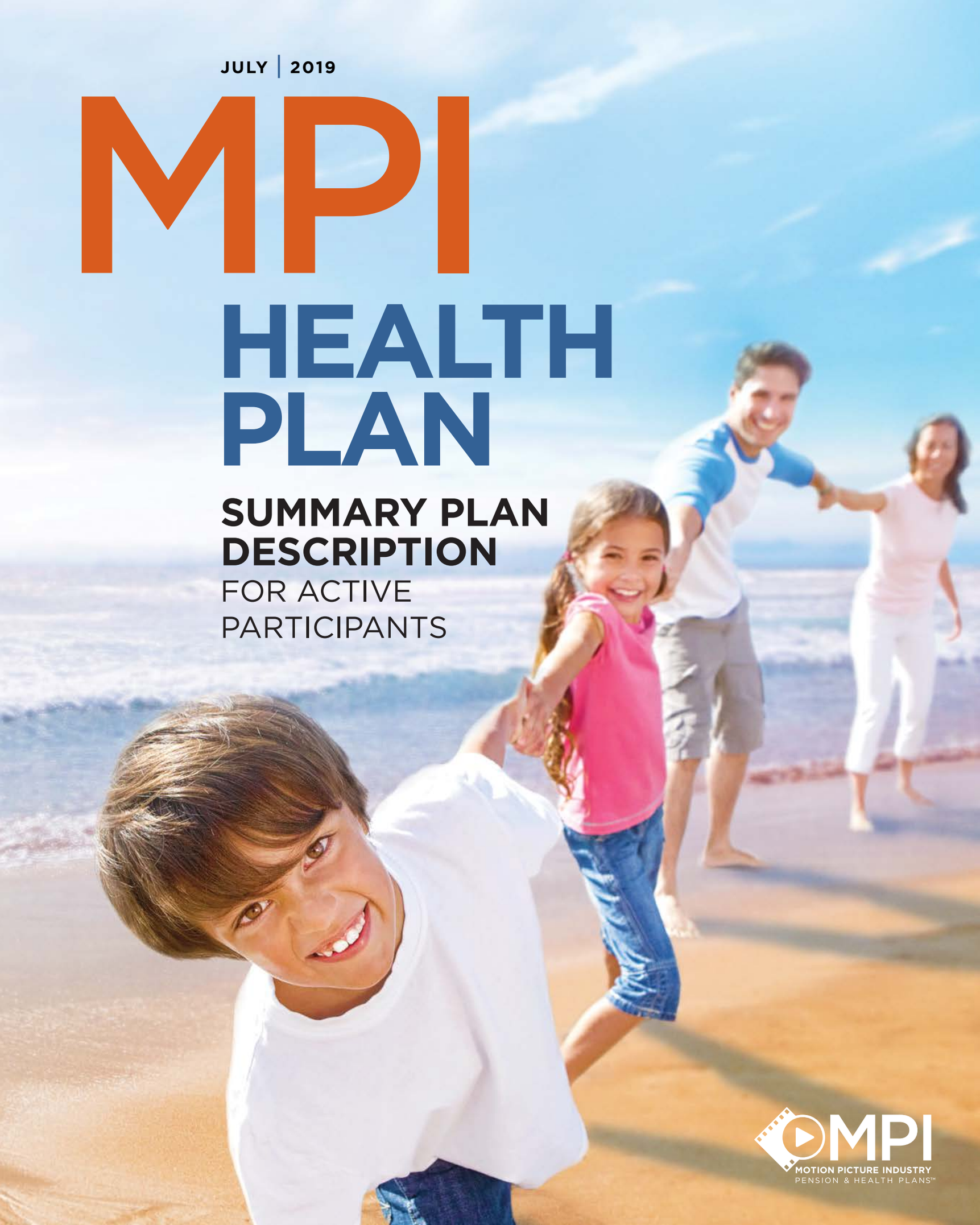
JULY | 2019

MPI HEALTH PLAN

SUMMARY PLAN DESCRIPTION
FOR ACTIVE PARTICIPANTS



MPI
MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS℠

MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS℠

CHIEF EXECUTIVE OFFICER
David Asplund

CHIEF MEDICAL OFFICER
Janice Spinner, M.D.

