

ENTERTAINMENT INDUSTRY

Flex Plan

Summary Plan Description

Table of Contents

Introduction	1
What is the purpose of the Flex Plan?	1
Who is eligible to participate in the Flex Plan?	2
Employer Contributions	2
Employee Contributions	2
The difference between Employer and Employee Contributions	2
Can you lose any part of your Employee Contributions?	2
What effect does making Employee Contributions have on your Social Security Benefits?	2
Pre-Tax Employee Contribution Withholding Request	3
Your Flex Plan Alternate Benefit (AB) Account	3
What benefits are available through Employer Contributions?	3
When do you become eligible to participate?	3
Enrollment in the Plan	4
Can Plan Elections be changed?	4
Insurance coverage from the Flex Plan Providers	4
What if your account balance is not sufficient to cover your insurance premium payment(s)?	5
How can I ensure there is no lapse in my insurance coverage?	6
Self-Payment Period	6
When does coverage terminate?	6
What are the rules on the continuation of coverage (COBRA) under the Flex Plan?	6
Am I required to have medical insurance?	7
Individual and Exchange Insurance Policies	8
Are Domestic Partner Benefits available under the Plan?	8
What is the purpose of Disability Insurance Coverage?	8
When does my Disability Insurance Coverage begin?	8
When does my Disability Coverage end?	8
Once Disability Coverage is terminated, can it be reinstated?	9
May I decline enrollment for Disability Coverage through the group contract?	9

Can I be denied Disability Insurance coverage? _____ 9

Can I be covered by the Flex Plan Group Disability Insurance Contract and also maintain another Group or Disability Policy? _____ 9

What happens if I am unable to submit claims on my own? _____ 9

Your Flex Plan Account Balance _____ 9

How does the Reimbursement Process work? _____ 9

Claims Deadline _____ 10

When am I eligible to submit a claim? _____ 10

How to submit a claim _____ 10

Medical Expense Reimbursement (MR) _____ 10

What over-the-counter items require a prescription? _____ 11

Direct Payment of Medical Expenses to the Provider of Services _____ 11

Can I make contributions to a Health Savings Account? _____ 11

Dependent Care Assistance (DC) _____ 11

Medical Insurance Premium Reimbursement _____ 12

Other Insurance premium reimbursements _____ 12

Claims and Appeals Procedures under the Plan _____ 12

Notice of Privacy Practices _____ 13

What are your rights under ERISA? _____ 16

Important Information _____ 17

Collectively Bargained Plan _____ 18

Closing... _____ 18

A brief history of the Flex Plan _____ 18

Administration Fees _____ 18

Board of Trustees' Information _____ 19

Index _____ 22

This summary is not meant to interpret, extend, or change the Flex Plan in any way. In case of a conflict between this Summary Plan Description (SPD) and the Plan documents or the insurance policies, the provisions of the Plan documents and insurance policies will govern your rights and benefits. Should a discrepancy arise between information contained within the SPD and oral information provided by a Flex Plan representative, the SPD shall prevail. The Flex Plan is intended to continue indefinitely; however, it may be amended or terminated at any time.

Introduction

Welcome to the Entertainment Industry Flex Plan (“Flex Plan”), the most innovative health and welfare benefit plan in “the industry.” The accompanying information is designed to inform you of the many options available to you and your family under the Flex Plan.

The Plan offers a “cafeteria style” benefit option list in which you design your individual plan according to your needs. You can custom tailor benefit selections that are right for you. It is important to note that if you want to get the most out of the Plan, your active involvement is necessary, so please read the following Summary Plan Description (SPD) carefully. After reviewing the information, you will see that the Flex Plan is truly a flexible benefit plan designed with you and your family in mind. If you have any questions after reviewing this summary, please call our Member Services Department.

What is the purpose of the Flex Plan?

The Flex Plan is an employee benefit plan which combines both Employer Contributions and Employee Contributions to fund a full array of welfare benefits such as medical, dental, vision, disability, group term life insurance and dependent care assistance (child care).

The Flex Plan is an IRS-approved Welfare Benefit Trust Fund which permits monies to be contributed to your individual account with the Plan that under present law are *not subject to income tax*.

The Flex Plan vs. the Traditional Plan

At first glance, the Flex Plan may seem confusing, so let’s begin with how our “cafeteria style” plan differs from the traditional “pooled coverage” plan.

Traditional Plan

In a “pooled coverage” plan, an individual must earn a certain amount of money or work a certain number of hours before any coverage can begin. After the “qualifying period” is reached, the benefit (usually a medical plan) is provided for a fixed period (usually 3-6 months). In the traditional plan, you are obligated to accept the medical plan offered with few, if any, alternatives. In cases where you do not earn the required wages or hours during the designated time period to qualify for the benefit package, you receive no benefit whatsoever and contributions made on your behalf are forfeited. If you exceed the required wages or hours during the qualifying period, you generally have a portion of the excess held in a limited bank and the rest is forfeited. These restrictions (limitations) do not exist under the Flex Plan.

Flex Plan

The Flex Plan allows you to make choices as an individual. You receive credit for every dollar that is contributed to the Plan on your behalf. If you already have health insurance from another source, you are not required to elect coverage from the Flex Plan. You may use the monies contributed on your behalf for other types of benefits. If your account is short, you may pay the difference to continue your coverage, subject to Plan rules. Employer Contributions made on your behalf are not lost for failure to reach a certain “qualifying” level, but are held in the Alternate Benefit (AB) Account and may be used to pay insurance premiums or used to reimburse allowable expenses in accordance with Plan guidelines described in this document.

A Plan for Everybody

The number of options you choose from the “menu of benefits” will be determined by your personal needs as well as the amount of money you have in your Flex Plan account. If you are employed regularly by one or more Employers, you may have enough money in your account to have your medical insurance premiums paid by the Plan on a monthly basis. If your work is not consistent or you do not receive sufficient contributions to cover you and/or your family’s medical insurance costs, you may not wish to enroll in optional insurance benefits such as dental, vision and life, as you will be responsible for the total cost of the premiums when your account balance is short. Once you make your insurance elections, you will not be able to change them until the next open enrollment period (December of each year).

In some cases, participants will not require health insurance because it may already be provided by a spouse’s employer or another plan; once the participant has satisfied Plan certification requirements (see section entitled “Am I required to have medical insurance?”, the participant may then use the funds in their account for other benefits offered by the Plan.

Who is eligible to participate in the Flex Plan?

The Flex Plan covers each person who is employed by an Employer who has entered into a Collective Bargaining Agreement (CBA) with a Local Union providing for Employer Contributions to the Flex Plan. If you are unsure if a specific employer participates in the Flex Plan, you may either contact your Local Union or the Flex Plan.

Employer Contributions

The amount of Employer Contributions made to your account is determined by the Collective Bargaining Agreement (CBA) between your Local Union and your Employer. The CBA may provide for Employer Contributions calculated based on a percentage of your gross wages or base wages, an amount per hour, an amount per day, shift/session or other formula. The Flex Plan requires that the Employer remit these contributions to the Plan by the 15th of the month following the month you worked unless your CBA provides for more frequent payments (many employers remit more frequently). For example, if you worked any time during the month of January, your Employer would be obligated to remit the contribution on your behalf to the Plan no later than the 15th of February.

It is important to note that the Employer Contribution is **not** a deduction from your paycheck, but is an amount over and above your pay as a result of negotiations between your Local Union and Employer. If you work for more than one signatory employer during the month, each employer will be required to make contributions into your individual account.

Employee Contributions

Increasing the contribution to your account through voluntary *pre-tax* payroll withholdings will decrease your *taxable* wages and is particularly valuable in instances where your insurance premiums or Dependent Care (childcare) expenses exceed the monthly Employer Contributions to your account. However, this option is not available through all Employers. Call Flex Plan Member Services to see if your Employer provides this option.

In addition, adding extra money to your account through Employee Contributions can avoid the need to make “self-payments” (after-tax) to continue your insurance coverage when your account does not have sufficient funds to pay your premiums. Employee Contributions may be made in increments of one percent (1%), up to eighty five percent (85%) of your gross earnings.

Employee Contributions can be used for all benefits *except* Medical Expense Reimbursement and reimbursement of other insurance premiums such as coverage through your spouse’s employer, coverage through another employer or Union’s Plan, an individual policy or coverage obtained through an exchange. Employee contributions may be used for Flex Plan group insurance premiums (excluding group disability insurance), individual disability insurance premiums and Dependent Care Assistance. In order to exercise this option you must make a “Pre-Tax Employee Contribution Withholding Request” as described below.

