 Drugs	$60/prescription	
Tier 3 Drugs	$90/prescription	
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $400/prescription	
Network Specialty Pharmacy Drugs		
Per prescription, up to a 30-day supply.		
Tier 4 Specialty Drugs	20% up to $200/prescription	
Oral anticancer Drugs		
Per prescription, up to a 30-day supply.	20% up to $200/prescription	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✔) in the Benefits chart above.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✔) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting www.blueshieldca.com/wellness/drugs/formulary#heading2.

Non-Participating Pharmacies. Drugs from Non-Participating Pharmacies are not covered except in emergency situations.

3 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

4 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the Tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Benefit designs may be modified to ensure compliance with State and Federal requirements.

PENDING REGULATORY APPROVAL

blue of california

SCHEDULE 3

Group Plan
PPO Savings Plan

Summary of Benefits

Full PPO Savings Two-Tier Embedded Deductible 1400/2800/2800

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Medical Provider Network: **Full PPO Network**

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Pharmacy Network: **Rx Ultra**

Drug Formulary: **Plus Formulary**

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical and pharmacy Deductible	*Individual coverage*	$1,400
This Plan combines medical and pharmacy Deductibles into one Calendar Year Deductible	*Family Coverage*	$2,800: individual $2,800: Family

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using a Participating Provider[3]	When using a Non-Participating Provider[4]
Individual coverage	$3,000	$5,000
Family Coverage	$3,000: individual $6,000: Family	$5,000: individual $10,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]				
Preventive Health Services	$0		Not covered	
California Prenatal Screening Program	$0		$0	
Physician services				
Primary care office visit	10%	✔	30%	✔
Specialist care office visit	10%	✔	30%	✔
Physician home visit	10%	✔	30%	✔
Physician or surgeon services in an outpatient facility	10%	✔	30%	✔
Physician or surgeon services in an inpatient facility	10%	✔	30%	✔
Other professional services				
Other practitioner office visit	10%	✔	30%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	10%	✔	30%	✔
Up to 20 visits per Member, per Calendar Year.				
Chiropractic services	10%	✔	30%	✔
Up to 20 visits per Member, per Calendar Year.				
Teladoc consultation	$5/consult	✔	Not covered	
Family planning				
• Counseling, consulting, and education	$0		Not covered	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		Not covered	
• Tubal ligation	$0		Not covered	
• Vasectomy	10%	✔	Not covered	
Podiatric services	10%	✔	30%	✔
Pregnancy and maternity care[7]				
Physician office visits: prenatal and postnatal	10%	✔	30%	✔
Physician services for pregnancy termination	10%	✔	30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Emergency services				
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.*	$150/visit plus 10%	✔	$150/visit plus 10%	✔
Emergency room Physician services	10%	✔	10%	✔
Urgent care center services	10%	✔	30%	✔
Ambulance services *This payment is for emergency or authorized transport.*	10%	✔	10%	✔
Outpatient facility services				
Ambulatory Surgery Center	5%	✔	30% of up to $350/day plus 100% of additional charges	✔
Outpatient Department of a Hospital: surgery	15%	✔	30% of up to $350/day plus 100% of additional charges	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%	✔	30% of up to $350/day plus 100% of additional charges	✔
Inpatient facility services				
Hospital services and stay	10%	✔	30% of up to $600/day plus 100% of additional charges	✔
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*				
• Special transplant facility inpatient services	10%	✔	Not covered	
• Physician inpatient services	10%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Bariatric surgery services, designated California counties				
This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the outpatient facility services and Outpatient Physician services payments apply.				
Inpatient facility services	10%	✔	Not covered	
Outpatient facility services	15%	✔	Not covered	
Physician services	10%	✔	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	10%	✔	30%	✔
• Outpatient Department of a Hospital	20%	✔	30% of up to $350/day plus 100% of additional charges	✔
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	10%	✔	30%	✔
• Outpatient Department of a Hospital	20%	✔	30% of up to $350/day plus 100% of additional charges	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Other outpatient diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*				
• Office location	10%	✔	30%	✔
• Outpatient Department of a Hospital	20%	✔	30% of up to $350/day plus 100% of additional charges	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	10%	✔	30%	✔
• Outpatient Department of a Hospital	$100/visit plus 10%	✔	30% of up to $350/day plus 100% of additional charges	✔
Rehabilitative and Habilitative Services *Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.*				
Office location	10%	✔	30%	✔
Outpatient Department of a Hospital	10%	✔	30% of up to $350/day plus 100% of additional charges	✔
Durable medical equipment (DME)				
DME	10%	✔	30%	✔
Breast pump	$0		Not covered	
Orthotic equipment and devices	10%	✔	30%	✔
Prosthetic equipment and devices	10%	✔	30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	10%	✔	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs and medical supplies.*	10%	✔	Not covered	
Home visits by an infusion nurse	10%	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	10%	✔	Not covered	
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*				
Freestanding SNF	10%	✔	10%	✔
Hospital-based SNF	10%	✔	30% of up to $600/day plus 100% of additional charges	✔
Hospice program services *Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.*	$0	✔	Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	10%	✔	30%	✔
• Self-management training	10%	✔	30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Dialysis services	10%	✔	30% of up to $350/day plus 100% of additional charges	✔
PKU product formulas and Special Food Products	10%	✔	10%	✔
Allergy serum billed separately from an office visit	10%	✔	30%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	When using a MHSA Participating Provider[3]	CYD[2] applies	When using a MHSA Non-Participating Provider[4]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	10%	✔	30%	✔
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	10%	✔	30%	✔
Partial Hospitalization Program	10%	✔	30% of up to $350/day plus 100% of additional charges	✔
Psychological Testing	10%	✔	30%	✔
Inpatient services				
Physician inpatient services	$0	✔	30%	✔
Hospital services	10%	✔	30% of up to $600/day plus 100% of additional charges	✔
Residential Care	10%	✔	30% of up to $600/day plus 100% of additional charges	✔

Prescription Drug Benefits[8,9]	Your payment			
	When using a Participating Pharmacy[3]	CYD[2] applies	When using a Non-Participating Pharmacy[4]	CYD[2] applies
Retail pharmacy prescription Drugs				
Per prescription, up to a 30-day supply.				
Contraceptive Drugs and devices	$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	✔
Tier 1 Drugs	$10/prescription	✔	25% plus $10/prescription	✔
Tier 2 Drugs	$25/prescription	✔	25% plus $25/prescription	✔
Tier 3 Drugs	$40/prescription	✔	25% plus $40/prescription	✔
Tier 4 Drugs (excluding Specialty Drugs)	30% up to $200/prescription	✔	30% up to $200/prescription plus 25% of purchase price	✔
Mail service pharmacy prescription Drugs				
Per prescription, up to a 90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$20/prescription	✔	Not covered	
Tier 2 Drugs	$50/prescription	✔	Not covered	
Tier 3 Drugs	$80/prescription	✔	Not covered	
Tier 4 Drugs (excluding Specialty Drugs)	30% up to $400/prescription	✔	Not covered	
Network Specialty Pharmacy Drugs				
Per prescription, up to a 30-day supply.				
Tier 4 Specialty Drugs	30% up to $200/prescription	✔	Not covered	
Oral Anticancer Drugs	30% up to $200/prescription	✔	Not covered	
Per prescription, up to a 30-day supply.				

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits
- Inpatient facility services
- Hospice program services
- Some prescription Drugs (see blueshieldca.com/pharmacy)

Please review the Evidence of Coverage for more about Benefits that require prior authorization.

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year combined medical and pharmacy Deductible. Some Covered Services received from Participating Providers are paid by Blue Shield before you meet any Calendar Year combined medical and pharmacy Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount, or
- any charges above the stated dollar amount, which is the Benefit maximum.

"Allowable Amount" is defined in the EOC. In addition:

Notes

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
- Charges above the Allowable Amount or Benefit maximum do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This Plan has a separate Participating Provider OOPM and Non-Participating Provider OOPM.

Covered Drugs obtained at Non-Participating Pharmacies. Any amounts you pay for Covered Drugs at Non-Participating Pharmacies count towards the Participating Provider OOPM.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

8 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This Plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

9 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate

Notes

that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Plans may be modified to ensure compliance with State and Federal requirements.

PENDING REGULATORY APPROVAL

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Notice of the Availability of Language Assistance Services

Blue Shield of California

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíílnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់៖ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866). (Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)

Professional Musicians, Local 47
PID 231472
EU 0 - Traditional HMO

Principal Benefits for
Kaiser Permanente Traditional HMO Plan (1/1/20—12/31/20)

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$30 per visit
Most Physician Specialist Visits	$30 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$30 per visit
Most physical, occupational, and speech therapy	$30 per visit

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$30 per procedure
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
MRI, most CT, and PET scans	$100 per procedure

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$500 per admission

Emergency Health Coverage	You Pay
Emergency Department visits	$100 per visit

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	You Pay
Ambulance Services	$150 per trip

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$15 for up to a 30-day supply
Most generic refills through our mail-order service	$30 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	$35 for up to a 30-day supply
Most brand-name refills through our mail-order service	$70 for up to a 100-day supply
Most specialty items at a Plan Pharmacy	$35 for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	20% Coinsurance

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$500 per admission
Individual outpatient mental health evaluation and treatment	$30 per visit
Group outpatient mental health treatment	$15 per visit

(continues)

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$500 per admission
Individual outpatient substance use disorder evaluation and treatment	$30 per visit
Group outpatient substance use disorder treatment	$5 per visit

Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	50% Coinsurance
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Professional Musicians, Local 47
PID 231472
EU 1 - DHMO

SCHEDULE 5

Principal Benefits for
Kaiser Permanente Deductible HMO Plan (1/1/20—12/31/20)

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductible(s) apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$4,000	$4,000	$8,000
Plan Deductible	$1,500	$1,500	$3,000
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	$20 per visit (Plan Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Family planning counseling and consultations	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	$20 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$20 per visit after Plan Deductible

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	No charge after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	20% Coinsurance up to a maximum of $50 per procedure after Plan Deductible

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Plan Deductible

Emergency Health Coverage	**You Pay**
Emergency Department visits	20% Coinsurance after Plan Deductible

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	**You Pay**
Ambulance Services	$150 per trip after Plan Deductible

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply (Plan Deductible doesn't apply)
Most generic refills through our mail-order service	$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name refills through our mail-order service	$60 for up to a 100-day supply (Plan Deductible doesn't apply)

(continues)

Prescription Drug Coverage	**You Pay**
Most specialty items at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	20% Coinsurance (Plan Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	$10 per visit (Plan Deductible doesn't apply)
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment	$5 per visit (Plan Deductible doesn't apply)
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the *EOC*	No charge (Plan Deductible doesn't apply)
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	50% Coinsurance (Plan Deductible doesn't apply)
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge (Plan Deductible doesn't apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Professional Musicians, Local 47
PID 231472
EU 2 - DHMO HSA

Principal Benefits for
Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO (1/1/20—12/31/20)

"Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO" is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. For a complete explanation, please refer to the *EOC*.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductible(s) apply to the Plan Out-of-Pocket Maximum amounts listed below.