LEGAL COUNSELS
Mitchell, Silberberg & Knupp, LLP
Spivak Lipton LLP
Wohlner Kaplon Cutler Halford & Rosenfeld

CONSULTANTS
Cheiron
Rael & Letson Consultants and Actuaries

BOARD OFFICERS

Thomas Davis
Chair

Patric Abaravich
Vice-Chair

Michael Rosenfeld
Secretary

Michael Campolo
Vice-Secretary

BOARD OF DIRECTORS

Patric Abaravich
Aric Ackerman
Alex Aguilar
Helayne I. Antler
Mark Badagliacca
Jay Barnett
Scott Bernard
Krysten A. Brennan
Ann Calfas
Michael Campolo
Stephanie A. Caprielian
Tommy Cole
Thomas Davis
Steve Dayan
Eryn Doherty
Colleen Donahue
Kenny Farnell
Marc Flynn
John Ford
Nicole Gustafson
Hank Lachmund
Matthew D. Loeb
Carol A. Lombardini
Michael P. Messina
Michael Miller
Diane Mirowski
Rebecca Rhine
Michael Rosenfeld
Joseph Scudiero
Joshua Staheli
Rachael M. Stanley

Summary Plan Description

DEAR PARTICIPANT:

The Motion Picture Industry Health Plan consists of two plans: (1) the Motion Picture Industry Health Plan for Active Participants; and (2) the Motion Picture Industry Health Plan for Retired Participants. We are pleased to welcome you into the Motion Picture Industry Health Plan for Active Participants (the "Plan") and to provide you with this guide that details the benefits available to you and your eligible Dependent(s).

As an eligible Participant, you have an extensive package of benefits available to you. These benefits include comprehensive medical, prescription drug, vision, dental and life insurance, as well as a behavioral health and wellness program.

This book, the Plan's *Summary Plan Description (SPD)*, includes important information to help you understand and appropriately assess the benefits available to you. As much as possible, the *SPD* is written in plain language. For legal reasons, however, there are times when the *SPD* uses terms common in the insurance industry and/or legal terms or phrases. Please refer to the *SPD's* Glossary of Terms for an explanation of terms used in this book.

This *SPD* also provides phone numbers, addresses and websites that can provide additional information about the benefits offered through the Plan; we encourage you to use them.

You are always welcome to contact the Plan's Participant Services Center by telephone at (855) 275-4674, or by email at service@mpiphp.org, for any questions that may arise.

Thank you for your participation.

Sincerely,

BOARD OF DIRECTORS
Motion Picture Industry Health Plan

Participants of Plans That Merged

If you are a former Participant of any other health plan that merged into the Motion Picture Industry Health Plan, it is important that you carefully review the appendix included in the back of this *SPD*. The appendix may contain special rules that are different from the main rules referenced in this *SPD*. Where there is a conflict between the terms of special rules included in the appendix and the main rules of this *SPD*, the terms of the appendix will govern you and your Dependent(s).

MPI
PARTICIPANT SERVICES CENTER

Email
service@mpiphp.org

Call Toll-Free
(855) ASK-4MPI or
(855) 275-4674
Hours: 6 am to 7 pm (Pacific Time)

Fax
(818) 766-1229 – California
(212) 634-4952 – New York

Website
www.mpiphp.org

Mailing Address
MPIPHP
P.O. Box 1999
Studio City, CA 91614-0999

Office Locations
11365 Ventura Boulevard
Studio City, California 91604
(818) 769-0007
Hours: 8 am to 5 pm (Pacific Time)

145 Hudson Street, Suite 6-A
New York, New York 10013
(212) 634-5252
(888) 758-5200 – Toll Free
Hours: 9 am to 5 pm (Eastern Time)

The Plans maintain administrative offices in California and New York.

The Plans' West Coast office maintains all records pertaining to your eligibility and processes all claims for benefits. Please address any inquiry, claim or correspondence to the West Coast office, and remember to include the Participant's Social Security Number or identification number.