The difference between Employer and Employee Contributions

It is very important that you understand the difference between Employer Contributions and Employee Contributions. Excess Employer Contributions in your account at the end of the year will roll over to be used in future Plan Years (they are not subject to forfeiture). Your Employee Contributions are used first (if any), then Employer Contributions.

Can you lose any part of your Employee Contributions?

The Flex Plan does not allow you to elect to withhold more voluntary contributions than the annual cost of your group insurance elections from the Flex Plan and any Dependent Care expenses. The Flex Plan first uses your Employee Contributions before using Employer Contributions to fund your benefits. Therefore, it is possible, but not likely, that you could forfeit Employee Contributions set aside for the payment of your premiums. For example, if your annual cost of insurance coverage through the Flex Plan is \$5,500, you would not be permitted to elect withholdings of more than \$5,500. It is important to estimate Employee Contributions carefully (primarily Dependent Care Expenses) because any Employee Contributions remaining in your account at the end of the Plan Year would be forfeited. This is called the “use it or lose it” rule. This provision is a Federal Tax requirement (not a rule created by the Flex Plan); any Employee Contributions forfeited are applied toward the administration expenses of the Plan. However, this Plan permits a Grace Period consistent with IRS Rules and any unused Employee Contributions that remain in your account at the end of the Plan Year may be used to reimburse expenses that are incurred during the immediately following Grace Period. The Grace Period will begin on the first day of the next Plan Year and will end two months and fifteen days later (March 15). In order to take advantage of the Grace Period, you must be a participant on the last day of the Plan Year to which the Grace Period relates. Expenses incurred during the Plan Year and the subsequent Grace Period must be submitted no later than March 31 following the end of the Grace Period.

What effect does making Employee Contributions have on your Social Security Benefits?

Employee Contributions under the Flex Plan will normally result in both you and your Employer making lower contributions to the Federal Social Security System, so your Social Security benefits may be slightly reduced. However, for most people

the current tax savings **are much greater** than any potential reduction in Social Security benefits. You should discuss your specific financial situation with a tax consultant.

Pre-Tax Employee Contribution Withholding Request

This option allows you to authorize your Employer to deduct a percentage between 1%-85% of your wages on a *pre-tax* basis and deposit it to your Alternate Benefit (AB) Account. This pre-tax contribution is in addition to the Employer Contributions already made on your behalf. You are eligible to make a Pre-Tax Employee Contribution Withholding Request during your first enrollment period and during each Open Enrollment Period. Participants who work on various projects, generally through payroll companies, may make a Pre-Tax Employee Contribution Withholding Request within 30 days of hire on a new project. However, the withholding percentage must be the same for all projects and/or Employers.

By making a Pre-Tax Employee Contribution Withholding Request through our website or a Member Services Representative, you irrevocably elect to redirect a portion of your pay for the year and have this amount contributed by your Employer to the Flex Plan. Once established, you will not be able to change the amount of your Employee Contributions during the remainder of the calendar year except if you have a "change in family status," as described below in "Can Plan Elections be changed". The withholding percentage you select must be the same for each employer. Your authorization terminates at the end of each calendar year. You may only change your election during the Open Enrollment period. The Open Enrollment Period is your initial enrollment period and each December (to take effect January 1 of each year) thereafter. The maximum contribution amount is equal to your monthly premium cost multiplied by the number of months of coverage in the year (plus your Dependent Care Assistance allocation, if applicable).

If you do not make a Pre-Tax Employee Contribution Withholding Request with the Flex Plan Office by December 31 of each year or for new members, the last day of the month before your insurance coverage begins, you waive your right to make pre-tax contributions to the Plan for that year. You will not have any Employee Contributions made to the Flex Plan by your Employer on your behalf; however, this will not impact any Employer Contributions made on your behalf.

Your Flex Plan Alternate Benefit (AB) Account

Contributions received on your behalf are deposited into an account identified by your Social Security Number. Although you may work with multiple local unions and employers, all contributions received are deposited into your individual account. From this account your group insurance premiums offered through the Flex Plan are paid automatically on a monthly basis and/or you may request that reimbursements be made to you for other eligible premiums and/or out-of-pocket expenses in accordance with Plan guidelines.

What benefits are available through Employer Contributions?

You may choose to have the Employer contributions in your Flex Plan Account applied toward the cost of one or more of the following benefits:

- MI
- DI
- VI
- LI
- DB
- ID
- MR
- DC
- Group Medical Insurance Premiums
- Dental Insurance Premiums
- Vision Insurance Premiums
- Group Term Life Insurance Premiums
- Group Disability Insurance Premiums
- Individual Disability Insurance Premiums
- Medical Expense Reimbursement
- (if you are covered by "group" insurance.)
- Dependent Care Assistance

When do you become eligible to participate?

Keep in mind that several factors will determine how quickly your account will accumulate sufficient funds to begin coverage. Insurance premium rates differ, depending on the type of coverage selected and the number of family members involved. In addition, the rate of contribution into the Plan by your Employer varies depending on the particular CBA in force and the frequency of your employment. You will qualify for coverage once your account balance reaches \$62.50 after any administrative fees have been collected. This will be referred to as the "qualifying amount". The Enrollment Fee will not be charged until your account balance accumulates \$100.00. If you have any questions regarding your wage rate or the rate of contribution for a particular employer participating in the Flex Plan, please contact your Local Union representative.

Example:

03/15

- \$100 or more in contributions received

03/16	<ul style="list-style-type: none"> • Welcome Letter Mailed with PIN recommending signup for email delivery
03/31	<ul style="list-style-type: none"> • Contributions post to account
04/01	<ul style="list-style-type: none"> • New Member Enrollment Package Sent via US Mail or email if requested.
04/01 - 04/30	<ul style="list-style-type: none"> • Enrollment may be done online. Payment must be made online if account balance is not sufficient to cover first month's premiums. Forms must be returned.
05/01	<ul style="list-style-type: none"> • Coverage Begins

Enrollment in the Plan

Within six weeks of your first date of hire by a Flex Plan Participating Employer, the Flex Plan should begin receiving Employer Contributions on your behalf. Once you become eligible to participate, as described above, you will be sent an enrollment package, provided the Flex Plan is able to obtain your address. To receive your notices sooner, you are encouraged to elect email delivery of your notices. Enrollment packages are generally mailed the first week of each month. If you believe sufficient contributions have been made on your behalf and you have not received information from the Flex Plan, call Member Services to confirm the Plan has your correct address on file. It is very important that you enroll, even if you do not wish to elect coverage from the Flex Plan. Enrollment may be done either on-line or through our automated member service system (via telephone). If elected, your insurance coverage will begin when your account has sufficient funds to cover the insurance premium(s), administrative fees and the Administrative Office has received any required carrier enrollment forms. Your insurance premiums will continue to be paid provided your account has a sufficient balance.

If you have not made insurance elections (during your normal enrollment period) and your account accumulates \$2,100 or more, you will receive a reminder notice to enroll. If you do not respond, you will automatically be enrolled under the default insurance option with single coverage. When you are automatically enrolled, you have the option to enroll dependents for coverage and make other insurance elections such as the addition of dental, vision or life insurance provided you contact the Administrative Office within 30 days of your enrollment effective date.

Changes to insurance coverage options and Dependent Care Assistance Allocations may only be made once a year during the Open Enrollment period. Your Dependent Care Allocation and any pre-tax elections are reset to zero each year. Open Enrollment takes place during December of each Plan Year and is effective January 1 of each year.

Can Plan Elections be changed?

Once you enroll in the Flex Plan, you may not make changes to benefit selections, cancel or change insurance elections or add or remove dependents until the next Open Enrollment period unless your coverage by another source is terminated (beyond your control) or you have a change in family status as described below.

If coverage by another source has been terminated and you wish to enroll under one of the Flex Plan group providers, you will be required to certify that the termination was due to circumstances beyond your control. In addition, your account balance must be greater than or equal to the "qualifying amount" described above. When there has been a change in family status, the change to your benefit selection(s) must be consistent with your change in family status. For example, if you and your spouse are covered by a Flex Plan group contract and you have a child, you would be able to add your child to your coverage, but you would not be able to drop your spouse. A "change in family status" may be one of the following:

- birth of a child
- marriage or divorce
- death of a spouse or child
- your spouse terminating or changing employment
- your spouse changing from full-time to part-time or vice versa
- adoption or obtaining legal guardianship of a child
- your child becoming eligible for a group insurance plan

Note: In order to process your change, the Flex Plan must receive notification of your change in writing within 30 days of the event. If you and/or your dependent's Medicaid or State Children's Health Insurance Program ("SCHIP") coverage is terminated due to loss of eligibility; or if you and/or your dependent become eligible for a premium assistance subsidy under Medicaid or SCHIP, then you may enroll yourself and/or your dependents in the Flex Plan within 60 days of such event.