Note: The Plan Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$5,250	$5,250	$10,500
Plan Deductible	$2,800	$2,800	$5,600
Drug Deductible	Not applicable	Not applicable	Not applicable

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$30 per visit after Plan Deductible
Most Physician Specialist Visits	$30 per visit after Plan Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Family planning counseling and consultations	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	$30 per visit (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	$30 per visit after Plan Deductible
Most physical, occupational, and speech therapy	$30 per visit after Plan Deductible

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	30% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	$5 per visit after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	30% Coinsurance up to a maximum of $50 per procedure after Plan Deductible

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	30% Coinsurance after Plan Deductible

Emergency Health Coverage	**You Pay**
Emergency Department visits	30% Coinsurance after Plan Deductible

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	**You Pay**
Ambulance Services	$100 per trip after Plan Deductible

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply after Plan Deductible
Most generic refills through our mail-order service	$20 for up to a 100-day supply after Plan Deductible
Most brand-name items at a Plan Pharmacy	$30 for up to a 30-day supply after Plan Deductible
Most brand-name refills through our mail-order service	$60 for up to a 100-day supply after Plan Deductible

(continues)

Prescription Drug Coverage	**You Pay**
Most specialty items at a Plan Pharmacy	$30 for up to a 30-day supply after Plan Deductible
Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	20% Coinsurance after Plan Deductible
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	30% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$30 per visit after Plan Deductible
Group outpatient mental health treatment	$15 per visit after Plan Deductible
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	30% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$30 per visit after Plan Deductible
Group outpatient substance use disorder treatment	$5 per visit after Plan Deductible
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge after Plan Deductible
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	30% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the *EOC*	No charge after Plan Deductible
Diagnosis and treatment of infertility and artificial insemination	Not covered
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge after Plan Deductible

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

SCHEDULE OF BENEFITS

Chiropractic/Acupuncture Expanded Benefit

Your Employer Group has contracted with Landmark Healthplan of California, Inc. (Landmark) to provide you with a combined chiropractic and acupuncture benefit that requires the use of Participating Chiropractors and Acupuncturists. You can obtain a directory of Participating Chiropractors and Acupuncturists through your employer, plan administrator, or Landmark, or you can access a continuously updated directory on Landmark's Web site at www.LHP-CA.com under the "Member" option. You may also call Landmark's Customer Service Department at **1-800-298-4875** for referrals to Participating Practitioners in your area.

FREE LANGUAGE ASSISTANCE IS AVAILABLE

If you need help in understanding your Landmark chiropractic or acupuncture benefits or need help to handle an issue about your benefits, please contact Landmark's Customer Service Department at 1-800-298-4875 between 5:30 AM and 5 PM, Monday through Friday, for free help. We can also help you in languages other than English.

If you or your dependents would like Landmark and your doctor to use a specific language when speaking or writing to you, please go to https://www.LHP-CA.com/Survey.aspx on the Internet and complete Landmark's brief language preference survey. The survey only takes about 3 minutes to complete and your answers will be strictly confidential. If you prefer to complete a paper copy of this survey, you may request one by writing to us at:

Landmark Healthplan of California, Inc.
Attn: QM Dept. - SURVEY
2629 Townsgate Rd, Suite 235
Westlake Village, CA 91361

Benefits and Co-payments	
Office Visit	**$20** co-payment
Maximum Annual Visits	**30** visits
X-ray Services*	$75 annual maximum benefit
Emergency Care**	Same co-payment as office visit
Durable Medical Equipment Purchase or Rental***	$50 annual maximum benefit
Acupuncture Herbal Therapies****	$5 co-payment per bottle / $500 annual max benefit

**X-ray Services must be prescribed by a Participating Chiropractor.*
***Services provided by Non-Participating Practitioners are covered for Emergency Services only.*
****Durable Medical Equipment must be prescribed by a Participating Chiropractor.*
*****Herbal therapies must be prescribed by a Participating Acupuncturist.*

A. Covered Services

1. Chiropractic Treatment

Covered Chiropractic Services are those within the scope of chiropractic care that are supportive or necessary to help Members achieve the physical state enjoyed before an injury or illness. In addition, services for preventive, maintenance, and wellness care for any mechanical neuromusculoskeletal condition are also covered. Services need not be pre-authorized, will not be reviewed for Medical Necessity, and include the following:

- Examinations
- Manipulation
- Conjunctive Physiotherapy
- X-rays
- Emergency Services

2. Acupuncture Treatment

Covered Acupuncture Services are those within the scope of acupuncture care for the treatment of neuromusculoskeletal pain resulting from an injury or illness. In addition, coverage is provided for preventive, maintenance and wellness care for any mechanical neuromusculoskeletal condition, uncomplicated asthma (that which is not effected by another condition or

disease), allergies, post-operative or chemo-therapy nausea and vomiting, nausea of pregnancy,

post-operative (including dental) pain, fibromyalgia, headaches and low-back pain. Services need not be pre-authorized, will not be reviewed for Medical Necessity, and include the following:

- Acupuncture
- Electro-acupuncture
- Moxibustion
- Cupping
- Acupressure

[*3. Acupuncture Herbal Therapies - Optional*

Herbal therapies are for oral ingestion or external application of naturally occurring botanical, animal, or mineral substances, to support normal structure and function of the human body according to the principles of traditional Oriental Medicine. These therapies are covered up to the annual maximum benefit amount when they are prescribed by a Participating Acupuncturist and do not include substances banned by the Food and Drug Administration and/or the Food and Drug Branch of the California Department of Health Services.**]**

4. Emergency Services

Emergency Services are covered for the sudden and unexpected onset of an acute illness, extreme neuromusculoskeletal pain or accidental injury to the nervous, musculoskeletal and/or skeletal body systems, that, in the reasonable judgment of the Member, requires immediate care, the delay of which could decrease the likelihood of maximum recovery, and for which the Member seeks to secure chiropractic or acupuncture services immediately after the onset, or as soon thereafter as practicable. Emergency Services do not require pre-authorization; however, Emergency Services rendered by a Non-Participating Practitioner are subject to Landmark's determination that the Member would reasonably have considered that Emergency Services were required.

Emergency Services rendered by a Non-Participating Practitioner are covered only when the practitioner rendering services can show that the services were for a neuromusculoskeletal condition and/or illness and were provided to reduce the severity of the condition including pain until a Participating Practitioner could safely assume treatment. Similarly, Emergency Services received outside of Landmark's Service Area will be covered only when the Non-Participating Practitioner rendering services can show that the services were for a neuromusculoskeletal condition and/or illness and were provided to reduce the severity of the condition including pain until a Participating Practitioner could safely assume treatment. Under the Landmark Plan, emergency care must be transferred to a Participating Practitioner as soon as such transfer would not create an unreasonable risk to the Member's health.

B. Second Opinions and Referrals

1. Second opinions

On occasion, a Participating Practitioner may require a second opinion, which is for consultation only, from another practitioner. Landmark does not require an authorization for any second opinion. Second opinions initiated by your Participating Practitioner will not count against your maximum annual visits and will not require a Member office visit co-payment. Second opinions initiated by Members will count against the maximum annual visits and will require a Member office visit co-payment.

2. Referrals to non-chiropractic and/or non-acupuncture practitioners

For referrals to non-chiropractic and/or non-acupuncture practitioners, Members or enrollees of full-service plans or HMOs will be referred to the plan or HMO practitioner network for non-neuromusculoskeletal conditions, conditions not improving with chiropractic and/or acupuncture care, and other such services that cannot be provided by another Participating Practitioner.

C. Limitations and Exclusions

Circumstances Causing Services to be Excluded or Limited

1. Services provided by a Non-Participating Practitioner, except for emergencies
2. Services provided outside of Landmark's Service Area, except for emergencies
3. Services incurred prior to the beginning or after the end of coverage
4. Services that exceed the combined maximum covered visits for the benefit year
5. Charges incurred for missed appointments
6. Educational programs
7. Pre-employment, school entrance, or athletic physical exams
8. Services for conditions arising out of employment, including self-employment or covered under any workers' compensation act or law
9. Services for any bodily injury arising from or sustained in an automobile accident that is covered under an automobile insurance policy
10. Charges for which the Member is not legally required to pay
11. Services rendered by a person who ordinarily resides in the Member's home or who is related to the Member by marriage or blood.

Specific Services that are Excluded or Limited

1. Experimental or investigational services
2. Vocational, stroke, or long-term rehabilitation
3. Hypnotherapy, behavior training, sleep therapy, or biofeedback
4. Rental or purchase of Durable Medical Equipment (DME)
5. Treatment primarily for purposes of weight control
6. Lab services
7. Thermography, hair analysis, heavy metal screening, or mineral studies
8. Transportation costs, including ambulance charges
9. Inpatient services
10. Advanced diagnostic services, such as MRI, CT, EMG, SEMG, and NCV

Chiropractic Only Limitations/Exclusions

1. Drugs, vitamins, nutritional supplements, or herbs
2. Massage or soft-tissue techniques
3. Manipulation under anesthesia
4. Services related to diagnosis and treatment of jaw joint or TMJ disorders
5. Treatment of non-neuromusculoskeletal disorders
6. X-ray services that exceed the annual maximum benefit

Acupuncture Only Limitations/Exclusions

1. Drugs, vitamins, nutritional supplements, or herbs, except as specified in the Schedule of Benefits
2. Massage or soft-tissue techniques other than acupressure as defined in your Evidence of Coverage
3. X-rays of any kind
4. Services related to menstrual cramps
5. Services related to addiction, including smoking cessation
6. Treatment of non-neuromusculoskeletal disorders except for those described under “Acupuncture Treatment” above

Keep Smiling

DeltaCare® USA

provided by
Delta Dental of California

Dental benefits made easy!

When you enroll in a DeltaCare USA[1] plan, you'll choose a primary care dentist from our network of carefully screened, private practice dentists. You must visit your primary care dentist to receive benefits.[2]

- No restrictions on pre-existing conditions (except work in progress)
- Access to specialty care and out-of-area emergency care

A partner in oral health

Your DeltaCare USA plan encourages regular dental care with an extensive list of covered services to help you stay healthy.

- Low or no copayments for services like cleanings and exams

Budget-friendly costs

With your DeltaCare USA plan, there are no surprises. You'll know your copayments, and your out-of-pocket costs are clearly defined before treatment begins.

- No deductibles or maximums[3] for covered services
- Pay only your copayment (if any) at the time of treatment

Convenient services

We make it easy for you — there are no claim forms to complete, and no plan ID card is required to receive treatment.

- Access plan information online
- Change your primary care dentist by phone or online

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html

[1] DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products. Delta Dental is a registered trademark of Delta Dental Plans Association.

[2] Verify your selected DeltaCare USA primary care dentist before each appointment.

[3] Plans with an Accidental Injury Rider have a $1,600 annual maximum for accidental injury. Consult your Evidence/Certificate of Coverage.

deltadentalins.com/enrollees

Frequently Asked Questions

What you need to know about your DeltaCare USA plan

Getting started

1. **How do I enroll in a DeltaCare USA plan?**
   Simply complete the enrollment process as directed by your benefits administrator. Be sure to select a primary care network dentist for yourself or your dependents, and indicate this dentist and the name of your group when you enroll.

2. **How do I get started using my DeltaCare USA plan?**
   Once we process your enrollment, we'll mail you welcome materials that will include:

   - **The name, address and phone number of your selected primary care dentist:** Simply call the dental facility to make an appointment. **Important note:** In order to receive benefits under your plan, you must visit your primary care network dentist for all services. If you require treatment from a specialist, your primary care dentist will coordinate a referral for you. You can change your primary care dentist by contacting us.
   - **Your Evidence/Certificate of Coverage (plan booklet):** This useful document provides a thorough description of how to use your benefits, including covered services, copayments and any limitations and exclusions of your plan.
   - **An ID card:** This card is for your records only — you do not need to present it in order to receive treatment.

3. **How long will it take to get an appointment with my primary care dentist?**
   Two to four weeks[1] is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time, you may need to wait longer. Most DeltaCare USA dentists are in private group practices, which generally offer greater appointment availability and extended office hours.