Table of Contents

Plan Overview

The information included in this *Summary Plan Description (SPD)* is effective July 1, 2019, and supersedes and replaces all similar information previously issued. A separate *SPD* is available for the Motion Picture Industry Health Plan for Retired Participants.

The Plan has been established by and currently operates under the provisions of an Agreement and Declaration of Trust. All benefits provided through the Plan are governed by the terms of its Agreement and Declaration of Trust, this *SPD* and its agreements with Anthem Blue Cross, Optum Behavioral Health, Health Net, Kaiser Permanente, Oxford Health Plans, Delta Dental PPO, DeltaCare USA, The Union Labor Life Insurance Company, Express Scripts, and Vision Service Plan, which together constitute the Plan documents. In the event of any conflict between the Plan documents and this *SPD*, the Plan documents will prevail.

The nature and extent of benefits provided by the Plan and the rules governing eligibility are determined solely and exclusively by the Board of Directors of the Plan. The Board of Directors shall also have full discretion and authority to interpret the Plan and to decide any questions related to eligibility for and the extent of benefits provided by it. Such interpretations are final and binding on Participants, their Dependents and Providers.

Employees of the Plan have no authority to alter benefits or eligibility rules. Any interpretations or opinions given by employees of the Plan are not binding upon the Board of Directors and cannot increase or change such benefits or eligibility rules. In accordance with the terms of the Trust Agreement, the Board of Directors reserve the right to change the nature and extent of benefits provided by the Plan and to amend the rules governing eligibility at any time.

GRANDFATHERED STATUS

The Plan is considered a "grandfathered" health plan under the Patient Protection and Affordable Care Act ("Act"). As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Act that apply to other plans (for example, the requirement for the provision of preventive health services without any cost sharing). However, grandfathered health plans must comply with certain other consumer protections in the Act (for example, the elimination of lifetime dollar limits on benefits).

Questions regarding which protections apply and which do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status may be directed to the Plan's Participant Services Center at (855) 275-4674 or at service@mpiphp.org. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at (866) 444-3272 or visit its website at www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

FALSE OR FRAUDULENT CLAIMS

Any Participant, Dependent or Provider who submits any false or fraudulent Claim or information to the Plan may be subject to criminal penalties, including a fine or imprisonment or both, as well as damages in a civil action under California, federal or other applicable law. Furthermore, the Board of Directors reserves the right to impose such restrictions upon the payment of future benefits to any such Participant, Dependent or Provider as may be necessary to protect the Plan, including the deduction from such future benefits of amounts owed to the Plan because of payment of any false or fraudulent Claim.

Participation In The Plan

PARTICIPATING EMPLOYERS

The Plan determines, subject to audit, a Participant's eligibility for benefits based on reports of hours and contributions received from his or her Employer(s). To be approved for participation by the Plan's Board of Directors and, therefore, eligible to contribute on a Participant's behalf, his or her Employer must execute a Collective Bargaining Agreement with a participating Union and complete certain other documents required by the Plan.

Except as stated under "Non-Affiliated Employees" and "Controlled Employers," below, if a Participant's Employer is not a signatory to a Collective Bargaining Agreement, participation may still be possible through a signatory payroll company that has executed a Collective Bargaining Agreement and has been approved for participation in the Plan.

AFFILIATED EMPLOYEES

Affiliated Employees are employees of an Employer that is signatory to a Collective Bargaining Agreement with a participating Union. Affiliated Employees who meet certain eligibility criteria may participate in the Plan.

NON-AFFILIATED EMPLOYEES

Some participating Employers may make contributions on behalf of Employees who are not covered by a Collective Bargaining Agreement, including certain producers and accountants. These are called Non-Affiliated Employees. These Employers have signed a Non-Affiliate Agreement with the Plan or are specified in the Trust Agreement by name. Non-Affiliated Employees who meet certain eligibility criteria may participate in the Plan.

PARTNERS AND OWNERS

Partners and owners of unincorporated businesses are not considered Employees of the Employer. Therefore, although unincorporated businesses are allowed to become a contributing Employer to the Plan and submit contributions on behalf of their covered Employees, they are not allowed to submit contributions on behalf of the owner(s) or partner(s) of the business.