Insurance coverage from the Flex Plan Providers

If you elect coverage from the Flex Plan Providers, the Flex Plan will make monthly premium payments on your behalf to the carrier(s) you select (provided your account balance is sufficient to pay all of the premiums). If your account balance is not sufficient to cover the full amount of your premium payments, no payment will be made and your coverage will be

interrupted. Please refer to the Flex Plan Summary of Benefits (www.flexplan.com/insurance) for descriptions and monthly costs of the coverages offered.

The Flex Plan is not an insurance provider but a welfare benefit plan and cannot receive commissions. In order to enroll under any of the group insurance contracts, you must enroll in medical insurance or have proof of medical insurance on file. The Flex Plan holds group insurance contracts for the following types of insurance coverage:

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Group Term Life Insurance
- Disability Insurance

The Flex Plan's insurance contracts are "guaranteed issue" contracts which means that you may enroll in any of the above insurance options during the enrollment period and cannot be denied the right to enroll due to a previous medical condition. Special rules may apply to the Disability and Life Insurance benefits.

What if your account balance is not sufficient to cover your insurance premium payment(s)?

If you do not have sufficient funds in your account to pay your premiums, the Flex Plan allows you to "self-pay" the necessary premiums for a period of twelve months. You may only self-pay the amount necessary to pay the current premium amount due and may not pay more than the amount currently due. You may only make changes to your coverage elections (add or terminate coverages) and add or remove dependents during Open Enrollment or the required special enrollment period (see "Can Plan Elections Be Changed" for more information). You will be sent a Self-Payment Billing for the required amount your account is short and you must remit payment to the Flex Plan Office by the due date provided to maintain your coverage. Self-Payment Billings are usually sent between the 17th and 18th of the month and are due by the end of the month. The billing you receive will be for the upcoming month. Example: On April 17, the billing will be sent for May eligibility and is due by the last day of April. You may be able to continue your insurance coverage beyond such 12-month self-payment period under the "COBRA" rules, as described below in "What Are the Rules on the Continuation of Coverage under the Flex Plan?"

If your payment is not received by the payment due date your coverage will be suspended and you will show as ineligible in the carrier(s) system. You will receive a billing the following month for both months. If you do not remit at least the first month's premium, your coverage will automatically terminate.

Example: 04/17 Billing Generated for May Eligibility
04/30 Payment Due for May Eligibility (no payment made)
05/01 Eligibility Suspended as of 05/01
05/17 Billing Generated for May and June Eligibility
05/31 If Payment is not received to cover at least the May Eligibility amount due, coverage will terminate.

If Payment is received for May Eligibility only, the May premium(s) will be paid and you will be ineligible for June coverage until the June payment has been made.

If this occurs, you will be dropped from the group policy and will not be eligible until the next Open Enrollment period (subject to your eligibility at that time). *You cannot self-pay to regain eligibility. You must become eligible by Employer Contributions.*

If you miss the payment due date, you may request your coverage be reinstated. If your payment was received after the payment due date and you wish your coverage reinstated, you will need to contact the Member Services Department to request the reinstatement which is subject to a reinstatement fee (see fee schedule). If you have not made your payment and wish reinstatement, you may make a payment over the phone for the amount due plus reinstatement fee (see "Administration Fees" for details). One courtesy reinstatement is available every 12 months. The reinstatement takes approximately 1-2 days to take effect. To ensure there is never a break in your coverage, consider signing up for automatic payments as described in the next section.

Because the Flex Plan must wait until the 15th of the month (the standard employer contribution due date) prior to mailing your Self Payment Billing, there may be little time from when you receive the billing until the actual due date. If you believe you may not have worked sufficient hours in the prior month to cover your premium costs, you may use our Automated Member Services System, website or call the Flex Plan Office around the 17th-18th of the month to obtain your self-payment amount due, if any. This will allow you to remit your payment sooner to ensure that it is received by the due date.

How can I ensure there is no lapse in my insurance coverage?

Enroll in the Automatic Payment Program. You may have the Flex Plan collect your premium payment from one of the following sources:

- Bank Debit (no fee)
- Visa or MasterCard (transaction fee applies)

If you pay by bank debit, the Flex Plan will send a notice approximately 10 days prior to debiting your account, providing the date the debit will occur and the exact amount. The amount will never exceed the premium cost with the exception of an employer collecting for an over payment to your account or months in which the administration fee is billed. Due to the nature of credit card processing, no advance notice is available. You will however receive a notice stating the amount of the charge. Any Bank Debit returned as NSF will be assessed an NSF Fee. If two bank debits are returned NSF within a 6 month period, you will not be eligible to participate in the automatic payment program for 6 months. You may request that a bank debit be cancelled before it debits your account provided you call the Member Services Department at least two business days prior to the debit date. You may only cancel one bank debit each 12 months.

Self-Payment Period

Once you have made self-payments for a period of eighteen months, and the Flex Plan has not received \$150 or more in Employer contributions ("required contribution amount") within the preceding twelve-month period your coverage through the Flex Plan will terminate. If the required contribution amount (\$150) is received by the Flex Plan, you can continue to self-pay contributions until such time as the Flex Plan fails to receive the required contribution amount within any preceding twelve-month period.

The required employer contribution amount must be physically received by the Flex Plan no later than the last day of the twelve-month period. The Flex Plan will use the date the Employer contribution is received, rather than the month in which work was performed to determine whether the required contribution has been paid.

When does coverage terminate?

You will remain eligible for benefits under the Flex Plan as long as there are sufficient funds in your account after deducting administration charges to provide such benefits. However, your coverage for Medical Insurance, Dental Insurance, Vision Insurance, Group Term Life Insurance and Disability Insurance benefits are further governed under the terms of the particular policy under which your coverage is provided. Please refer to your evidence of coverage for each policy for a description of additional terms and conditions which may cause termination of coverage. If you die, your beneficiary may use any remaining funds in your account. However, your beneficiary has a right to obtain an extension of health coverage from the Plan only if entitled to such an extension under COBRA. Beneficiaries are required to have group medical insurance in order to submit claims. The IRS defines a beneficiary as a spouse or tax dependent.

Employee contributions must be used by the earlier of the remainder of the Plan Year or until funds are exhausted. After this period, the Flex Plan is required to forfeit your account balance and it will be used to offset Plan administrative expenses.

If you die, your estate can submit claims that were incurred by you and/or your eligible dependents in the calendar year preceding your death up through your date of death. The claim(s) must be received within one calendar year following the date of your death. There is no forfeiture of Employer Contributions unless you die and have no beneficiaries.

What are the rules on the continuation of coverage (COBRA) under the Flex Plan?

If your Medical, Dental, or Vision Insurance coverage or Medical Expense Reimbursement option offered through the Flex Plan is lost (due to insufficient employer contributions) under the Flex Plan, continuation of coverage will be available as follows:

- a period not to exceed eighteen (18) months if a loss of coverage occurs because of termination of employment or reduction of hours (which may be extended to twenty-nine (29) months in the event a person is determined by the Social Security Administration to be "disabled" upon termination of employment or reduction in hours and such person notifies the Flex Plan Office before the end of the 18 month coverage period);
- for a period not to exceed 36 months if the Participant's spouse or dependent loses coverage as a result of the participant's death, divorce or legal separation, or if coverage for a dependent child ceases as a result of that child no longer qualifying as a dependent child under the terms of the Flex Plan; or
- in the case of an employee becoming entitled to Medicare benefits, the period for his/her spouse and dependents shall not end before the close of the 36 month period beginning when the employee first becomes eligible for Medicare.

Any period of time during which you pay for your Medical Insurance coverage through self-pay contributions immediately after an event triggering this continuation coverage will reduce accordingly the period of time you or your spouse or dependents will remain eligible for this continuation coverage. The cost of continuation coverage is borne by the individual choosing such coverage. Though cost may not exceed 102% of the cost of the same coverage for a "similarly situated"

employee or family member and 150% of such cost for the 19th through 29th month for a disabled person, the Flex Plan does not assess the COBRA charge, rather only the standard administration fees.