4. **How much will my dental treatments cost? How do I pay?**
   With your DeltaCare USA plan, some services are covered at no cost, while others have a copayment (amount you pay) for certain services. To find out how much a treatment will cost, refer to the "Description of Benefits and Copayments" in this brochure for a list of covered services and copayments. It's a good idea to bring your Evidence/Certificate of Coverage to your appointment in case you need to discuss your copayment for a service with your dentist. If you have any questions about the charges for a service, please contact Customer Service. If you receive treatment that requires a copayment, simply pay the dental facility at the time of service.

Choosing a dentist

5. **How do I select my primary care dentist?**
   When you enroll, you must select a primary care dentist from the DeltaCare USA network. To search for a dentist, use the "Find a Dentist" tool at **deltadentalins.com** and select the DeltaCare USA network. If you do not select a dentist when you enroll, we will choose one for you.

6. **Does everyone in my family have to choose the same primary care dentist?**
   No. Each family member can select his or her own primary care network dentist.[2]

7. **Can I change my primary care dentist?**
   Yes. You can request to change your primary care dentist at any time. Simply visit our website and log on to your online account or call or write to Customer Service. Change requests received by the 21st of the month will become effective the first day of the following month.

[1] In TX, three weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. In TX, there is no limit on the number of miles or on the dollar amount per emergency.
[2] In MA, you cannot select more than three primary care dentist facilities per family.

8. **My dentist says she is a Delta Dental dentist, but she isn't listed in the DeltaCare USA directory. Can I still visit her for services?**
No. You must visit your selected primary care network dentist to receive benefits under this plan. Delta Dental has many networks, and participation may vary — not all Delta Dental dentists are DeltaCare USA dentists.

9. **What should I do if I need to see a specialist?**
If you require specialty dental care — such as oral surgery, endodontics, periodontics or pediatric dentistry — contact your primary care dentist to request a referral. Specialty dental services not performed by your selected primary care dentist must be authorized by us. You are responsible for any applicable copayments.

General plan information

10. **If I'm traveling, is emergency treatment covered under my plan?**
You and your eligible dependents have out-of-area coverage for dental emergencies when you are more than 35 miles[3] from your primary care dentist. Your out-of-area emergency benefit (typically limited to $100 per person[4]) is for services to relieve pain until you can return to your primary care network dentist. Standard plan limitations, exclusions and copayments may apply.

11. **Can I access my plan online?**
Yes. Visit **deltadentalins.com** to create a free, secure online account. You can access your plan benefits and ID card, select (or change) your primary care dentist and more.

12. **Does my plan cover pre-existing conditions? What about treatments that are in progress?**
Treatment for pre-existing conditions (except work in progress[3]), including missing or extracted teeth, is covered under your plan. Treatment in progress includes services such as preparations for crowns or root canals, or impressions for dentures. If you started treatment before your plan's effective date, you and your prior dental carrier are responsible for any costs. Some DeltaCare USA plans may cover in-progress orthodontic treatment.

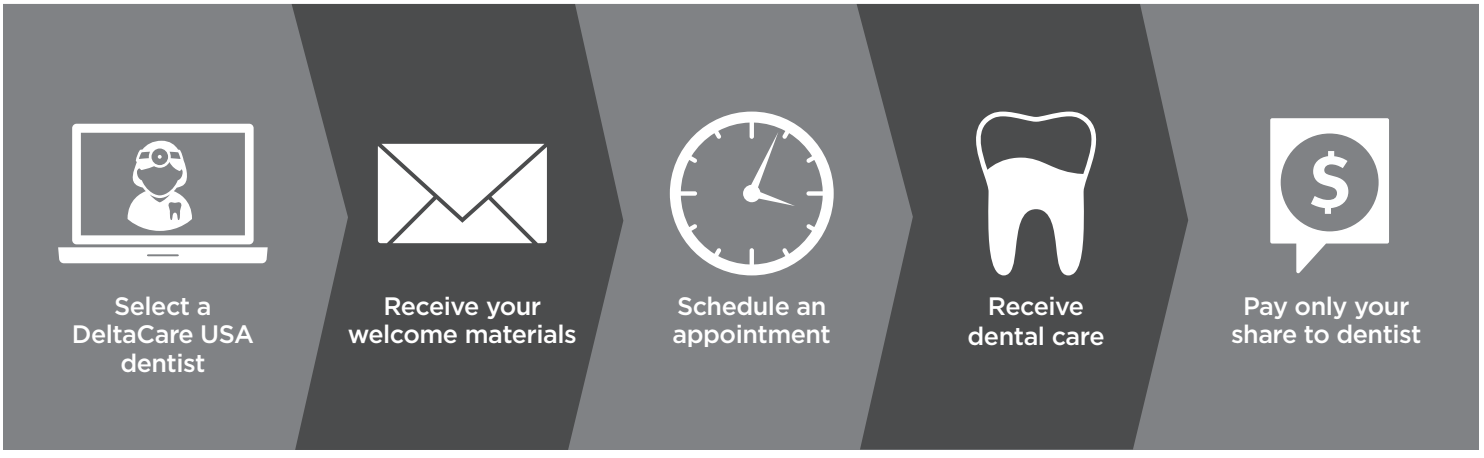
13. **Does my plan cover teeth whitening?**
Yes. External bleaching is a benefit under your DeltaCare USA plan. Review your plan booklet for more information and talk to your dentist about your options.

14. **Does my plan cover tooth-colored fillings and crowns?**
Yes. Porcelain and other tooth-colored materials are included in this plan.

15. **What if I have additional questions about my plan?**
Please contact us for additional support. Our Customer Service representatives can answer benefits questions as well as help you change your primary care dentist or arrange for urgent care referrals. See the back page of this brochure for our contact information.

[3] In TX, there is no limit on the number of miles or on the dollar amount per emergency.
[4] In TX, there is no exception for work in progress for covered DeltaCare USA benefits.

We make it easy for you!



FAQ_DCU_USA_STD_M9856A (rev. 02/19)

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2019 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost
D1000-D1999	**II. PREVENTIVE**	
D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost

D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral	$25.00
D1516	Space maintainer - fixed - bilateral, maxillary	$25.00
D1517	Space maintainer - fixed - bilateral, mandibular	$25.00
D1520	Space maintainer - removable - unilateral	$25.00
D1526	Space maintainer - removable - bilateral, maxillary	$25.00
D1527	Space maintainer - removable - bilateral, mandibular	$25.00
D1550	Re-cement or re-bond space maintainer	No Cost
D1555	Removal of fixed space maintainer	No Cost
D1575	Distal shoe space maintainer - fixed - unilateral - *child to age 9*	$25.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $100.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	$35.00
D2391	Resin-based composite - one surface, posterior	$55.00
D2392	Resin-based composite - two surfaces, posterior	$65.00
D2393	Resin-based composite - three surfaces, posterior	$75.00
D2394	Resin-based composite - four or more surfaces, posterior	$85.00
D2510	Inlay - metallic - one surface	No Cost
D2520	Inlay - metallic - two surfaces	No Cost
D2530	Inlay - metallic - three or more surfaces	No Cost
D2542	Onlay - metallic - two surfaces	No Cost
D2543	Onlay - metallic - three surfaces	No Cost
D2544	Onlay - metallic - four or more surfaces	No Cost
D2610	Inlay - porcelain/ceramic - one surface	$165.00
D2620	Inlay - porcelain/ceramic - two surfaces	$190.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$200.00
D2642	Onlay - porcelain/ceramic - two surfaces	$185.00
D2643	Onlay - porcelain/ceramic - three surfaces	$205.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$220.00
D2650	Inlay - resin-based composite - one surface	$105.00
D2651	Inlay - resin-based composite - two surfaces	$120.00
D2652	Inlay - resin-based composite - three or more surfaces	$145.00
D2662	Onlay - resin-based composite - two surfaces	$140.00
D2663	Onlay - resin-based composite - three surfaces	$155.00
D2664	Onlay - resin-based composite - four or more surfaces	$185.00

D2710	Crown - resin-based composite (indirect)	$50.00
D2712	Crown - 3/4 resin-based composite (indirect)	$50.00
D2720	Crown - resin with high noble metal	$195.00
D2721	Crown - resin with predominantly base metal	$95.00
D2722	Crown - resin with noble metal	$135.00
D2740	Crown - porcelain/ceramic	$240.00
D2750	Crown - porcelain fused to high noble metal	$240.00
D2751	Crown - porcelain fused to predominantly base metal	$140.00
D2752	Crown - porcelain fused to noble metal	$180.00
D2780	Crown - 3/4 cast high noble metal	$210.00
D2781	Crown - 3/4 cast predominantly base metal	$110.00
D2782	Crown - 3/4 cast noble metal	$150.00
D2783	Crown - 3/4 porcelain/ceramic	$240.00
D2790	Crown - full cast high noble metal	$210.00
D2791	Crown - full cast predominantly base metal	$110.00
D2792	Crown - full cast noble metal	$150.00
D2794	Crown - titanium	$240.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$20.00
D2930	Prefabricated stainless steel crown - primary tooth	$15.00
D2931	Prefabricated stainless steel crown - permanent tooth	$15.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$25.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$20.00
D2940	Protective restoration	$5.00
D2941	Interim therapeutic restoration - primary dentition	$5.00
D2949	Restorative foundation for an indirect restoration	$15.00
D2950	Core buildup, including any pins when required	$15.00
D2951	Pin retention - per tooth, in addition to restoration	$10.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$35.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$25.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$20.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$15.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$28.00
D2980	Crown repair necessitated by restorative material failure	$15.00
D2981	Inlay repair necessitated by restorative material failure	$15.00
D2982	Onlay repair necessitated by restorative material failure	$15.00
D2983	Veneer repair necessitated by restorative material failure	$15.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15* .	$10.00

D3000-D3999 **IV. ENDODONTICS** ***When referable services are provided by a Participating Specialty Care Dentist, the Enrollee pays 75 percent of that Dentist's usual fee.****

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	$10.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$20.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$20.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$55.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$120.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$250.00
D3331	Treatment of root canal obstruction; non-surgical access	$55.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$55.00

D3333	Internal root repair of perforation defects	$55.00
D3346	Retreatment of previous root canal therapy - anterior	$85.00
D3347	Retreatment of previous root canal therapy - premolar	$150.00
D3348	Retreatment of previous root canal therapy - molar	$280.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$75.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$50.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$50.00
D3410	Apicoectomy - anterior	$60.00
D3421	Apicoectomy - premolar (first root)	$70.00
D3425	Apicoectomy - molar (first root)	$80.00
D3426	Apicoectomy (each additional root)	$50.00
D3427	Periradicular surgery without apicoectomy	$60.00
D3430	Retrograde filling - per root	$60.00
D3450	Root amputation - per root	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy	$30.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$125.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$280.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$225.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$205.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$70.00
D4270	Pedicle soft tissue graft procedure	$205.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$45.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$205.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$205.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$25.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$20.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$25.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$15.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	$145.00
D5120	Complete denture - mandibular	$145.00
D5130	Immediate denture - maxillary	$165.00
D5140	Immediate denture - mandibular	$165.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$120.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$120.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$160.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$160.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$120.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$120.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$160.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$160.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$210.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$210.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$20.00
D5512	Repair broken complete denture base, maxillary	$20.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$10.00
D5611	Repair resin partial denture base, mandibular	$20.00
D5612	Repair resin partial denture base, maxillary	$20.00
D5621	Repair cast partial framework, mandibular	$20.00
D5622	Repair cast partial framework, maxillary	$20.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$20.00
D5640	Replace broken teeth - per tooth	$10.00
D5650	Add tooth to existing partial denture	$10.00
D5660	Add clasp to existing partial denture - per tooth	$10.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$135.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$135.00
D5710	Rebase complete maxillary denture	$55.00
D5711	Rebase complete mandibular denture	$55.00
D5720	Rebase maxillary partial denture	$55.00
D5721	Rebase mandibular partial denture	$55.00
D5730	Reline complete maxillary denture (chairside)	$20.00
D5731	Reline complete mandibular denture (chairside)	$20.00
D5740	Reline maxillary partial denture (chairside)	$20.00
D5741	Reline mandibular partial denture (chairside)	$20.00
D5750	Reline complete maxillary denture (laboratory)	$60.00
D5751	Reline complete mandibular denture (laboratory)	$60.00
D5760	Reline maxillary partial denture (laboratory)	$60.00
D5761	Reline mandibular partial denture (laboratory)	$60.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$75.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$75.00

D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.

- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$210.00
D6211	Pontic - cast predominantly base metal	$110.00
D6212	Pontic - cast noble metal	$150.00
D6240	Pontic - porcelain fused to high noble metal	$240.00
D6241	Pontic - porcelain fused to predominantly base metal	$140.00
D6242	Pontic - porcelain fused to noble metal	$180.00
D6245	Pontic - porcelain/ceramic	$240.00
D6250	Pontic - resin with high noble metal	$195.00
D6251	Pontic - resin with predominantly base metal	$95.00
D6252	Pontic - resin with noble metal	$135.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$190.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$200.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$100.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$100.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces	$40.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$40.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$185.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$205.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$100.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$100.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces	$40.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$40.00
D6720	Retainer crown - resin with high noble metal	$195.00
D6721	Retainer crown - resin with predominantly base metal	$95.00
D6722	Retainer crown - resin with noble metal	$135.00
D6740	Retainer crown - porcelain/ceramic	$240.00
D6750	Retainer crown - porcelain fused to high noble metal	$240.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$140.00
D6752	Retainer crown - porcelain fused to noble metal	$180.00
D6780	Retainer crown - 3/4 cast high noble metal	$210.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$110.00
D6782	Retainer crown - 3/4 cast noble metal	$150.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$240.00
D6790	Retainer crown - full cast high noble metal	$210.00
D6791	Retainer crown - full cast predominantly base metal	$110.00
D6792	Retainer crown - full cast noble metal	$150.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	$15.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$25.00
D7220	Removal of impacted tooth - soft tissue	$50.00
D7230	Removal of impacted tooth - partially bony	$70.00
D7240	Removal of impacted tooth - completely bony	$90.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$110.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	$110.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$85.00
D7280	Exposure of an unerupted tooth	$90.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$55.00
D7971	Excision of pericoronal gingiva	$55.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

	The benefit for pre-treatment records and diagnostic services includes:	$200.00
D0210	Intraoral - complete series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intraorally or extraorally	
D0351	3D photographic image	
D0470	Diagnostic casts	
	The benefit for post-treatment records includes:	$70.00
D0210	Intraoral - complete series of radiographic images	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	$950.00
D8020	Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$950.00
D8030	Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$950.00
D8040	Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,150.00
D8050	Interceptive orthodontic treatment of the primary dentition	$950.00

D8060	Interceptive orthodontic treatment of the transitional dentition	$950.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,700.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,900.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$5.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	$80.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$80.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$25.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$100.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$100.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$100.00
D9951	Occlusal adjustment, limited	$35.00
D9952	Occlusal adjustment, complete	$55.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.

9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.
11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures D9944, D9945, D9946 (occlusal guard).
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Useful information at your fingertips

Check out our SmileWay® Wellness program

Find oral health resources, including a risk self-assessment tool, quizzes, articles, videos and a subscription to *Grin!*, our free dental wellness e-magazine, at **mysmileway.com**.

Find a network dentist near you

Use our convenient "Find a Dentist" tool and select DeltaCare USA as your network.

- Find a dentist near your home or office
- Narrow your search by location, specialty, languages spoken — and more

Sign up for an online account

Use your mobile device or desktop to sign up for a free, secure online account.

- Review your plan benefits
- Access your ID card

Contact us

Need help? Let us know.

Online: Visit **deltadentalins.com/contact** and choose the "DeltaCare USA Customer Service" form.

Write to:
Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

Call toll-free: 800-422-4234
Customer Service agents are available Monday through Friday, 8 am to 9 pm, Eastern time.
Or, use our automated phone system, available 24/7.

Underwritten by:
Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703

Administered by:
Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

NOTE: This is only a brief summary of your plan.
This brochure is not intended to replace your legally required plan booklet. The Group Dental Service Contract determines the exact terms and conditions of your coverage. Please refer to the "Description of Benefits and Copayments" and "Limitations and Exclusions of Benefits" in this brochure for a complete list of covered procedures, copayments, plan limitations and exclusions. You may also consult your Evidence/Certificate of Coverage, which will be mailed to you upon enrollment. If you wish to review an Evidence/Certificate of Coverage prior to enrollment, you may request a copy by calling Customer Service at 800-422-4234.

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Keep Smiling

Delta Dental PPO™

Save with PPO

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.

Set up an online account

Get information about your plan anytime, anywhere by signing up for an online account at **deltadentalins.com**. This useful service, available once your coverage kicks in, lets you check benefits and eligibility information, find a network dentist and more.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they will need your information. Prefer to take a paper or electronic ID card with you? Simply log in to your account, where you can view or print your card with the click of a button.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Generally, multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.[4] You can find this date by logging in to your online account.

Newly covered?

Visit **deltadentalins.com/welcome**.

Save with a PPO dentist

PPO

NON-PPO

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

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Plan Benefit Highlights for: Professional Musicians Local 47 and Employers Health and Welfare Fund
Group No: 01811 **Effective Date:** 1/1/2020

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	$50 per person / $150 per family each calendar year			
Deductibles waived for Diagnostic & Preventive (D & P)?	Yes			
Maximums	$1,500 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics N/A

Benefits and Covered Services*	**Delta Dental PPO dentists****	**Non-Delta Dental PPO dentists****
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100%	80%
Basic Services Fillings and sealants	80%	80%
Endodontics (root canals) Covered Under Basic Services	80%	80%
Periodontics (gum treatment) Covered Under Basic Services	80%	80%
Oral Surgery Covered Under Basic Services	80%	80%
Major Services Crowns, inlays, onlays and cast restorations	50%	50%
Prosthodontics Bridges, dentures and implants	50%	50%
Orthodontic Benefits	0%	0%

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California	**Customer Service**	**Claims Address**
560 Mission St., Suite 1300 San Francisco, CA 94105	888-335-8227	P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

mesvision

Professional Musicians, Local 47

Using your MESVision® benefits is easy!

1. **Select a provider.** Select a participating vision care provider by using the MESVision® provider search feature on our website at **mesvision.com**. Obtaining services from a Participating Provider will maximize your benefits.
2. **Make an appointment.** Make an appointment with the Participating Provider of your choice and inform them of your vision coverage.
3. **You're done!** Your participating vision care provider will take care of the rest. The Participating Provider will contact MESVision® to verify your eligible benefits and submit a claim for services covered by your plan.

MESVision® Provides *Real Choice*

With MESVision® your vision care Network includes ***Real Choices*** in providers:

- Independent Ophthalmologists (MD)
- Independent Optometrists (OD)
- Independent Opticians (OPT)
- Optical Chain Locations Including…

- LensCrafters
- Sam's Club
- For Eyes Optical
- America's Best
- Costco Optical
- VisionWorks
- Pearle Vision
- Sterling Optical
- Wal-Mart
- Target Optical
- Site for Sore Eyes
- EyeMart

And many more…

With MESVision® you can utilize one provider for both your examination and eyewear materials or you can receive your examination from one provider and your materials from another provider. The ***Choice*** is yours!

With MESVision® your benefit may be used with any frame! Your plan will pay up to the plan allowance. You ***Choose!***

With MESVision® you may choose contact lenses in lieu of spectacle lenses and frames according to your plan's benefit schedule. It's up to ***You!***

This is a brief outline of the plan and is not to be accepted or construed as a substitute for the provisions of the contract. The policy may contain certain Limitations and Exclusions not stated here. Please refer to your Policy if you require additional information.

Summary of Vision Benefits

Co-pay:	$10
Comprehensive Vision Exam:	One every 12 months
Lenses:	One pair every 12 months
Frame:	One frame every 12 months
Contact Lenses:	One pay every 12 months

	In Network Allowance	Out of Network Allowance
Ophthalmologic Exam	Covered	Up to $60
Optometric Exam	Covered	Up to $50
Single Vision Lenses	Covered	Up to $43
Bifocal Lenses	Covered	Up to $60
Trifocal Lenses	Covered	Up to $75
Polycarbonate Lenses[3]	Up to $85	Up to $55
Progressive Lenses	Covered	Up to $75
Premium Progressive Lenses	Up to $89.50	Up to $75
Ultra Progressive Lenses	Up to $89.50	Up to $75
Aphakic Monofocal	Covered	Up to $120
Aphakic Multifocal	Covered	Up to $200
Frame[1]	Up to $75	Up to $40
Contact Lenses[2]		
One pair Medically Necessary	One Covered	Up to $250
Cosmetic or Convenience	Up to $105	Up to $100

[1] Participating Providers allow a selection of frames that retail up to **$75.00** with lenses that fit an eyesize less than 61 millimeters. If a more expensive frame is selected, you are responsible for the additional cost above **$75.00.** Please refer to your Policy if you require additional information.

[2] This benefit is in addition to the comprehensive vision exam, but in lieu of lenses and frame. If contact lenses are for cosmetic or convenience purposes, the Policy will pay up to **$105.00** toward the contact lens evaluation, fitting costs and materials. Any balance is your responsibility. If contact lenses are medically necessary, one pair is a fully covered benefit. Approval from MESVision is required. Please refer to your Policy if you require additional information. **Rigid gas permeable scleral and hybrid contact lenses for advanced keratoconus may be partially covered.**

[3] For Dependent Children through age 18.

Additional Savings

20% Discount	Available for cosmetic extras, such as tints, coatings and other add-on charges to standard lenses, after Covered Services are rendered. Discount is not applied twice when coordinating benefits.
20% Discount	Also applies to additional pairs of glasses and/or pairs of standard contact lenses. This discount is not available at Warehouse or Wholesale locations.
Lasik Discount	Discounts opportunities available through LasikPlus® & QualSight® LASIK.

To determine whether a provider offers the 20% discount, an insured individual can review their Participating Provider Directory, call MESVision or visit MESvision.com

If you have any questions about your vision benefits,
please contact Medical Eye Services at:
PO Box 25209; Santa Ana, CA 92799
800/877-6372 or MESVision.com

Underwritten By:

Gerber Life Insurance

Professional Musicians, Local 47 and Employers' Health & Welfare Fund

Basic Participant Term Life Coverage

Basic Accidental Death and Dismemberment Coverage

Prudential

Disclosure Notice

FOR ARKANSAS RESIDENTS

Prudential's Customer Service Office:

The Prudential Insurance Company of America
Prudential Group Life Claim Division
P.O. Box 8517
Philadelphia, PA 19176
1-800-524-0542

If Prudential fails to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-800-852-5494

FOR CALIFORNIA RESIDENTS

Prudential's Address:

The Prudential Insurance Company of America
751 Broad Street
Newark, New Jersey 07102

Customer Service Office:

The Prudential Insurance Company of America
Prudential Group Life Claim Division
P.O. Box 8517
Philadelphia, Pennsylvania 19176
1-800-524-0542

Should you have a dispute concerning your coverage you should contact Prudential first. If the dispute is not resolved, you may contact the California Department of Insurance at the following address and phone number:

California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, California 90013
1-800-927-HELP

http://www.insurance.ca.gov/01-consumers/

FOR FLORIDA RESIDENTS

The benefits of the policy providing your coverage are governed by the law of a state other than Florida.