CONTROLLED EMPLOYERS

Officers or controlling Employee shareholders or the spouse of an officer or controlling Employee of a signatory Employer may participate in the Plan under the rules governing Employee shareholders. Similarly, members or officers of a Limited Liability Company (LLC) or the spouse of such a member or officer may participate in the Plan under the rules governing LLCs.

See Exhibit "A" of the Motion Picture Industry Health Plan Agreement and Declaration of Trust available upon request from the Plan Office and on the Plan's website.

Controlled Employers are required to employ at least one other Employee – aside from the Controlling Employee(s) – covered by a Collective Bargaining Agreement in any 12-month period and report a minimum of 1,500 hours (in the aggregate) for such other Employee(s). This is a rolling 12-month period, and any Controlled Employer which ceases to meet this criterion will be terminated as an Employer Party to the Plan effective on the first of the month following the end of the 12-month period during which the 1,500 hour requirement was not met. Non-Affiliated Employees are not considered covered Employees for the purpose of meeting this 1,500 hour requirement.

In the event that no Employee, including the Controlling Employee(s), has worked under the Collective Bargaining Agreement during a 12-month period, the Employer will be terminated effective on the first of the month following the end of the 12-month period during which no covered work was performed.

PERMANENT FACILITIES

In general, a permanent facility is a company that maintains a permanent address and year-round staff that provides services to the motion picture industry. A permanent facility must directly be a signatory to a Collective Bargaining Agreement in order to participate in the Plan; a non-signatory permanent facility may not make contributions through a payroll company.

QUICK TIP

WANT TO LEARN MORE ABOUT EMPLOYER CONTRIBUTIONS?

See page 21

Participant Eligibility

QUALIFYING PERIODS FOR MONTHLY HEALTH ELIGIBILITY

Eligibility for Plan benefits is determined on a monthly basis according to the schedule below.

After satisfying the initial eligibility requirements of 600 work hours in one or two consecutive Qualifying Periods, Participants must work at least 400 hours in subsequent Qualifying Periods to maintain health benefits during the corresponding Eligibility Period, unless an eligibility extension(s) applies.

QUALIFYING STANDARDS

Eligibility for health benefits is contingent upon whether or not a Participant's Employer(s) makes the appropriate contributions to the Plan in accordance with the Trust Agreement.

The rules describing how your work hours are credited are generally discussed on page 21. If you work on something other than an hourly or weekly basis, your Union or Guild can tell you the formula used to determine your work hours, provided contributions are made by your Employer(s) for that number of hours. If you are not covered by a Collective Bargaining Agreement (i.e., a Non-Affiliated Employee), the Employer Contracts Department of the Plan can tell you the hourly requirements for you to be eligible under the Plan.

QUALIFYING PERIODS	ELIGIBILITY PERIODS
Work 400 Or More Hours During This Period	**Active Health Plan Benefits During This Period**
07/22/18 - 01/26/19	04/01/19 - 09/30/19
08/26/18 - 02/23/19	05/01/19 - 10/31/19
09/23/18 - 03/23/19	06/01/19 - 11/30/19
10/21/18 - 04/20/19	07/01/19 - 12/31/19
11/25/18 - 05/25/19	08/01/19 - 01/31/20
12/23/18 - 06/22/19	09/01/19 - 02/29/20
01/27/19 - 07/20/19	10/01/19 - 03/31/20
02/24/19 - 08/24/19	11/01/19 - 04/30/20
03/24/19 - 09/21/19	12/01/19 - 05/31/20
04/21/19 - 10/26/19	01/01/20 - 06/30/20
05/26/19 - 11/23/19	02/01/20 - 07/31/20
06/23/19 - 12/21/19	03/01/20 - 08/31/20
07/21/19 - 01/25/20	04/01/20 - 09/30/20

INITIAL ELIGIBILITY

The commencement of eligibility for a six-month Benefit Period is determined on a monthly basis. If you have never been eligible before, or have not been eligible for benefits in any of the five (or more) prior consecutive Eligibility Periods, you may only become eligible for benefits under one of the following circumstances:

1. After you have worked a minimum of 600 hours in a Qualifying Period; or
2. After you have earned a combined total of at least 600 hours in two consecutive Qualifying Periods.