Spouses of Participants may elect continuation coverage for themselves if they lose coverage for any of the following Qualifying Events:

- death of the participant;
- termination of the participant's employment (for reasons other than gross misconduct) or reduction in the participant's hours of employment;
- divorce or legal separation from the participant; or
- the participant becomes eligible for Medicare.

Dependent children of participants may elect continuation coverage for themselves, if they lose coverage for any of the following Qualifying Events:

- death of their parent;
- parent's divorce or legal separation;
- parent becomes eligible for Medicare, or
- dependent ceases to be a dependent child under the Plan.

The "Self-Payment Billing" notice which you will receive if self-pay contributions are required to maintain your Medical Insurance coverage will also constitute your notice of your right to continuation coverage under COBRA. You will not receive another notice or election form for COBRA continuation coverage when your 12 months of self-pay coverage expires. It is the participant's responsibility to notify the Flex Plan Office in writing of a divorce, legal separation, termination of domestic partnership or other change in marital status, change in a spouse's address, or a child losing dependent status under the Plan, within sixty (60) days of the event. It is also the participant's responsibility to notify the Flex Plan Office in writing within sixty (60) days if such participant is determined to be disabled and within thirty (30) days if such participant is determined no longer to be disabled. In addition, any participant who is enrolled under any of the Flex Plan group insurance contracts must notify the Flex Plan of Medicare entitlement within thirty (30) days of such entitlement. If the Flex Plan is not notified in a timely manner, any dependents enrolled under Flex Plan group insurance contracts may lose their ability to elect COBRA continuation of coverage due to Qualifying Events mentioned above.

Coverage under COBRA Coverage will automatically terminate upon the earlier of:

- The date upon which the Qualified Beneficiary becomes covered under any other group health plan (including a retiree health plan) after electing COBRA. COBRA Coverage will not terminate if the Qualified Beneficiary had other coverage before the Qualifying Event; or
- The first day of the month for which a timely payment is not received by the Flex Plan Office; or
- The date on which the Qualified Beneficiary becomes entitled to Medicare benefits under the Title XVIII of the Social Security act; or
- The date this Flex Plan terminates; or
- At the end of the last day of the maximum coverage period applicable to the Qualified Beneficiary; or
- The date the Employee's Employer stops making contributions to Flex Plan on behalf of its Active Employees and provides alternative coverage to those Employees under another plan.

Am I required to have medical insurance?

All participants with an account balance sufficient to pay at least 3 months of medical insurance premiums must either show proof of insurance or you will be automatically enrolled.

Your coverage may be from one of the following sources:

- A Flex Plan provider (shown in the Summary of Benefits)
- Another Employer or Union's Plan
- Your spouse's Employer
- An Individual or Exchange Insurance Policy you hold
- Medicare

If you do not elect medical insurance from one of the Flex Plan medical insurance providers, you will be required to certify your policy is in force at least 1 time per year. If the proof of insurance is not provided to the Plan within the time required, you will be automatically enrolled under the default insurance option with single coverage. It is your responsibility to notify the Flex Plan if you have been automatically enrolled but have other coverage. The Flex Plan insurance carriers will not retroactively refund premiums for a period beyond 60 days. In order to terminate group insurance coverage outside of the Open Enrollment Period, you must:

- provide proof of other insurance,
- provide documentation that other insurance coverage was in effect either:
 - as of the participant's automatic enrollment date, or
 - their most recent enrollment or open enrollment date,
- sign and date a Flex Plan insurance coverage waiver form,

- not have submitted any claims under the Flex Plan group insurance contract,
- sign a Credit Request Form (affidavit that no claims have been incurred and you will be responsible for payment of any claims submitted).

If the previous conditions are completed, a credit will be issued retroactively (generally up to 60 days, from the time all documentation is received by the Flex Plan, as allowed by carriers) to the later of your other insurance coverage effective date or your Flex Plan insurance effective date. If claims were incurred under the Flex Plan group insurance contract, then you are not eligible to terminate the group insurance contract until the next Open Enrollment or until coverage is canceled due to non-payment of premiums.

Individual and Exchange Insurance Policies

To comply with the Affordable Care Act (“ACA”) the Flex Plan was required to make certain mandated benefit modifications that affect group and individual insurance policies effective January 1, 2014. The ACA also mandated changes to Health Reimbursement Arrangements (“HRA”); the Entertainment Industry Flex Plan is an HRA. As a result of the ACA, employer contributions cannot be used to pay for individual medical policies or coverage through an exchange. In addition, reimbursement of out-of-pocket medical expenses is only available to participants and dependents covered by a group insurance plan and have current proof of insurance on file with the Flex Plan.

Are Domestic Partner Benefits available under the Plan?

Domestic Partner Benefits are available to same sex as well as opposite sex partners if the following conditions are satisfied:

- the partnership is similar to a marriage and has been in existence for at least six months
- the domestic partner must be a tax dependent of yours, or you must submit one of the following which names both you and your domestic partner:
 - bank statement
 - lease or rental agreement (for your residence)
 - trust deed (for your residence)
 - automobile document of ownership

In addition, if you reside in a city, state or country that provides for domestic partner registration, you may submit a copy of your Certificate of Domestic Partnership or similar registration document in lieu of the items listed above.

If you claim your domestic partner as a tax dependent, the cost of coverage (insurance premiums) as well as out-of-pocket medical expenses may be reimbursed from your Flex Plan account subject to the Plan rules. Reimbursement claims for domestic partners must be submitted on a separate claim form. The claim(s) must be submitted in accordance with Plan guidelines and will not be reimbursed until the Plan has received a copy of your tax return for the year in question showing your domestic partner is a tax dependent.

If your domestic partner is not your tax dependent, the IRS does not permit reimbursement of premium, out-of-pocket or any other expenses from your Flex Plan account balance. The cost of your domestic partner’s coverage must be automatically collected on a monthly basis by bank debit. The cost is computed by taking the difference of the rate which includes your domestic partner and the single coverage rate. For more detailed information on Domestic Partner Benefits, please call the Member Services Department and request a full copy of the Domestic Partner Policy and Instructions.

What is the purpose of Disability Insurance Coverage?

Disability Insurance was established by the Plan to provide income during a period for which you may be unable to work due to an injury, whether work related or not. To receive benefits, you must have worked for a signatory employer within 90 days of your date of disability and be disabled for a minimum of 3 months (2 months on the High Option plan).

When does my Disability Insurance Coverage begin?

You will automatically be enrolled for disability insurance coverage when the Flex Plan receives at least \$100.00 in Contributions (excluding self-payments) on your behalf in two out of three consecutive work months, provided the Flex Plan has your address. Further, you must have an account balance sufficient to pay your disability insurance premium(s) as well as premiums for any other insurance option selected by you.

When does my Disability Coverage end?

Your coverage will end after the Flex Plan does not receive at least \$100 per month of Contributions (excluding self-payments) on your behalf during six consecutive work months. At the end of the sixth month, your account will be credited for premiums paid for that month and the preceding two months. Therefore, your coverage will terminate the last day of the third month. This is done to allow a full six-month period for work to resume in an effort to continue your disability insurance coverage without interruption. Note: In order to be eligible to receive disability benefits, you must have worked for a participating employer within 90 days of the date of disability.

Once Disability Coverage is terminated, can it be reinstated?

Coverage may be reinstated subject to the conditions described above in, “When does my Disability Insurance Coverage Begin?”

May I decline enrollment for Disability Coverage through the group contract?

Only if you meet one of the following requirements:

- you are covered by another disability insurance policy (other than state disability insurance) and can certify the policy is in force,
- you can certify you are already disabled, or
- if you are 65 or older, retired from full-time employment and are receiving a Social Security retirement benefit, you may waive coverage within 30 days of commencement of receipt of Social Security Benefits,

If you wish to decline the Group Disability Insurance coverage you must do so during your initial or open enrollment period. You will need to execute a waiver form and submit proof that you have another disability policy (workers compensation is not a disability policy) in force. If the Flex Plan does not receive the completed waiver form and required documentation within 30 days of your first notice, you will forfeit the right to decline enrollment until the next Open Enrollment period and premiums will be paid retroactive to your original effective date.

IMPORTANT: If coverage is waived, enrollment during a later Open Enrollment period may require medical underwriting at your own expense and you may be denied the right to enroll.

Can I be denied Disability Insurance coverage?