FOR IDAHO RESIDENTS

If you need the assistance of the governmental agency that regulates the business of insurance, you can contact the Idaho Department of Insurance by contacting:

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise ID 83720-0043

1-800-721-3272 or 208-334-4250 or www.DOI.Idaho.gov

FOR INDIANA RESIDENTS

Questions regarding your policy or coverage should be directed to:

The Prudential Insurance Company of America
(800) 524-0542

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

FOR MARYLAND RESIDENTS

The Group Insurance Contract providing coverage under this Certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

FOR NORTH CAROLINA RESIDENTS

Notice: This Certificate of Insurance provides all of the benefits mandated by the North Carolina Insurance Code, but is issued under a group master policy located in another state and may be governed by that state's laws.

FOR TEXAS RESIDENTS

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

FOR WISCONSIN RESIDENTS

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

Problems with Your Insurance? – If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Prudential's Customer Service Office:

The Prudential Insurance Company of America
Prudential Group Life Claim Division
P.O. Box 8517
Philadelphia, PA 19176
1-800-524-0542

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at *http://oci.wi.gov/*, or by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103

THIS NOTICE IS FOR TEXAS RESIDENTS ONLY

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Web: http://www.tdi.texas.gov

Email: consumerprotection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact Prudential first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Web: http://www.tdi.texas.gov

Email: consumerprotection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con Prudential primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:

Este aviso es sólo para propósito de información y no se convierte en parte o condición del documento adjunto.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Certificate of Coverage

Prudential certifies that insurance is provided according to the Group Contract(s) for each Insured Employee. Your Booklet's Schedule of Benefits shows the Contract Holder and the Group Contract Number(s).

Insured Participant: You are eligible to become insured under the Group Contract if you are in the Covered Classes of the Booklet's Schedule of Benefits and meet the requirements in the Booklet's Who is Eligible section. The When You Become Insured section of the Booklet states how and when you may become insured for each Coverage. Your insurance will end when the rules in the When Your Insurance Ends section so provide. Your Booklet and this Certificate of Coverage together form your Group Insurance Certificate.

Beneficiary for Participant Death Benefits: See the Booklet's Beneficiary Rules.

Coverages and Amounts: The available Coverages and the amounts of insurance are described in the Booklet.

If you are insured, your Booklet and this Certificate of Coverage form your Group Insurance Certificate. Together they replace any older booklets and certificates issued to you for the Coverages in the Booklet's Schedule of Benefits. All Benefits are subject in every way to the entire Group Contract which includes the Group Insurance Certificate.

The Prudential Insurance Company of America
751 Broad Street
Newark, New Jersey 07102

Foreword

We are pleased to present you with this Booklet. It describes the Program of benefits we have arranged for you and what you have to do to be covered for these benefits.

We believe this Program provides worthwhile protection for you and your family.

Please read this Booklet carefully. If you have any questions about the Program, we will be happy to answer them.

IMPORTANT NOTICE: *This Booklet is an important document and should be kept in a safe place. This Booklet and the Certificate of Coverage made a part of this Booklet together form your Group Insurance Certificate.*

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: *There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code.* ***Your Access Code is 45588.***

If you are unable to access this website, want to receive a printed copy of these requirements or have any questions, call Prudential at 1-866-439-9026.

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Schedule of Benefits

Covered Classes: The “Covered Classes" are all Participants who have met the qualifications for eligibility as determined by the Professional Musicians, Local 47 and Employers' Health & Welfare Board of Trustees.

Program Date: November 1, 2011. This Booklet describes the benefits under the Group Program as of the Program Date.

- This Booklet and the Certificate of Coverage together form your Group Insurance Certificate. The Coverages in this Booklet are insured under a Group Contract issued by Prudential. All benefits are subject in every way to the entire Group Contract which includes the Group Insurance Certificate. It alone forms the agreement under which payment of insurance is made.

BASIC PARTICIPANT TERM LIFE COVERAGE

BENEFIT AMOUNTS:

Amount For Each Benefit Class:

Benefit Classes	**Amount of Insurance**
All Participants	$20,000

Amount Limit Due to Age: When you are age 70 or more, your amount of insurance is limited. It is the Limited Percent (for that Age) of the amount for which you would then be insured if there were no limitation. Each Age and the Limited Percent for that Age are shown below.

Age	**Limited Percent**
70	65
75 and more	50

The Limited Percent for an Age takes effect on the day you become insured if you are then that Age. Otherwise, each Limited Percent for an Age takes effect on the first day of the month following your birthday for that Age.

The Delay of Effective Date section does not apply to this Amount Limit Due to Age provision.

Effect of Option to Accelerate Payment of Death Benefits: Your amount of insurance (as determined in the absence of this provision) will be reduced by the amount of any Terminal Illness Proceeds paid under the Option to Accelerate Payment of Death Benefits.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

BENEFIT AMOUNTS UNDER EMPLOYEE INSURANCE:

Amount For Each Benefit Class: An amount equal to the amount for which you are insured under the Basic Participant Term Life Coverage. For this purpose only, that amount will be the amount as determined above, except that if your Basic Participant Term Life Coverage is reduced by any amount paid under the Option to Accelerate Payment of Death Benefits, that reduction will not apply to this Coverage.

ADDITIONAL BENEFITS UNDER PARTICIPANT INSURANCE:

For the purposes of determining benefits under the Coverage, Amount of Insurance does not include any additional amount payable as shown below.

Additional Amount Payable for Loss of Life as a Result of an Accident in a Four Wheel Vehicle While Using a Seat Belt: An amount equal to the lesser of:

(1) 10% of your Amount of Insurance; and

(2) $10,000.

Additional Amount Payable for Loss of Life as a Result of an Accident in a Four Wheel Vehicle Equipped with a Supplemental Restraint System: An amount equal to the lesser of:

(1) 10% of your Amount of Insurance; and

(2) $10,000.

Additional Amount Payable for Return of Remains: An amount equal to the lesser of:

(1) the amount of Covered Expenses; and

(2) $2,500.

Additional Amount Payable for Your Loss as a Result of Felonious Assault: An amount equal to 5% of the amount payable under the Coverage for the Loss that results from a Felonious Assault.

Additional Amount Payable for Tuition Reimbursement for Your Spouse or Registered Domestic Partner: An amount equal to the least of:

(1) the actual tuition charged for the program;

(2) 1% of your Amount of Insurance; and

(3) $2,500.

Additional Annual Amount Payable for Tuition Reimbursement for Your Dependent Child: An amount equal to the least of:

(1) the actual annual tuition, exclusive of room and board, charged by the School;

(2) 1% of your Amount of Insurance; and

(3) $2,500.

This benefit is payable annually for up to four consecutive years, but not beyond the date the child reaches age 23.

If there is no dependent child eligible for this benefit, a benefit of $1,000 will be paid.

Additional Annual Amount Payable for Day Care Expenses for Your Dependent Child: An amount equal to the least of:

(1) the actual cost charged by such Day Care Center per year;

(2) 1% of your Amount of Insurance, and

(3) $2,000.

This benefit is payable annually for up to four consecutive years, but not beyond the date the child reaches age seven.

If there is no dependent child eligible for this benefit, a benefit of $1,000 will be paid.

TO WHOM PAYABLE:

Accidental Death and Dismemberment benefits are payable to you with these exceptions:

(1) Benefits for tuition reimbursement for your spouse or Registered Domestic Partner payable on account of your Loss of life will be paid to:

   (a) your spouse or Registered Domestic Partner, if living; or

   (b) your spouse's or Registered Domestic Partner's estate.

(2) Benefits for day care expenses or tuition reimbursement for your dependent children payable on account of your Loss of life will be paid to the person or institution appearing to Prudential to have assumed the main support of the children.

(3) Benefits for any other of your Losses that are unpaid at your death or become payable on account of your death will be paid to your Beneficiary or Beneficiaries. (See Beneficiary Rules.)

OTHER INFORMATION

Contract Holder: PROFESSIONAL MUSICIANS, LOCAL 47 AND EMPLOYERS' HEALTH & WELFARE FUND

Group Contract No.: G-45588-CA

Cost of Insurance: The insurance in this Booklet is Non-contributory Insurance

Prudential's Address:

The Prudential Insurance Company of America
80 Livingston Avenue
Roseland, New Jersey 07068

WHEN YOU HAVE A CLAIM

Each time a claim is made, it should be made without delay. Use a claim form, and follow the instructions on the form.

If you do not have a claim form, contact the Contract Holder.

Who is Eligible to Become Insured

FOR PARTICIPANT INSURANCE

You are eligible to become insured for Participant Insurance if:

- You have met the qualifications for eligibility as determined by the Professional Musicians, Local 47 and Employers' Health & Welfare Board of Trustees.

Your class is determined by the Contract Holder. This will be done under its rules, on dates it sets. The Contract Holder must not discriminate among persons in like situations. You cannot belong to more than one class for insurance on each basis, Contributory or Non-contributory Insurance, under a Coverage. “Class" means Covered Class, Benefit Class or anything related to work, such as position or Earnings, which affects the insurance available.

The rules for obtaining Participant Insurance are in the When You Become Insured section.

When You Become Insured

FOR PARTICIPANT INSURANCE

Your Participant Insurance under a Coverage will begin the first day on which:

- You are eligible for Participant Insurance; and
- You are in a Covered Class for that insurance; and
- You have met any evidence requirement for Participant Insurance; and
- Your insurance is not being delayed under the Delay of Effective Date section below; and
- That Coverage is part of the Group Contract.

At any time, the benefits for which you are insured are those for your class, unless otherwise stated.

When evidence is required: In either of these situations, you must give evidence of insurability. This requirement will be met when Prudential decides the evidence is satisfactory.

(1) You wish to become insured for life insurance and have an individual life insurance contract which you obtained by converting your insurance under a Coverage of the Group Contract.

(2) You have not met a previous evidence requirement to become insured under any Prudential group contract covering Participants of the Employers.

Delay of Effective Date

FOR PARTICIPANT INSURANCE

Your Participant Insurance under a Coverage will be delayed if you do not meet the Active Work Requirement (refer to the definition on page 26) on the day your insurance would otherwise begin. Instead, it will begin on the first day you meet the Active Work Requirement and the other requirements for the insurance. The same delay rule will apply to any change in your insurance that is subject to this section.

Basic Participant Term Life Coverage

FOR YOU ONLY

A. DEATH BENEFIT WHILE A COVERED PERSON.

If you die while a Covered Person, the amount of your Participant Term Life Insurance under this Coverage is payable when Prudential receives written proof of death.

B. DEATH BENEFIT DURING CONVERSION PERIOD.

A death benefit is payable under this Section B if you die:

(1) within 31 days after you cease to be a Covered Person; and

(2) while entitled (under Section D) to convert your Participant Term Life Insurance under this Coverage to an individual contract.

The amount of the benefit is equal to the amount of Participant Term Life Insurance under this Coverage you were entitled to convert. It is payable even if you did not apply for conversion. It is payable when Prudential receives written proof of death.

C. EXTENDED DEATH BENEFIT AND WAIVER OF PREMIUMS DURING TOTAL DISABILITY.

If you meet the conditions below, your death benefit protection will be extended while you are Totally Disabled, and from the date Prudential receives proof as described below, premiums for your Participant Term Life Insurance under this Coverage will be waived while your death benefit protection is extended. The “Extended Death Benefit" is the benefit described in this Section C.

The conditions referred to above are:

(1) You become Totally Disabled while you are a Covered Person.

(2) You are less than age 60 when your Total Disability starts.

Total Disability: You are “Totally Disabled" when:

(1) You are not working at any job for wage or profit; and

(2) Due to Sickness, Injury or both, you are not able to perform for wage or profit, the material and substantial duties of any job for which you are reasonably fitted by your education, training or experience.