Your benefits will start at the beginning of the Eligibility Period that follows; after that, your eligibility will only be reviewed when your benefits are set to expire.

Example:

If you began work on December 4, 2018 and reach 600 hours by April 14, 2019, then you would have satisfied the 600 hour requirement for the Qualifying Period of October 21, 2018 through April 20, 2019 and would be eligible for coverage for the Eligibility Period of July 1, 2019 through December 31, 2019.

Note:

Excess hours earned for Initial Eligibility are not credited to your Bank of Hours.

ELIGIBILITY NOTIFICATION

When you become eligible, the Plan will mail you information and materials about your participation. If you are initially eligible, the Plan will contact your Employer(s) and/or Union to obtain your mailing address; however, you may send the Plan your contact information in advance by submitting a Change of Address form. This form is available online at www.mpiphp.org.

CONTINUING ELIGIBILITY

Once you have met the requirements for Initial Eligibility, you will be eligible for benefits in each subsequent six-month Eligibility Period provided you work, or are on a weekly guarantee for, at least the minimum number of hours required to maintain your health benefits eligibility (400 hours). Once you qualify, your eligibility will only be reviewed when your benefits are set to expire.

Example:

If you earn 600 hours during the six consecutive Plan Months ending on November 24, 2018, you will be eligible for the six-month Eligibility Period from February 1, 2019 through July 31, 2019.

In order to be eligible for the next Eligibility Period, which would begin August 1, 2019, you would need to earn 400 hours (absent a recognized eligibility extension) during the Qualifying Period from November 25, 2018 through May 25, 2019.

If you do not qualify for the Eligibility Period commencing August 1, 2019, your eligibility will automatically be reviewed again for the Eligibility Period commencing September 1, 2019 to determine whether you are eligible based on hours earned during the Qualifying Period consisting of the six consecutive Plan Months ending on June 22, 2019.

If you believe there is any discrepancy between your hours worked and the hours reported on your statement of hours as shown on the Plan's website, you must first attempt to resolve the discrepancy with your Employer(s) before the Plan may assist.

Dependent Eligibility

ELIGIBLE DEPENDENTS

Your eligible Dependents are:

- Your lawful spouse;
- Any child required to be recognized under a Qualified Medical Child Support Order (QMCSO); and
- Your children (including your biological children, legally adopted children, children placed with you for adoption, stepchildren, foster children, and/or any child for whom you, the Participant, are the legal guardian), such that:
  - Your children are eligible for medical and prescription drug coverage until they reach the age of 26.
  - Your unmarried children are eligible for dental and vision coverage until they reach the age of 19 (or 23, if a full-time student).

Application must be made by the Participant to determine eligibility for all Dependent family members. Birth certificates, marriage certificates, spousal Coordination of Benefits forms and/or other forms of documentation (e.g., divorce/custody documents) are required to make this determination.

Required premiums must be paid timely in order for eligible Dependents to receive coverage through the Plan.

It is extremely important that you are aware of how coverage for your spouse is affected by primary and secondary insurance requirements. See pages 36 through 40 for additional information regarding spouse Coordination of Benefits.

DIVORCE NOTIFICATION REQUIREMENTS

You must notify the Plan's Eligibility Department immediately in the event of a divorce and submit a copy of the final decree of divorce.

A divorced spouse is not eligible for Plan benefits. He or she becomes ineligible for benefits at the end of the month in which the date of the final decree of dissolution of marriage or divorce is entered. However, the divorced spouse may elect continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as described on page 26.

Note:

If you fail to notify the Plan's Eligibility Department of a change in your marital status, and the Plan pays a Claim for your former spouse for services rendered after the end of the month in which the divorce occurred, you will be held personally liable for reimbursement to the Plan for benefits paid, as well as any additional expenses, including attorneys' fees and costs incurred by the Plan as a result of your statements, actions or failure to notify the Plan. The amount of any such Overpayment may be deducted from the benefits to which you would otherwise be entitled.