If you do not waive coverage during your original enrollment period or during a later Open Enrollment period, you cannot be denied coverage. However, if you waive coverage at any time and wish to re-enroll in a subsequent enrollment period, the carrier may require medical underwriting at your own expense and you could be denied coverage. For example, you may be required to answer questions regarding your medical history. If you have a pre-existing medical condition, you may not be covered if you become disabled by that specific medical condition until you have been covered by this group disability contract for a period of 12 months. Please refer to the Group Long Term Disability Income Insurance Certificate for specific details.

Can I be covered by the Flex Plan Group Disability Insurance Contract and also maintain another Group or Disability Policy?

Yes. In most cases, the Flex Plan Group Contract will pay independent of your other Disability Policy with no reduction in benefits. However, you must contact the issuer of your other disability insurance provider to see if your benefit payments will decrease in the event you receive payments from another plan.

Your Flex Plan Account Balance

You may contact the Flex Plan Office at any time to obtain your account balance. This information is also available through the Flex Plan website or through the 24-hour Automated Member Services System. Contributions for hours worked in a given month are not generally received until the following month.

Shortly after the close of each quarter, you will receive from the Flex Plan Office a detailed statement of your Alternate Benefit (AB) Account. If you elect email delivery of notices, you will receive faster delivery and a discount on your administration fees. Please refer to the “Administration Fees” section for details. This statement will include all contributions made to your account as well as disbursements. It is very important that you review your statement for accuracy.

Although it is rare for an Employer to make a reporting error, it is not impossible. For example, you may know that you were employed during a particular month; however, your Benefit Statement shows no contribution for that month. If you believe there is an error with your account, contact the Flex Plan Office within 30 days so the matter may be researched and corrected if necessary.

Please note that your Flex Plan account does not earn interest nor are any of the disbursements made to you by the Plan taxable under current law. The interest earned by the Plan is used to offset administration expenses, which in turn, decreases the administrative fees charged.

How does the Reimbursement Process work?

Expenses may be reimbursed on a semi-monthly basis (subject to your eligibility as described below in the section “The Reimbursement Process”). Claim forms may be obtained by calling the Member Services Department or by downloading them from our website (www.flexplan.com/forms).

- Claims received (with proper documentation) between the 1st and the 14th of each month are paid on the 5th of the following month.
- Claims received between the 15th and the end of the month (with proper documentation) will be paid on the 20th of the following month.

Claims Deadline

All claims incurred in a calendar year must be *received* by the Flex Plan or postmarked no later than March 31 of the following year to be eligible for reimbursement. Due to the large number of claims submitted during the last claims cycle each year (3/15-3/31) there may be a delay in issuing your claims payment. In order to receive timely payment of your reimbursable claims, you should file your claims as they are incurred rather than waiting until the March 31 deadline.

Claim payments not issued on the 4/20 payout will be issued on the 5/5 payout, provided necessary information is submitted. Special Note for Medical Expense Reimbursement: Late billings from providers will be processed after the deadline date of March 31st provided that a claim form is submitted by the "Claims Deadline" listing a description of charges incurred prior to December 31st. The Provider billings must be submitted within 30 days of the date which appears on the statement and the invoices must contain the actual dates of service (ie: pre-natal visits are normally not billed until after date of delivery, which can take charges into a new calendar year).

When am I eligible to submit a claim?

In order to be eligible for reimbursement of expenses, you must have sufficient funds to pay two months coverage of your insurance elections as defined in a previous section titled, "Am I Required to have Medical Insurance?" in your Alternate Benefit (AB) Account. If a claim is submitted and you do not have the 2-month reserve in your account, the Flex Plan will hold the claim and notify you that your claim will not be paid until you have sufficient funds in your account. The Flex Plan will make payments on your claim once there is a sufficient reserve in your AB account and will continue to make payments on submitted claims until they are paid in full (subject to your account balance).

Your medical insurance policy must be current or you must have current proof of insurance on file with the Plan to be eligible for reimbursement of either Medical Expense Reimbursement, Dependent Care Assistance Claims and Medical Insurance Premiums.

In addition, Participants who are insured but do not have group medical insurance are eligible for reimbursement of expenses or premiums when they have "grandfathered" employer contributions (received prior to January 1, 2014).

How to submit a claim

To request reimbursement, you must submit a properly completed Flex Plan Claim Form and attach evidence that the expense was incurred. **To ensure your claim is not denied, carefully read the instructions on the claim form before submitting your claim.** Submit only the information requested on the claim form. There is a fee assessed each time you *submit* a claim. Therefore, you should wait to submit your claims until you determine the claim amount warrants the claim-processing fee. Claims paid over multiple months are *not* assessed additional fees. Please refer to the "Administration Fees" section for claim reimbursement fees.

Claims may only be submitted for you and/or your eligible dependents. An eligible dependent for purposes of premium reimbursement or medical expense reimbursement under the terms of the plan is someone 1) you claim on your tax return and provide at least 51% of his or her financial support or 2) your children up to age 26. In order to be eligible to submit claims for dependents, they must be on file with the Plan.

Each item on your Claim Form must be accompanied by documentation showing that the expense has been incurred (evidence of expense). It is recommended that you write the Flex Plan claim form line number on each evidence of expense document.

Evidence of Expense for Medical Expense Reimbursement Claims must be an Explanation of Benefits (EOB) from an insurance carrier or provider of services and must contain:

- Provider's name;
- Patient name;
- Date of service;
- Description of services;
- Amount charged for services;
- Patient responsibility; and
- Co-pay amount or amount due from Patient, Insurance Payments and/or Adjustments
 - Note: Insurance estimates cannot be accepted.

Please refer to the claim form for detailed information regarding the documentation which must be submitted with your claim. Please remember that your claim form and supporting documents cannot be returned to you, so keep a copy for your records (do not submit original supporting documents).

Medical Expense Reimbursement (MR)

Medical Expenses may only be reimbursed from Employer Contributions; Employee Contributions cannot be used to reimburse Medical Expenses.

Medical Expenses include those expenses defined by the Plan that comply with Section 213(d) of the Internal Revenue Code to the extent that the expense has not been reimbursed through insurance or otherwise. For a listing of items that may be reimbursed please review the Medical Expense Reimbursement List (www.flexplan.com/mrlist). If you do not have internet access, contact our Member Services Department to request a copy to be mailed or faxed to you. In order for some items to be reimbursed they may require a prescription or a Letter of Medical Necessity, refer to the Medical Reimbursement List for specifics. Due to changing regulations and IRS determinations, the list is updated frequently. If you are unsure or have any doubt whether a specific expense will qualify, contact the Member Services Department prior to purchasing the item or incurring the expense. Generally, medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. Medical expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health or comfort.

For example, you may file claims for reimbursement of eligible medical expenses such as:

- deductibles and co-payments for your medical plan (including prescription co-pays)
- visits to a doctor or medical group
- expenses that may not be covered by your insurance plan (for example: eyeglasses, prescription contact lenses, dental exams, dental work and much more)
- prescription drugs and prescribed over-the-counter items not covered by insurance
- counseling services: psychiatrist, psychologist, drug or alcohol abuse, impotency and infertility
- birth control pills or other prescribed birth control items
- acupuncture, acupressure
- chiropractic services
- cost of your Flex Plan administration and check fees (these fees may only be submitted in January through March of the year following the year the fees were charged). The fee amount is provided in your fourth quarter statement.

You must have in your Alternate Benefit (AB) Account sufficient funds to pay two months coverage of your insurance elections as defined in a previous section titled, "Am I Required to have Medical Insurance?" If a claim is submitted and you do not have the 2-month reserve in your account, the Flex Plan will hold the claim and notify you that your claim will not be paid. The Flex Plan will make payments on your claim once you accumulate a sufficient reserve and will continue to make payments on claims until they are paid in full (subject to your account balance). Your medical insurance policy must be current to be eligible for reimbursement.

What over-the-counter items require a prescription?

To be eligible for reimbursement, prescriptions are required for all over-the-counter (OTC) medicines or drugs other than insulin. OTC items that are not medicines or drugs (equipment, medical devices, and supplies) are reimbursable without a prescription. Examples of items that do not require a prescription include crutches, bandages, eye glasses, contact lenses, contact lens solution, blood sugar test kits, diabetic supplies, and oxygen.