The extension ends one year after your Total Disability started, unless, within that year, you give Prudential written proof that:

(1) You have met the above conditions; and

(2) You are still Totally Disabled; and

(3) Your Total Disability has continued for at least 6 months.

Prudential will then further extend your death benefit protection for successive one year periods. The first of these periods will start on the date Prudential receives this proof. After that first period, you must give written proof when and as required by Prudential once each year that your Total Disability continues.

If you die while your death benefit protection is being extended, the Extended Death Benefit is payable when Prudential receives written proof that:

(1) Your Total Disability continued until your death; and

(2) All of the above conditions have been met.

If you die within one year after your Total Disability started and before you give Prudential proof of Total Disability, written notice of your death must be given to Prudential within one year after your death.

Your extension protection ends if and when:

(1) Your Total Disability ends; or

(2) You reach age 65; or

(3) You fail to furnish any required proof that your Total Disability continues; or

(4) You fail to submit to a medical exam by Doctors named by Prudential when and as often as Prudential requires. After two full years of this protection, Prudential will not require an exam more than once a year.

If your extension protection ends after you have given the first proof of continued Total Disability, you have the same rights and benefits under Sections B and D as if you ceased to be a member of the Covered Classes for the insurance. But this does not apply if you become a Covered Person within 31 days after this protection ends.

Amount of Extended Death Benefit: This amount is determined as if you had remained a Covered Person until death. But it is reduced by any amount payable under Sections A or B above or any Prudential group life insurance that replaces this Coverage for a class of Participants.

Effect of Conversion: An individual contract issued under Section D will be in place of all rights under this Section C. But if you have met all the requirements of this Section C, you can obtain these rights in exchange for all benefits of the individual contract. Premiums paid under the individual contract will be refunded. Your choice of Beneficiary in the individual contract, if different than for this Coverage, will be considered notice of change of Beneficiary for any claim under this Section C.

D. CONVERSION PRIVILEGE.

If you cease to be insured for the Participant Term Life Insurance of the Group Contract for one of the reasons stated below, you may convert all or part of your insurance under this Coverage, which then ends, to an individual life insurance contract. Evidence of insurability is not required. The reasons are:

(1) Your employment ends or you transfer out of a Covered Class.

(2) All term life insurance of the Group Contract for your class ends by amendment or otherwise, if on the date that it ends:

(a) You are Totally Disabled (as defined in Section C above) and remain Totally Disabled until the effective date of the individual contract; or

(b) You have been insured for five years for that insurance (or for that insurance and any Prudential rider or group contract replaced by that insurance).

Any such conversion is subject to the rest of this Section D.

Availability: You must apply for the individual contract and pay the first premium according to the following rules:

(1) If you have been given written notice of the conversion privilege by the fifteenth day after you cease to be insured for the Participant Term Life Insurance, you must apply for the individual contract and pay the first premium by the thirty-first day after you cease to be insured for that coverage.

(2) If you have been given written notice of the conversion privilege more than fifteen days after you cease to be insured for the Participant Term Life Insurance, you must apply for the individual contract and pay the first premium by the twenty-fifth day after you have been given the notice. But, in no event may you convert the insurance to an individual contract if you do not apply for the contract and pay the first premium prior to the ninety-second day after you cease to be insured for the Participant Term Life Insurance.

Individual Contract Rules: The individual contract must conform to the following:

Amount: Not more than your Participant Term Life Insurance under this Coverage when your insurance ends. But, if it ends because all term life insurance of the Group Contract for your class ends, the total amount of individual insurance which you may get in place of all your life insurance then ending under the Group Contract will not exceed the following:

(1) If you are Totally Disabled (as defined in Section C above) when the life insurance ends and remain continuously so disabled until the effective date of the individual contract, the total amount of all your life insurance then ending under the Group Contract reduced by the amount of group life insurance from any carrier for which you become insured within the next 31 days.

(2) In all other instances, the lesser of (a) and (b):

(a) The total amount of all your life insurance then ending under the Group Contract reduced by the amount of group life insurance from any carrier for which you are or become eligible within the next 31 days.

(b) $10,000.

Form: Any form of a life insurance contract that:

(1) conforms to Title VII of the Civil Rights Act of 1964, as amended, having no distinction based on sex; and

(2) is one that Prudential usually issues at the age and amount applied for.

This does not include term insurance or a contract with disability or supplementary benefits.

Premium: Based on Prudential's rate as it applies to the form and amount, and to your class of risk and age at the time.

Effective Date: The end of the 31 day period after you cease to be insured for the Participant Term Life Insurance.

Any death benefit provided under a section of this Coverage is payable according to that section and the Beneficiary and Mode of Settlement Rules.

Option to Accelerate Payment of Death Benefits

The following is added to the Participant Term Life Coverage provision:

Definitions

- Terminally Ill Participant: A Participant whose life expectancy is 12 months or less.
- Terminal Illness Proceeds: The amount of Participant Term Life Insurance that you may elect to place under this option. The Terminal Illness Proceeds are equal to 80% of the amount in force on your life on the date Prudential receives the proof that you are a Terminally Ill Participant, but not more than $16,000. However, the Terminal Illness Proceeds may be reduced if, within 12 months after the date Prudential receives such proof, a reduction on account of age would have applied to the amount of your Participant Term Life Insurance. In that case, the amount of the Terminal Illness Proceeds may not exceed the amount of such Insurance after applying the reduction.

Option: If you become a Terminally Ill Participant while insured under the Participant Term Life Insurance provision or while your death benefit protection is being extended under the Participant Term Life Coverage provision, you may elect to have the Terminal Illness Proceeds placed under this option. That election is subject to the conditions set forth below.

Payment of Terminal Illness Proceeds: If you elect this option, Prudential will pay the Terminal Illness Proceeds you place under this option in one sum when it receives proof that you are a Terminally Ill Participant.

If you do not want the Terminal Illness Proceeds in one sum, you may elect to have them paid in 12 equal monthly installments. The first monthly payment will be due when Prudential receives proof that you are a Terminally Ill Participant. The other payments are due on the same day of each later month.

To Whom Payable: The benefits under this provision are payable to you.

Amount Due But Unpaid at Your Death: If you elect monthly installments and you die before all payments have been made, Prudential will pay your Beneficiary or Beneficiaries determined under the Beneficiary Rules in one sum. That sum will be the total of the payments that remain.

Conditions: Your right to be paid under this option is subject to these terms:

(1) You must choose this option in writing in a form that satisfies Prudential.

(2) You must furnish proof that satisfies Prudential that your life expectancy is 12 months or less, including certification by a Doctor.

(3) Your Participant Term Life Insurance must not be assigned.

(4) Terminal Illness Proceeds will be made available to you on a voluntary basis only. Therefore:

(a) If you are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise, you are not eligible for this benefit.

(b) If you are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement, you are not eligible for this benefit.

Effect on Insurance: This benefit is in lieu of the benefits that would have been paid on your death with respect to the Terminal Illness Proceeds. When you elect this option, the total amount of Participant Term Life Insurance otherwise payable on your death, including any amount under an extended death benefit, will be reduced by the Terminal Illness Proceeds. Also, any amount you could otherwise have converted to an individual contract will be reduced by the Terminal Illness Proceeds.

The Claim Rules apply to the payment of benefits under this option.

Accidental Death and Dismemberment Coverage

FOR YOU

This Coverage pays benefits for accidental Loss.

Loss means the person's:

(1) loss of life;

(2) total and permanent loss of sight;

(3) loss of hand or foot by severance at or above the wrist or ankle;

(4) total and permanent loss of speech;

(5) total and permanent loss of hearing in both ears;

(6) loss of thumb and index finger of the same hand by severance at or above the metacarpophalangeal joint;

(7) loss due to Quadriplegia, Paraplegia, or Hemiplegia; or

(8) loss due to Coma.

Quadriplegia means the complete and irreversible paralysis of both upper and both lower limbs.

Paraplegia means the complete and irreversible paralysis of both lower limbs.

Hemiplegia means the complete and irreversible paralysis of the upper and lower limbs on one side of the body.

Coma means a profound state of unconsciousness from which the person cannot be aroused, even by powerful stimulation, as determined by the person's physician.

A. BENEFITS.

Benefits for accidental Loss are payable only if all of these conditions are met:

(1) The person sustains an accidental bodily Injury while a Covered Person.

(2) The Loss results directly from that Injury and from no other cause.

(3) The person suffers the Loss within 365 days after the accident. But, if the Loss is due to Coma, that Loss:

(a) begins within 365 days after the accident; and

(b) continues for six consecutive months; and

(c) is total, continuous and permanent at the end of that six month period.

Any benefit for a Loss due to Coma will not begin until the end of the six-month period in (c) above.

For the purposes of the Coverage:

(1) Exposure to the elements will be considered an accidental Injury.

(2) It will be presumed that the person has suffered a Loss of life if the person's body has not been found within one year of disappearance, stranding, sinking or wrecking of any vehicle in which the person was an occupant.

Not all such Losses are covered. See Losses Not Covered below.

Benefit Amount Payable: The amount payable depends on the type of Loss as shown below. All benefits are subject to the Limitation Per Accident below.

Loss of or by Reason of:	Percent of the Person's Amount of Insurance
Life	100
Both Hands	100
Both Feet	100
Sight of Both Eyes	100
One Hand and One Foot	100
One Hand and Sight of One Eye	100
One Foot and Sight of One Eye	100
Speech and Hearing	100
Quadriplegia	100
Paraplegia	75
One Hand	50
One Foot	50
Sight of One Eye	50
Speech	50
Hearing	50
Hemiplegia	50
Thumb and Index Finger of the Same Hand	25
Coma	1% per month, up to 11 months

Limitation Per Accident: No more than the Amount of Insurance on a person at the time of the accident will be paid for all Losses resulting from Injuries sustained in that accident.

B. LOSSES NOT COVERED.

A Loss is not covered if it results from any of these:

(1) Suicide or attempted suicide, while sane or insane.

(2) Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries.

(3) Sickness, whether the Loss results directly or indirectly from the Sickness.

(4) Medical or surgical treatment of Sickness, whether the Loss results directly or indirectly from the treatment.

(5) Any infection. But, this does not include:

(a) a pyogenic infection resulting from an accidental cut or wound; or

(b) a bacterial infection resulting from accidental ingestion of a contaminated substance.

(6) War, or any act of war. “War" means declared or undeclared war and includes resistance to armed aggression.

(7) An accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces. But this does not include Reserve or National Guard active duty for training.

(8) Travel or flight in any vehicle used for aerial navigation. This includes getting in, out, on or off any such vehicle. This (8) applies only if:

(a) the person is riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;

(b) the person is performing as a pilot or a crew member of any aircraft; or

(c) you are riding as a passenger in an aircraft owned, leased or operated by your Employer.

(9) Commission of or attempt to commit a felony.

(10) Being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a Doctor.

(11) Participation in these hazardous sports: scuba diving; bungee jumping; skydiving; parachuting; hang gliding; or ballooning.

C. ADDITIONAL BENEFITS

An additional benefit may be payable for a Loss for which a benefit is payable under the other terms of this Coverage or would be payable except for the Limitation Per Accident of those terms. Any such benefit is payable in addition to any other benefit payable under this Coverage. Any additional conditions that apply to an additional benefit are shown below. An additional benefit is payable only if those conditions are met.

(1) **Additional Benefit for Loss of Life as a Result of an Accident in a Four Wheel Vehicle While Using a Seat Belt:**

This additional benefit for the person's Loss of life is payable only if this test is met.

The person sustains an accidental bodily Injury resulting in the Loss while:

(a) the person is a driver or passenger in a Four Wheel Vehicle; and

(b) the person is wearing a Seat Belt in the manner prescribed by the vehicle's manufacturer; and

(c) the actual use of a Seat Belt at the time of the Injury is verified in an official report of the accident, or is certified in writing by the investigating official(s).