Participant Extension of Eligibility

BANK OF HOURS

When you first become eligible, hours in excess of 600 earned for Initial Eligibility are not credited to the Bank of Hours.

For each Qualifying Period following Initial Eligibility, hours earned in excess of 400 will be credited to your Bank of Hours, up to a maximum of 450 banked hours.

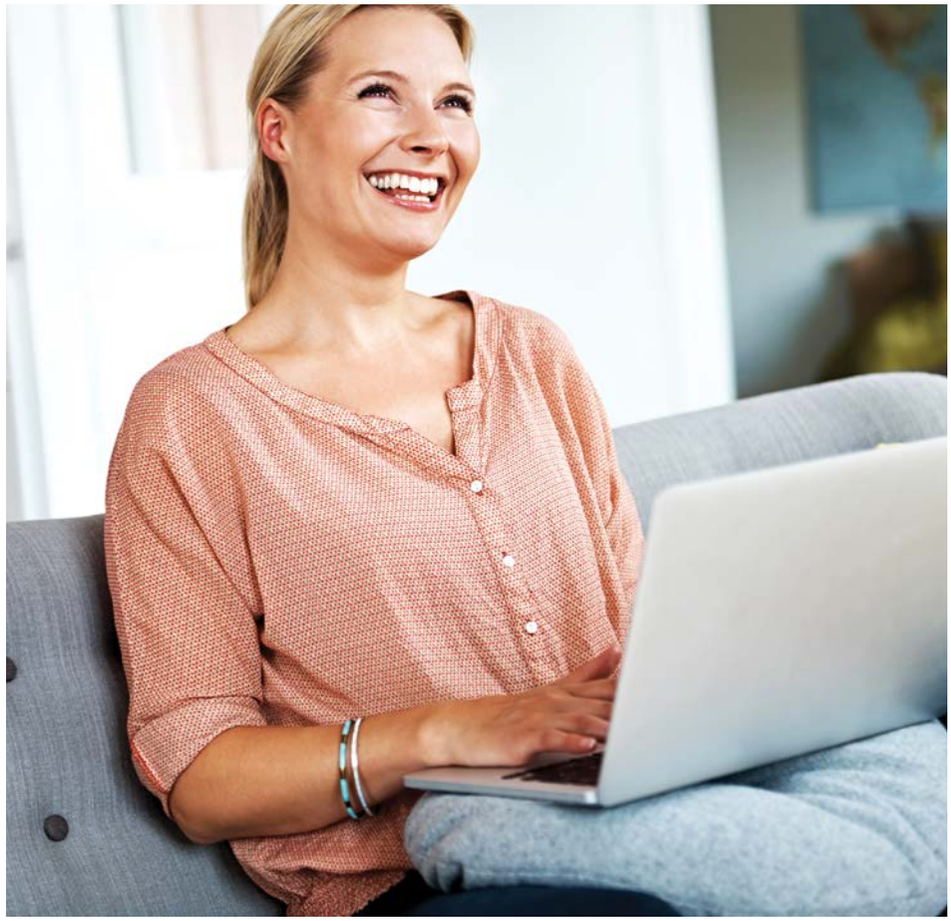
If hours earned in a subsequent Qualifying Period do not equal 400, the required number of hours from your bank needed to establish eligibility for the new Benefit Period will be automatically withdrawn. Any remaining hours will stay in your bank for subsequent eligibility. In each subsequent Qualifying Period, if the combination of hours worked and the Bank of Hours equals or exceeds the required amount, you will remain eligible.

However, if hours worked and your Bank of Hours do not equal the required amount, all remaining Bank of Hours will be canceled and you will have to re-qualify by working the required number of hours or more in one Qualifying Period.

If you do not qualify for five or more consecutive Eligibility Periods, you must meet the 600-hour requirement described under Initial Eligibility.

You will receive notice of the automatic use of your Bank of Hours. You cannot apply the Bank of Hours to (or save the hours for) a future Eligibility Period.