Direct Payment of Medical Expenses to the Provider of Services

You may request that the Flex Plan make a payment directly to the provider of medical services on your behalf. However, please note that if your account balance is less than the amount required to pay the provider, the unpaid balance will not be carried forward and subsequently paid to your provider. You must complete a Medical Expense Direct Payment Claim Form and must attach Evidence of Expense (as described above). The charge for this service may be found on the Administrative Fee Schedule.

What happens if I am unable to submit claims on my own?

In the event that you are unable to submit your own claims, you may authorize another individual to submit claims on your behalf if you have a valid Power of Attorney for Health Care Claims on file at the Flex Plan Office. The Power of Attorney for Health Care Claims Form is available on the Flex Plan website (www.flexplan.com/forms) and can be downloaded. You may also contact Member Services to have the form mailed to you.

Can I make contributions to a Health Savings Account?

Generally, employees covered by an HRA like the Medical Reimbursement option will not be eligible for HSA contributions. The Flex Plan cannot provide tax advice. If you have any questions, please contact your administrator of the HSA.

Dependent Care Assistance (DC)

In order to participate in this benefit, an allocation must be made during your initial enrollment in the Plan (for the balance of that year) or during the Open Enrollment period (for the upcoming year, unless there is a change in family status as previously described). If an allocation is not made, you will not be eligible to submit Dependent Care Expenses for that year even if you have a balance in your Dependent Care Assistance account.

Claims may be submitted during the year for reimbursement of Dependent Care Expenses incurred in that calendar year. Each time a claim is paid, that amount will be deducted from the Allocation Amount. At the end of the year, the unused portion (allocation amount less Dependent Care claims paid) will be subtracted from your Alternate Benefit (AB) Account balance and moved into a separate Dependent Care Account which may only be used for reimbursement of Dependent Care claims incurred in the Plan Year or the immediately following Grace Period (1/1-3/15) for which the allocation was made. You should consult your tax advisor to see if the submission of claims during the Grace Period may affect your taxable income. Any unused Employer funds may be used in future years if an allocation is made for the upcoming year. Any amounts remaining in the Dependent Care Account may revert back to the Alternate Benefit (AB) Account upon written request provided the source of the funds did not come from voluntary pre-tax contributions. Voluntary pre-tax contributions not exhausted by the end of the Grace Period (1/1-3/15) will be forfeited.

Any amounts paid for providing household services (baby-sitters, nurses) or out-of-home care for qualifying individuals may be reimbursed from this Dependent Care Assistance account if these expenses are incurred in order to enable you to continue working. The maximum contribution allowed each year is the lesser of \$5,000 per family (or \$2,500 if you are married and file separate federal income tax returns), your earned income, or your spouse's earned income. The Dependent Care Assistance allocation you make with the Flex Plan may affect the amount of the Dependent Care Federal Tax Credit to which you may be entitled. Consult your tax advisor to see which option is best for you.

Amounts paid to your spouse, your children under age 19 or to any other individual you claim as a dependent on your Federal Income Tax Return are not eligible for reimbursement from this account.

You must complete a Dependent Care Assistance Certification Form for each provider for whom you request reimbursement.

If you provide more than half of their support and have the same principal place of abode for more than half of the year. qualifying individuals are:

- your children under age 13,
- your spouse, or dependent who is physically or mentally unable to care for himself or herself

Medical Insurance Premium Reimbursement

Reimbursement for Medical Insurance Premiums is only available to participants who have proof of medical insurance on file and:

- are covered by their spouse (provided their spouse pays additional funds to cover Flex Plan member)
- have made self-payments to another Trust Fund
- have paid medical insurance premiums through another employer
- are covered by Medicare (Medicare premiums for your spouse may not be reimbursed)

If you or your spouse pays for your coverage through your/their employer and has additional funds withheld from your/their pay to cover you (and your dependents) under their medical plan, you may be reimbursed for those expenses as well (from Employer Contributions only, you may not use Employee Contributions to be reimbursed for premiums through another employer). Once proof of insurance is on file you will need to submit a claim form along with copies of pay stubs or a pay stub showing year-to-date withholdings for medical insurance premiums.

Important Note: In order to be eligible to receive reimbursement for premiums for your dependent(s) the participant must be on the policy. The Flex Plan cannot reimburse the cost of any premiums for a dependent if the participant is not on the policy with the dependent(s).

Other Insurance premium reimbursements

You may also request reimbursement for the following types of insurance premiums:

- Disability Insurance Premiums (participant only). Disability Insurance may be paid with pre-tax dollars through the Flex Plan. However, the benefit you receive if you become disabled is taxable. No dependent coverage may be reimbursed under this benefit.
- Dental Insurance Premiums
- Vision Insurance Premiums

You must submit a copy of your policy summary as well as evidence of expense from the provider. Group Term Life Insurance Premiums are not reimbursable. You may, however, elect Group Term Life Insurance coverage under the Flex Plan group contract to be paid on a monthly basis.

Claims and Appeals Procedures under the Plan

Each of the benefits (Medical, Dental, Vision, Group Term Life and Disability) has separate claims procedures through the insurance company sponsoring such benefit(s). You will find these procedures in the materials provided to you by the Flex Plan Office describing the insured benefit in question. You may obtain an additional copy of such materials submitted upon request to the Flex Plan Office.

As for the reimbursement type benefits provided by the Flex Plan, if you believe any right or benefit has been improperly denied, you may file a claim in writing with the Flex Plan Office. If your claim is denied in whole or in part, the Flex Plan Office will notify you of its decision in writing. Such notification will be written in a manner calculated to be understood by you and will contain the following:

- Specific reason for the denial,
- Specific reference to pertinent Flex Plan provisions,
- A description of any additional material or information necessary for you to perfect such claim and an explanation of why such material or information is necessary, and
- Information as to the steps to be taken if you wish to submit a request for review.

Such notification will be given within 30 days after the claim is received by the Flex Plan Office (or within 45 days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to you within the initial 30-day period). In the event the extension is due to the Claimant's failure to submit information necessary to make the benefit determination, the Flex Plan will notify the Claimant in writing of the specific information which is required within the initial 30 days, and the Claimant will have 45 days from the receipt of the Flex Plan's request to provide the additional information. The period within which the Flex Plan is waiting for additional information will not be counted toward the time within which the Flex Plan is required to respond. A Claimant may voluntarily consent to a longer extension. Within 180 days after the date on which you receive a written notice of a denied claim (or, if applicable, within 180 days after the date on which denial is considered to have occurred), you (or your duly authorized representative) may:

- File a written request with the Trustees for a review of your denied claim along with any pertinent documents, and
- Submit written issues and comments to the Trustees.

The Trustees will notify you of their decision in writing. Such notification will be written in a manner calculated to be understood by you and will contain specific reasons for the decision as well as specific references to pertinent Flex Plan provisions. Appeals will be heard at the Trustees' meeting that follows receipt of the appeal, if it is received more than 30 days before the meeting. If received less than 30 days before the meeting, the appeal may be heard at the second meeting after such receipt. However, if special circumstances exist, the Committee will inform the Participant of the need for a further extension, what those special circumstances are, and the date the appeal will be decided. In that instance the appeal will be decided not later than the date of the third meeting following the appeals request. You will be provided notice of the appeals decision within five days of the decision.

Notice of Privacy Practices

This section describes how medical information about you may be used and disclosed and how you may get access to this information. This section only describes the privacy practices of the Flex Plan, it does not address the health information policies and practices of your health care insurance carriers or providers. This section only applies to health-related information created or received by or on behalf of the Flex Plan. We are providing this information to you because the privacy regulations issued under federal law, the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164 ("HIPAA") require us to provide you with a summary of the Flex Plan's privacy practices and related legal duties, and your rights in connection with the use and disclosure of your health related information.

The Flex Plan is subject to federal and California medical information privacy rules. The Flex Plan will only use the information submitted by you, your spouse, or dependents for the purpose of verifying that the submitted items qualify for reimbursement as provided under the Plan. The Flex Plan does not make any determination as to treatment or healthcare options.

What is Protected?

HIPAA requires the Flex Plan to have a special policy for safeguarding a category of medical information called "protected health information" or "PHI," received or created in the course of administering the Flex Plan. PHI is health information that can be used to identify you and that relates to:

- Your physical or mental health condition,
- The provision of health care to you, or
- Payment for your health care.

Uses and Disclosure of Your PHI

To protect the privacy of your PHI, the Flex Plan not only guards the physical security of your PHI, but we also limit the way your PHI is used or disclosed to others. We may use or disclose you PHI in certain permissible ways described below. To the extent required under HIPAA, we will use the minimum amount of your PHI necessary to perform any of the tasks listed below.