Four Wheel Vehicle means a vehicle that is:

(a) duly licensed for passenger use;

(b) designated primarily for use on public streets and highways; and

(c) in the list below:

(i) a private passenger automobile;

(ii) a station wagon; or

(iii) a self-propelled motor home.

Seat Belt means an unaltered lap restraint or lap and shoulder restraint.

Losses Not Covered under this Additional Benefit: A Loss is not covered under this additional benefit if it results from driving or riding in any Four Wheel Vehicle used in a race or a speed or endurance test, or for acrobatic or stunt driving.

Benefit Amount Payable for Loss of Life as a Result of an Accident in a Four Wheel Vehicle While Using a Seat Belt: The additional amount payable is shown in the Schedule of Benefits.

(2) **Additional Benefit for Loss of Life as a Result of an Accident in a Four Wheel Vehicle Equipped with a Supplemental Restraint System:**

This additional benefit for the person's Loss of life is payable only if this test is met.

The person sustains an accidental bodily Injury resulting in the Loss while:

(a) the person is a driver or passenger in a Four Wheel Vehicle equipped with a factory-installed Supplemental Restraint System; and

(b) the person is in a seat designed to be protected by an air bag; and

(c) the person is wearing a Seat Belt in the manner prescribed by the vehicle's manufacturer; and

(d) the actual use of a Seat Belt at the time of the Injury is verified in an official report of the accident, or is certified in writing by the investigating official(s).

Four Wheel Vehicle means a vehicle that is:

(a) duly licensed for passenger use;

(b) designated primarily for use on public streets and highways; and

(c) in the list below:

(i) a private passenger automobile;

(ii) a station wagon; or

(iii) a self-propelled motor home.

Seat Belt means an unaltered lap restraint or lap and shoulder restraint.

Supplemental Restraint System means an air bag system intended to add protection to the head and chest areas.

Losses Not Covered under this Additional Benefit: A Loss is not covered under this additional benefit if it results from driving or riding in any Four Wheel Vehicle used in a race or a speed or endurance test, or for acrobatic or stunt driving.

Benefit Amount Payable for Loss of Life as a Result of an Accident in a Four Wheel Vehicle Equipped with a Supplemental Restraint System: The additional amount payable is shown in the Schedule of Benefits.

(3) **Additional Benefit for Return of Remains:**

This additional benefit for return of remains only applies if the person suffers a Loss of life and such Loss occurs outside a 150-mile radius of the person's home. It is payable for Covered Expenses incurred to return the person's body home to the United States or Canada.

Covered Expenses includes expenses for: (a) embalming; (b) cremation; (c) a coffin; and (d) transportation of the remains.

Benefit Amount Payable for Return of Remains: The additional amount payable is shown in the Schedule of Benefits.

(4) **Additional Benefit for Your Loss as a Result of Felonious Assault:**

This additional benefit for Felonious Assault only applies if you suffer a Loss that is the result of a Felonious Assault.

Felonious Assault means a Physical Attack by another person resulting in bodily harm to you. But, a Felonious Assault is not a moving violation as defined under the applicable state motor vehicle laws.

Physical Attack means any willful or unlawful use of force or violence upon you with the intent to cause bodily Injury to you. The Physical Attack must be considered a felony or misdemeanor in the jurisdiction in which it occurs.

Benefit Amount Payable for Your Loss as a Result of Felonious Assault: The additional amount payable is shown in the Schedule of Benefits.

(5) **Additional Benefit for Tuition Reimbursement for Your Spouse or Registered Domestic Partner:**

This additional benefit for tuition reimbursement for your spouse or Registered Domestic Partner only applies if you suffer a Loss of life.

An additional benefit for tuition reimbursement is payable for the person who:

(a) is your spouse or Registered Domestic Partner on the date of your death; and

(b) enrolls in any professional or trades program within 30 months after the date of your death for the purposes of obtaining an independent source of support or enriching that spouse's or Registered Domestic Partner's ability to earn a living. Proof of enrollment must be given to Prudential.

Benefit Amount Payable for Tuition Reimbursement for Your Spouse or Registered Domestic Partner: The additional benefit payable is shown in the Schedule of Benefits.

(6) **Additional Benefit for Tuition Reimbursement for Your Dependent Child:**

This additional benefit for tuition reimbursement for your dependent child only applies if you suffer a Loss of life.

An additional benefit for tuition reimbursement is payable for each dependent child less than age 23 who, on the date of death, is:

(a) your child who wholly depends on you for support and maintenance; and

(b) enrolled as a full-time student in a School; or

(c) in the 12th grade and becomes a full-time student in a School within 365 days after that date.

Proof of enrollment must be given to Prudential.

School means an institution of higher learning. This includes, but is not limited to, a university, college or trade school.

Benefit Amount Payable for Tuition Reimbursement for Your Dependent Child: The additional amount payable is shown in the Schedule of Benefits.

(7) **Additional Benefit for Day Care Expenses for Your Dependent Child:**

This additional benefit for day care expenses for your dependent child only applies if you suffer a Loss of life.

This additional benefit is payable for each dependent child less than age 7 who:

(a) is your child who is wholly dependent on you for support and maintenance on the date of death; and

(b) is enrolled at a Day Care Center on the date of death; or

(c) becomes enrolled at a Day Care Center within 90 days after the date of death.

Proof of enrollment must be given to Prudential.

A Day Care Center is a facility which:

(a) is duly licensed, certified or accredited to provide child care by the jurisdiction in which it is located; and

(b) is operating in compliance with applicable laws and regulation of that jurisdiction.

Benefit Amount Payable for Day Care Expenses for Your Dependent Child: The additional amount payable is shown in the Schedule of Benefits.

The Claim Rules and the “To Whom Payable" part of the Schedule of Benefits apply to the payment of the benefits.

General Information

BENEFICIARY RULES

The rules in this section apply to insurance payable on account of your death, when the Coverage states that they do. But these rules are modified by any burial expenses rule in the Schedule of Benefits and, if there is an assignment, by the following sections: Limits on Assignments; and Effect of Gift Assignment of Rights of Group Life Insurance Under Another Group Contract.

“Beneficiary" means a person chosen, on a form approved by Prudential, to receive the insurance benefits.

You have the right to choose a Beneficiary for each Coverage under this Prudential Group Contract.

If there is a Beneficiary for the insurance under a Coverage, it is payable to that Beneficiary. Any amount of insurance under a Coverage for which there is no Beneficiary at your death will be payable to the first of the following: your (a) surviving spouse or Registered Domestic Partner; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate. This order will apply unless otherwise provided in the Limits on Assignments.

You may change the Beneficiary at any time without the consent of the present Beneficiary. The Beneficiary change form must be filed through the Contract Holder. The change will take effect on the date the form is signed. But it will not apply to any amount paid by Prudential before it receives the form.

If there is more than one Beneficiary but the Beneficiary form does not specify their shares, they will share equally. If a Beneficiary dies before you, that Beneficiary's interest will end. It will be shared equally by any remaining Beneficiaries, unless the Beneficiary form states otherwise.

If you and a Beneficiary die in the same event and it cannot be determined who died first, the insurance will be payable as if that Beneficiary died before you.

MODE OF SETTLEMENT RULES

The rules in this section apply to Participant Life and Accident Insurance payable on account of a Covered Person’s death. But these rules are subject to the Limits on Assignments section.

Insurance payable on account of a Covered Person’s death is normally paid to the Beneficiary in one sum. Subject to applicable law, where the amount of the benefit meets Prudential's current minimum requirement, payment in one sum will be made by establishing a retained asset account in the Beneficiary’s name, unless the Beneficiary elects another settlement or payment option available at the time of claim, and the benefit distribution will be deemed complete when the account is established. The retained asset account is an interest-bearing draft account backed by the financial strength of Prudential. Funds are held in Prudential’s general account or elsewhere as Prudential may direct and an account in the Beneficiary’s name is credited interest at a rate set by Prudential’s discretion, subject to a minimum rate that will change no more than once every 90 days on advance notice to the Beneficiary. The Beneficiary is provided a draftbook and has immediate access to the entire amount by writing drafts for any amount up to the account balance. The retained asset account is not a bank account and is not insured by the Federal Deposit Insurance Corporation; it is a contractual undertaking between Prudential and the Beneficiary. Further information about the account is provided at the time of claim. Prudential may at its discretion provide other forms of

payment in one sum. But another mode of settlement may be arranged with Prudential for all or part of the insurance, as stated below.

Arrangements for Mode of Settlement: You may arrange a mode of settlement by proper written request to Prudential.

If, at a Covered Person's death, no mode of settlement has been arranged for an amount of the person's Life or Accident Insurance, the Beneficiary and Prudential may then mutually agree on a mode of settlement for that amount.

Conditions for Mode of Settlement: The Beneficiary must be a natural person taking in the Beneficiary's own right. A mode of settlement will apply to secondary Beneficiaries only if Prudential agrees in writing. Each installment to a person must not be less than $20.00. A change of Beneficiary will void any mode of settlement arranged before the change.

Choice by Beneficiary: A Beneficiary being paid under a mode of settlement may, if Prudential agrees, choose (or change the Beneficiary's choice of) a payee or payees to receive, in one sum, any amount which would otherwise be payable to the Beneficiary's estate.

Prudential has prepared information about the modes of settlement available. Ask the Contract Holder for this.

INCONTESTABILITY OF LIFE INSURANCE

This limits Prudential's use of a person's statements in contesting an amount of Life Insurance for which the person is insured. These are statements made to persuade Prudential to accept the person for insurance. They will be considered to be made to the best of the person's knowledge and belief. These rules apply to each statement:

(1) It will not be used in the contest unless:

   (a) It is in a written application signed by the person and

   (b) A copy of that application is or has been furnished to the person or to the person's Beneficiary.

(2) If it relates to the person's insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two years during the person's lifetime.

LIMITS ON ASSIGNMENTS

You may assign your insurance under a Coverage. Unless the Schedule of Benefits states otherwise, the following rules apply to assignments: (1) insurance under any Coverage providing periodic benefits on account of disability or accidental death benefits may be assigned only as a gift assignment; (2) Insurance under any other Coverage providing death benefits may be assigned either as a gift assignment or as a value assignment made in consideration of terminal illness. Any rights, benefits or privileges that you have as an Participant may be assigned. This includes any right you have to choose a Beneficiary or to convert to another contract of insurance. Prudential will not decide if an assignment does what it is intended to do. Prudential will not be held to know that one has been made unless it or a copy is filed with Prudential through the Contract Holder.

This paragraph applies only to insurance for which you have the right to choose a Beneficiary, when that right has been assigned. If an assigned amount of insurance becomes payable on account of your death and, on the date of that death, there is no Beneficiary chosen by the assignee, it will be payable to:

(1) the assignee, if living; or

(2) the estate of the assignee, if the assignee is not living.

It will not be payable as stated in the Beneficiary Rules.

EFFECT OF GIFT ASSIGNMENT OF RIGHTS OF GROUP LIFE INSURANCE UNDER ANOTHER GROUP CONTRACT

This Section applies to all Coverages providing Participant death benefits.

If you are eligible for insurance under the Group Contract on the Group Contract's effective date you will have no rights, benefits or privileges under any such Coverage if, on the day before that date, all the following were true:

(1) You were insured for group life insurance under another group contract. That contract was issued by Prudential or another insurance carrier to cover Participants of the Employers.

(2) Your group life insurance under the other group contract ended.

(3) An irrevocable and absolute gift assignment made by you was in effect. It was made before the other contract ended. That assignment was of all your rights, benefits and privileges of the group life insurance under the other group contract. Those rights were owned by the assignee or the assignee's successor.

The owner of those rights of the group life insurance under the other group contract on the day before this Group Contract's effective date will be the owner of the rights, benefits, and privileges you would have had under a Coverage if this section did not apply. This includes, but is not limited to, any right of assignment you would have had under the Limits on Assignments section above. The term "assignee" as used in that section includes such an owner.

The term "group life insurance", as used above, means only group life insurance provided under a group contract in effect on the day before the date the Employers became included under the Group Contract.

DEFINITIONS

Active Work Requirement: A requirement that you be actively at work as determined by the Professional Musicians, Local 47 and Employers' Health & Welfare Board of Trustees.

Calendar Year: A year starting January 1.

Contributory Insurance, Non-contributory Insurance: Contributory Insurance is insurance for which the Contract Holder has the right to and may require your direct contribution to the cost of coverage. Non-contributory Insurance premiums are paid by the Contract Holder, usually without direct contribution from you. The rate for Non-contributory insurance may be determined, or in some cases, reduced, in part, based on your contributions for contributory insurance or other benefits offered to you under the Contract Holder benefit plan.

Coverage: A part of the Booklet consisting of:

(1) A benefit page labeled as a Coverage in its title.

(2) Any page or pages that continue the same kind of benefits.

(3) A Schedule of Benefits entry and other benefit pages or forms that by their terms apply to that kind of benefits.

Covered Person under a Coverage: A Participant who is insured for Participant Insurance under that Coverage.

Doctor: A licensed practitioner of the healing arts acting within the scope of the license.

Earnings: This is the gross amount of money paid to you by the Employers in cash for performing the duties required of your job. Bonuses, overtime pay, Earnings for more than 40 hours per week, and all other benefits are not included.

Employers: Collectively, all employers who are required to make contributions to the fund on the Participant's behalf.

Fund: Professional Musicians, Local 47 and Employers' Health & Welfare Fund.

Injury: Injury to the body of a Covered Person.

Participant: A person employed by any Employer on whose behalf contributions are required to be made. The term also applies to that person for any rights after insurance ends.

Participant Insurance: Insurance on the person of a Participant.

Prudential: The Prudential Insurance Company of America.

Registered Domestic Partner: Your Registered Domestic Partner means a person whose domestic partnership with you has been validly registered by the California Secretary of State; or a person with whom you have established a union other than marriage, recognized under California law as the equivalent of a Registered Domestic Partner.

Sickness: Any disorder of the body or mind of a Covered Person, but not an Injury; pregnancy of a Covered Person, including abortion, miscarriage or childbirth.

You: A Participant.

CLAIM RULES

These rules apply to payment of benefits under a Coverage when the Coverage states that they do.

Proof of Loss: Prudential must be given written proof of the loss for which claim is made under the Coverage. This proof must cover the occurrence, character and extent of that loss. It must be furnished within 90 days after the date of the loss. But, if any Coverage provides for periodic payment of benefits at monthly or shorter intervals, the proof of loss for each such period must be furnished within 90 days after its end.

A claim will not be considered valid unless the proof is furnished within these time limits. However, it may not be reasonably possible to do so. In that case, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.

When Benefits are Paid: Benefits are paid when Prudential receives written proof of the loss. But, if a Coverage provides that benefits are payable at equal intervals of a month or less, Prudential will not have to pay those benefits more often.

Physical Exam and Autopsy: Prudential, at its own expense, has the right to examine the person whose loss is the basis of claim. Prudential may do this when and as often as is reasonable while the claim is pending. Prudential also has the right to arrange for an autopsy in case of accidental death, if it is not forbidden by law.

Legal Action: No action at law or in equity shall be brought to recover on the Group Contract until 60 days after the written proof described above is furnished. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

INCONTESTABILITY OF INSURANCE TO WHICH THE CLAIM RULES APPLY

This limits Prudential's use of a person’s statements in contesting an amount of that insurance for which the person is insured. These are statements made to persuade Prudential to effect an amount of that insurance. They will be considered to be made to the best of the person’s knowledge and belief. These rules apply to each statement:

(1) It will not be used in a contest to avoid or reduce that amount of insurance unless:

  (a) It is in a written application signed by the person; and

  (b) A copy of that application is or has been furnished to the person.

(2) It will not be used in the contest after that amount of insurance has been in force, before the contest, for at least two years during the person’s lifetime.

NOT IN PLACE OF WORKERS' COMPENSATION INSURANCE

The Group Contract is not in place of and does not affect any requirement for coverage by Workers' Compensation Insurance.

When Your Insurance Ends

PARTICIPANT INSURANCE

Your Participant Insurance under a Coverage will end when the first of these occurs:

- Your membership in the Covered Classes for the insurance ends because you no longer meet the qualifications for eligibility as determined by the Professional Musicians, Local 47 and Employers' Health & Welfare Board of Trustees.
- Your class is removed from the Covered Classes for the insurance.
- The part of the Group Contract providing the insurance ends.
- You make a written request to the Contract Holder to end your Employee Insurance under a Coverage.

End of Employment: For insurance purposes, your employment will end when you no longer have the minimum accumulated contributions required for eligibility as determined by the Professional Musicians, Local 47 and Employers' Health & Welfare Board of Trustees.

Continued Insurance During Absence from Work Because of a Labor Dispute: These provisions apply only if any part of the premium for the insurance under the Coverage is paid by the Employer under the terms of a collective bargaining agreement. They apply when your Participant Insurance under the Coverage would otherwise end on any date because of your absence from work as a result of a labor dispute. Your insurance under the Coverage will not end on that date. It will be continued during such absence from work from the date it would have ended until the first of these occurs:

(1) The end of the six month period immediately following the first day of your absence from work.

(2) The date you become actively engaged in work on a full-time basis for another employer.

(3) The first day you fail to pay, when due, any contribution required for the continued insurance. Your contribution will not be more than the premium that applies to your Covered Class on the first day of your absence from work.

(4) The first day the entity responsible for collecting Participation contributions fails to pay, when due, the premium required for the continued insurance following the cessation of work as a result of a labor dispute.

Additional Information About Your Plan

The Certificate of Coverage and the following Additional Information (together, the Booklet), are intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA requires that your employer provide you with a "Summary Plan Description" which describes the plan and informs you of your rights under it. Information about eligibility rules, benefits amounts, benefit limitations, and exclusions from coverage is contained in the Certificate of Coverage. The following Additional Information about your plan is provided at the request of your Employer/Plan Sponsor.

Plan Name

Professional Musicians, Local 47 and Employers' Health & Welfare Fund Life Insurance Plan

Plan Number

501

Type of Plan

Employee Welfare Benefit Plan

Plan Sponsor

Professional Musicians, Local 47 and Employers' Health & Welfare Fund
1000 North Central Ave.
Suite 400
LOS ANGELES, California 90038

Employer Identification Number

95-2645084

Plan Administrator

Professional Musicians, Local 47 and Employers' Health & Welfare Fund
Attention: Human Resources Department
1000 North Central Ave.
Suite 400
LOS ANGELES, California 90038

Agent for Service of Legal Process

Professional Musicians, Local 47 and Employers' Health & Welfare Fund
Attention: Human Resources Department
1000 North Central Ave.
Suite 400
LOS ANGELES, California 90038

Service of legal process may also be made upon the plan administrator at the address above.

Plan Year Ends

December 31

Plan Benefits Provided by

The Prudential Insurance Company of America
751 Broad Street
Newark, New Jersey 07102

Plan Sponsor's Designation of Prudential As Claims Administrator

It is the Plan Sponsor's intention and direction that The Prudential Insurance Company of America as Claims Administrator has the sole discretion to interpret the terms of the plan, to make factual findings, and to determine eligibility for benefits. The Plan Sponsor has determined that benefits are payable under the plan only if The Prudential Insurance Company of America, in its sole discretion, determines that they are due. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. *

* This paragraph does not apply to residents of AK, AR, CA, CO, DC, IL, KY, MD, ME, MI, NJ, NY, OR, PR, RI, SD, TX, VT, WA

Plan Sponsor, Policyholder and Employer not Agents of Prudential

The Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits under your Employer/Policyholder/Plan Sponsor's ERISA plan(s). For all purposes associated with the plan or the Group Contract under which The Prudential Insurance Company of America provides benefits, the Employer/Policyholder/Plan Sponsor acts on its own behalf or as an agent of its employees. Under no circumstances will the Employer/Policyholder/Plan Sponsor be deemed the agent of The Prudential Insurance Company of America, absent a written authorization of such status executed between the Employer/Policyholder/Plan Sponsor and The Prudential Insurance Company of America. Nothing in these documents shall, of themselves, be deemed to be such a written authorization.

Allocation of Contributions

The insurance benefit coverages described in this Booklet are being offered to you under a single ERISA plan. Coverages described as non-contributory or as being paid entirely by the Employer/Policyholder/Plan Sponsor (if any) are those paid for directly by the Employer/Policyholder/Plan Sponsor such that you have no out of pocket expense for such coverages. However, the premium rate that the Employer/Policyholder/Plan Sponsor pays for insurance coverage offered to you under the Plan may be determined, or in some cases, reduced, in part, based on your contributions for other coverages or other benefits offered under the Plan. When this occurs, your contributions for one benefit coverage may cover some or all of the costs or plan expenses for another benefit coverage offered to you under the Plan.

Loss of Benefits

You must continue to be a member of a class of eligible employees or beneficiaries to which the plan pertains and continue to make any contributions or payments that are due, including those you agreed to when you enrolled for coverage. Failure to make required contributions may result in partial or total loss of your benefits.

Plan Sponsor May Amend or Terminate the Plan at any Time

It is intended that this plan will be continued for an indefinite period of time. But, the Plan Sponsor reserves the right to change or terminate the plan at any time. This Booklet elsewhere describes your rights upon termination of the plan.

Claim Procedures

1. Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will include:

(a) the specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

(b) references to the specific plan provisions on which the benefit determination was based,

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

(d) 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 your claim for benefits,

(e) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals,

(f) a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, and

(g) copies of any internal rules or guidelines relied upon in making this determination, if applicable.

2. Appeals of Adverse Determination

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your claim within the time described in Section 1 above, you may appeal, although you are not required to do so. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Prudential will provide you, free of charge and prior to any adverse decision on appeal, with any new or additional evidence that is considered by Prudential in connection with the claim (including evidence that may be the basis for denial as well as any evidence that may support granting the claim), and any new or additional rationale that will form the basis for the Prudential's decision on appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination must be provided in order to give you a reasonable opportunity to respond prior to that date.

If the appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will include:

(a) the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

(b) references to the specific plan provisions on which the determination was based,

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

(d) a description of Prudential's review procedures and applicable time limits,

(e) a statement that if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request,

(f) copies of internal rules or guidelines relied upon in making this determination, if applicable and

(g) a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your appeal within the time described in Section 1 above, you may appeal again, although you are not required to do so. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Time Limit To File Suit

If your claim for benefits and any required appeals are denied (or not decided within the time periods discussed above), you may file suit as discussed below. If you elect to file suit, you should do so as soon as possible. However, you must file suit no later than three

years after proof of your claim was first due as explained elsewhere in this Booklet, regardless of whether your claim is still pending in the claim or appeal process.

Rights and Protections

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

Receive Information about Your Plan and Benefits

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

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

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you a fine that accrues on a daily basis (based on amounts set by the Department of Labor, and subject to a cap) from the time the materials were due to you 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. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 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.

TRUST ADMINISTRATOR'S OFFICE:

Professional Musicians, Local 47 and Employers' Health and Welfare Fund
c/o PacFed Benefit Administrators
1000 North Central Ave., Suite 400
Glendale, CA 91202
(818) 243-0222