- **To Determine Proper Payment of Your Medical Claim.** The Flex Plan may use or disclose your PHI to reimburse you for eligible medical claims and services.

- **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 Plan's proper operation. For example we may use your claims information for fraud and abuse detection activities.
- **For Health-Related Benefits and Services.** The Flex Plan may use or disclose your PHI to provide you with information regarding health-related benefits and services that may be of interest to you.
- **Disclosure to Plan Sponsor.** PHI may be disclosed to the Board of Trustees and the Flex Plan administrative staff solely for purposes of carrying out Plan-related administrative functions. These individuals will protect the privacy of your health information and ensure that it is used only as described in this notice or as permitted by law.
- **To an Individual Involved in Your Care or Payment of Your Care.** The Flex Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care.
- **To a Business Associate.** The Flex Plan may disclose PHI to other persons or organizations, known as business associates, who provide services on the Flex Plan's behalf. To protect your health information, the Flex Plan requires its business associates to appropriately safeguard the health information disclosed to them.
- **As Required by Law.** The Flex Plan may disclose PHI when required to do so by federal, state, or local law.
- **Military and Veterans.** The Flex Plan may use and disclose your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** The Flex Plan may release your PHI when necessary to comply with applicable workers' compensation or similar laws.
- **To Avert Serious Threat to Health or Safety.** The Flex Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Public Health Activities.** The Flex Plan may disclose your PHI for public health activities, such as providing information to an authorized public health authority for the purposes of preventing or controlling a disease, injury or disability.
- **Health Oversight Activities.** The Flex Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections and licensure necessary for the government to monitor the health care system and government programs, or to ascertain compliance with applicable civil rights laws.
- **Judicial and Administrative Proceedings.** The Flex Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request or other lawful process.
- **Law Enforcement.** The Flex Plan may release PHI if asked to do so by a law enforcement official.
- **Coroners and Medical Examiners.** The Flex Plan may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of a person's death.
- **Organ and Tissue Donation.** If you are an organ donor, the Flex Plan may release PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Specialized Government Functions.** In certain circumstances, federal regulations require the Flex Plan to use or disclose your PHI to facilitate government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.
- **For 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.
- **Incident to a Permitted Use or Disclosure.** The Flex Plan may use and disclose PHI incident to any use or disclosure permitted or authorized by law.
- **As Part of a Limited Data Set.** The Flex Plan may use and disclose a limited data set that meets the technical requirements of 45 Code of Federal Regulations, Section 164.514(e), if the Flex Plan has entered into a data use agreement with the recipient of the limited data set.

Other Uses and Disclosures of Health Information

Other Uses and disclosures of PHI not covered by this notice or by the laws that apply to the Flex Plan will be made only with your written authorization on a form provided by the Flex Plan. If you authorize the Flex Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Flex Plan will no longer disclose or use your PHI for the reasons covered by your written authorization. However, the Flex Plan will not retract any uses or disclosures previously made a result of your prior authorization. If the individual is asked for authorization for use or disclosure of protected health information, the individual will be provided with a copy of the signed authorization.

If you have any over age dependents on your account (spouse, child over 18 years of age) the Flex Plan will not discuss any information regarding reimbursement claims with you or your dependents unless you and your over age dependents complete and return a Health Information Disclosure Authorization Form provided by the Flex Plan which may be obtained by calling our Member Services Department or by downloading the form from our website: www.flexplan.com/forms.

Your Rights

Federal law provides you with certain rights regarding your PHI. Parents of minor children and other individuals with legal authority to make health decisions for a Flex Plan participant may exercise these rights on behalf of the participant, consistent with Federal and state law. Your rights regarding your health information are described below.

- **Request restrictions on certain uses and disclosures of protected health information as provided under the law;** You have the right to request a limitation on the Flex Plan's use or disclosure of your PHI; however, the Flex Plan is not required to agree to a requested restriction. The Flex Plan will not agree to any restriction that is necessary to administer the Flex Plan or will cause it to violate or be noncompliant with any legal requirement. If we do agree to your requested restriction or limitation, we will honor the restriction until you agree to terminate the restriction or until we notify you that we are terminating the restriction with respect to PHI created or received by the Plan in the future. You may make a request for restriction on the use and disclosure of your PHI by submitting a written request to the Flex Plan Privacy Officer.
- **Right to receive confidential communications of protected health information.** You have the right to request that the Flex Plan communicate with you about your PHI at an alternative address or by alternative means if you believe that communication through normal business practices could endanger you. For example, you may request that the Plan contact you only at work and not at home. You may request confidential communication of your PHI by completing submitting a written request to the Flex Plan Privacy Officer. We will accommodate all reasonable requests if you clearly state that you are requesting the confidential communication because you feel that disclosure in another way could endanger your safety.
- **Right to inspect and copy protected health information.** You have the right to inspect and copy your health information maintained by the Flex Plan. To inspect and copy PHI maintained by the Flex Plan, you must submit your request in writing to the Flex Plan Privacy Officer. The Flex Plan may charge a fee for the costs of copying and mailing your request. In limited circumstances, the Flex Plan may deny your requests to inspect and copy your health information. Generally, if you are denied access to health information, you may request a review of the denial.
- **Right to amend protected health information.** You have the right to request an amendment of your PHI if you believe the information the Flex Plan has about you is incorrect or incomplete. You have this right as long as your PHI is maintained by the Flex Plan in a designated record set. We will correct any mistakes if we created the PHI or if the person or entity that originally created the PHI is no longer available to make the amendment. However, we cannot amend PHI that we believe to be accurate and complete. You may request amendments of your PHI by submitting a written request to the Flex Plan Privacy Officer.
- **Right to receive an accounting of disclosures of protected health information.** You have the right to request a list of certain disclosures of your PHI by the Flex Plan. The accounting will not include disclosures (1) to carry out treatment, payment and health care operations, (2) to you or to a person involved in your care, (3) incident to a use or disclosure permitted or required by law, (4) pursuant to an authorization provided by you, (5) for directories or to people involved in your 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 your request. Your first request for an accounting within a 12-month period will be free. We may charge you for costs associated with providing you additional accountings. We will notify you in advance of any costs, and you may choose to withdraw or modify your request before you incur any expenses. You may make a request for an accounting by submitting a written request to the Flex Plan Privacy Officer.
- **Right to receive PHI in an electronic format.** To the extent that the Flex Plan maintains an electronic record of the requested PHI, you have the right to receive PHI in an electronic format. In addition, upon your request, the Flex Plan will transmit the copy directly to an entity or person you designate, provided that the directive is clear and specific. To request an electronic copy of your health information, you must submit a written request to the Flex Plan Privacy Officer.
- **Right to receive a paper copy of this information.** You may obtain a copy of this information at any time by requesting a copy from the Flex Plan Privacy Officer.

The Flex Plan reserves the right to change its privacy practices with respect to protected health information already in its possession before it notifies you of those changes. If it does so, the Flex Plan will provide a revised notice of its privacy practices to each individual covered under the Plan within 60 days of any material change. In order for Flex Plan employees to assist with claims processing, an individual may provide authorization for the insurance carriers to share information with Flex Plan employees by completing an authorization form. Individuals may complain to the Flex Plan if they believe their privacy rights have been violated by writing a letter describing what privacy rights they believe were violated and the method of the violation. The individual will not be retaliated against for filing a complaint. If you have any questions regarding the privacy issues described in this section, please contact the Flex Plan's designated Privacy Office

Privacy Officer Contact Information

Sean Dugan
844 Seward St.
Los Angeles, CA 90038-1116
Telephone Number: (323) 993-8888 / (888) 353-9401

Individuals may also file a complaint with the Flex Plan's Privacy Official and/or the Secretary of Health and Human Services (<http://www.hhs.gov> or 877/969-6775.)

What are your rights under ERISA?

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

- 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 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.
- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the 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 up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan

administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Important Information

Name of Plan:

Entertainment Industry Flex Plan

Names and Addresses of Plan Insurance Providers:

For a list of all of the Plan's Insurance Providers, please visit www.flexplan.com/insurance

Type of Plan:

The Flex Plan is a welfare benefit plan with both employer and cafeteria plan funding. It includes insured medical, life and disability benefits; medical and dependent care assistance expense reimbursement benefits. The medical expense reimbursement benefit aspect of the Plan is an HRA (Health Reimbursement Arrangement). The Plan believes the medical expense reimbursement HRA is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Benefit Plans, Inc. 844 Seward St. Los Angeles, CA 90038-1116; (323) 993-8888 / (888) 353-9401. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Plan Number:

501

Federal Tax Identification Number of the Plan:

Tax ID Number: 95-6832043

Agent for Service of Process:

Benefit Plans, Inc.
844 Seward St.
Los Angeles, CA 90038-1116
(323) 993-8888 / (888) 353-9401

Legal process may also be served on any Plan Trustee listed below.

Plan Year:

January 1st to December 31st

Plan Sponsor:

The Plan Sponsor is the Board of Trustees of the Entertainment Industry Flex Plan

Plan Administration:

The Plan is administered by the Joint Board of Trustees. The Board of Trustees has contracted with Benefit Plans, Inc. to act as administrative manager to provide for the day to day administration of the Plan. The address and telephone number of the "Flex Plan Office" is:

Benefit Plans, Inc.
844 Seward St.
Los Angeles, CA 90038-1116
(323) 993-8888 / (888) 353-9401

Fund Manager:

Sean Dugan

General Manager:
Steve Schmit

A complete list of the Employers and employee organizations sponsoring the Flex Plan may be obtained by participants and beneficiaries upon written request to the Flex Plan Office and is available for examination by participants and beneficiaries at the Flex Plan Office at the above address.

Participants and beneficiaries may receive from the Flex Plan Office upon written request information as to whether a particular Employer or employee organization is a sponsor of the Plan and, if so, the sponsor's address.

Collectively Bargained Plan

This Plan is collectively bargained. Participants or beneficiaries may request, in writing, copies of collective bargaining agreements related to the Plan. Collective bargaining agreements related to the Plan are available for inspection. Please contact the Flex Plan Office during normal business hours for more information.

Closing...

As you can see, the Entertainment Industry Flex Plan truly lives up to its name by making a flexible "cafeteria-style plan" available to all of its participants. Please review all the information carefully. If you have any questions, please call the Member Services Department.

The Flex Plan is contained in a written document, which sets forth the provisions of this fringe benefit program. The insured benefits provided under this program are set forth in the insurance policies in effect currently and which may be amended from time to time. In order to find out how the program affects you and your family, you may read the actual document and/or such policies (copies are available to you at the Flex Plan Office during regular business hours).

Call your Local Union office if you have any questions regarding which Employers include the Flex Plan in their Local Union/Company Agreement.

A brief history of the Flex Plan

In response to a growing number of daily-hire members employed by the networks without medical benefits, ABC, CBS and NBC established the Entertainment Industry Flex Plan in 1985.

Benefit Plans, Inc. provides administration services to the Plan under the direction of Sean Dugan, the Fund Manager. Since its inception, the Flex Plan has grown to over 30,000 participants and covers many unions in the Entertainment Industry throughout the United States.

Administration Fees

Plan Enrollment Fee (1-time)	\$25.00	Claims Processing Fees *	7.50
Quarterly Administration Fee	14.50	Per claim form submitted	
Quarterly Fee Discount for Internet Delivery	-2.00	(maximum 5 lines per claim)	
		Manual Check Fee +	15.00
		Per Claim/Group/Year	
		Direct Payment to Provider *	5.00
Monthly Premium Payments		Direct Payment to Provider (manual check)*+	10.00
MI Medical Insurance	2.50	Credit Card Convenience Fee	4%
DI Dental Insurance	1.00	Insurance Reinstatement Fee	20.00
VI Vision Insurance	.50	Members whose payments are received late and	
LI Group Term Life Insurance	.50	wish immediate reinstatement are subject to this	
DB Disability Insurance	.50	Fee	
ID Individual Disability Insurance	1.00	NSF/Returned Item Fee	20.00
		* Subject to eligibility	
		+ Manual Checks are generally mailed within 3	
		business days of receipt provided all necessary	
		information is on file	

Board of Trustees' Information

Employer Trustees:

Rob Brandwene
Senior Vice President, Global Benefits
Viacom CBS Inc.
51 West 52nd St.
New York, NY 10019

Steven Moy
Director, Labor Relations
Fox Entertainment Group
2121 Avenue of the Stars, #2230
Los Angeles, CA 90067

Veronica Perez
Director, Labor Relations
Warner Bros. Pictures
400 Warner Blvd. Bldg 137
Burbank, CA 91522

Nick Rowe
Senior Counsel, Labor Relations
NBCUniversal
Universal Studios Hollywood
100 Universal City Plaza
Universal City, CA 91608

Jason Vogel
Senior Counsel, Labor Relations
Disney Entertainment
2121 Avenue of the Stars,
Office 522 Los Angeles, CA 90067

Union Trustees:

Pete Anthony
American Federation of Musicians (AFM), Local 47
3220 Winona Ave
Burbank, CA 91504

Charlie Braico
Sector President
NABET-CWA, AFL-CIO
501 Third St, NW
Washington, DC 20001

Joel Cohen
Associate National Executive Director
Art Directors Guild, IATSE Local 800
11969 Ventura Blvd. Second Floor
Studio City, CA 91604

Lindsay Dougherty
Western Region Vice President
Director, Motion Picture and Theatrical Trade Division
International Brotherhood of Teamsters
4747 Vineland Ave
North Hollywood, CA 91602

Robert Prunn
Director, Broadcasting & Telecommunications
IBEW
900 7th Street N.W.
Washington, DC 20001

A

Administration Fees · 7, 8, 11, 12, 20
Allocation · 6, 13
Alternate Benefit Account · 3, 5, 11, 12
Automatic Enrollment · 6, 9, 10

B

Board of Trustees · 21

C

Change in Family Status · 5, 6, 13
Claims and Appeal Procedures · 14
Claims Procedures · 11, 12, 13, 14, 15
Claims Reimbursement · 4, 5, 11, 12, 13, 14, 15, 19
COBRA · 7, 8, 9, 18
Collective Bargaining Agreement · 4, 5

D

Default Carrier · 9
Dental Insurance · 3, 5, 7, 8, 13, 14
Dependent · 3, 4, 5, 9, 10, 12, 13, 14, 19
Dependent Care Assistance · 3, 5, 6, 13, 14, 19
Direct payment of Medical Expenses · 13
Disability Insurance · 5, 7, 8, 10, 11, 14
Disability Insurance Requirement · 10
Disability Waiver Form · 11
Domestic Partner Benefits · 10

E

Eligibility · 4, 5, 6, 7, 8, 9, 11, 12, 13, 14
Eligibility (Medical Expense Reimbursement) · 12
Employee Contributions · 3, 4, 5, 12
Employer Contributions · 3, 4, 5, 6, 7, 8, 10, 12
Enrollment · 6, 11, 13
ERISA · 18
Evidence of Expense · 12, 13

F

Federal Tax Credit · 14
Fee Schedule · 11, 13
Forfeiture of Account Balance · 11

H

HIPPA · 15

I

Individual Disability Insurance · 5
Individual Insurance Policy · 4, 9, 10, 11

L

Life Insurance · 5
Local Union · 4, 5, 20

M

Medical Expense Reimbursement · 4, 5, 11, 12, 13
Medical Expense Reimbursement (covered items) · 13
Medical Expense Reimbursement (direct payment) · 13
Medical Expense Reimbursement (eligibility) · 12
Medical Insurance · 3, 5, 7, 8, 9, 14
Medical Insurance Premiums · 8, 14
Medical Insurance Requirement · 9
Medicare · 8, 9, 14

O

Open Enrollment · 5, 6, 7, 9, 10, 11, 13

P

Plan Year · 4, 19
Premium Payments · 6, 7, 8
Premium Reimbursement · 14
Premium Reserve · 12
Pre-Tax Contributions · 4, 5
Proof of Payment · 12

Q

Qualifying Contribution Amount · 5

R

Retroactive Premium Credit · 9, 10

S

Self-Payment of Premiums · 4, 7, 8, 9, 10, 14
Statement of Account · 10, 11

T

Tax Dependent · 12
Termination of Coverage · 8, 10
Termination of Employment · 8
Type of Plan · 19

V

Vision Insurance · 3, 5, 7, 8, 14



Administrative Office:

844 Seward St
Los Angeles, CA 90038

Mailing Address:

PO Box 17928
Los Angeles, CA 90017-0928

Phone:

(323) 993-8888
(888) FLEX-401K
(888) 353-9401

Fax:

(323) 993-8834

Website:

www.flexplan.com