The Bank of Hours provision does not apply to Initial Eligibility or if you have not been eligible for benefits in any of the five prior consecutive Eligibility Periods.



DISABILITY EXTENSIONS

There are three types of disability extensions, as described below. The extensions cover Short-Term, Long-Term and Permanent Disabilities, and each extension has different qualifications and benefits. If you do not qualify for one extension, you may still qualify for one or both of the other extensions.

SHORT-TERM DISABILITY – 6 MONTHS EXTENSION

If you lost Eligibility because you were unable to work due to an illness or injury requiring a Physician's care, your disability may still be counted as work time. Eight hours for each weekday in the Qualifying Period (excluding holidays and weekends) for which you were paid disability benefits (or would have been paid such benefits if you resided in California) will be credited to the actual dates for which you received payment. These disability hours are added to any credited work hours (not to your Bank of Hours) for the Qualifying Period. If the total is 400 hours or more, your eligibility will be extended for the new Benefit Period with full benefits.

Qualification Requirements

In order to qualify for a Short-Term Disability extension, your disability must meet all of the following requirements:

- Your disability must be properly certified by a Physician.

- The onset of your disability must occur within 180 days of your last reported hours to the Plan.
- The onset of your disability must occur while you are eligible for Plan benefits based on active work hours and/or your Bank of Hours.
- If there is a break in your period of disability, only days during the second period of disability (for the same disability) will be counted as hours worked and the commencement of the second period of disability must occur within 180 days of your last reported hours.
- Your disability must last for at least seven days.
- You must have a minimum of 400 hours (this can be a combination of disability hours and hours worked) during the Qualifying Period in which you failed to work the minimum hours.
- If the state in which you reside maintains a state disability system, you must collect State Disability Insurance (SDI) benefits or provide other proof if there is no SDI in your state of residence.
- You must provide a copy of your determination letter from your state, awarding you state disability benefits, to the Plan Office within 60 days of the date of your award letter.

Note:

If you were not covered under the Plan during the period in which the onset of your disability occurred, you cannot use your disability hours to requalify for health coverage.

You may not have two successive Short-Term Disability extensions, nor may you have two Short-Term Disability extensions for the same disability claim. You may not combine hours in the Bank of Hours with disability; they are two separate extensions and each has its own set of rules. Excess disability hours are not credited to the Bank of Hours.

Any Short-Term Disability extension granted after your initial qualifying event will reduce your COBRA period by six months for each such extension.

How to Apply for a Short-Term Disability Extension

At the time you are sent a Notice of Ineligibility, it will be necessary for you to submit copies of all check stubs included with the disability checks sent to you by the California Employment Development Department or the applicable state agency if you do not reside in California. A payment history from the department regarding the period of disability will suffice.

If your disability was work-related, you may submit a statement from the Workers' Compensation carrier regarding the period of disability.

LONG-TERM DISABILITY - UP TO 18 MONTHS EXTENSION

If you lose your eligibility for benefits and are totally disabled (you are unable to work at your normal occupation or perform similar job functions at the time eligibility is terminated), you may remain eligible for medical and prescription benefits under the Motion Picture Industry Health Plan/ Anthem Blue Cross plan. Hospital benefits are not included in this extension, nor are vision, dental or life insurance benefits.

Your Dependents are not covered under this extension. However, they can continue their medical/hospital, prescription, vision and dental coverage under COBRA.

How to Apply for a Long-Term Disability Extension

At the time you are sent a Notice of Ineligibility, or when your Short-Term Disability extension expires, you will be advised of your option to apply for a Long-Term Disability extension. Proof of disability will be required, and the Plan will advise you as to what documents are needed to certify your disability. These documents must then be reviewed and authorized by the Plan's Chief Medical Officer before this extension may be granted.

A Long-Term Disability extension applies during continuous disability for a maximum of 18 months. If you have a Short-Term Disability extension in the prior six-month period(s), the Long-Term Disability extension will decrease by six months for each extension.

In order to be covered under this Long-Term Disability extension, you must be enrolled in the Motion Picture Industry Health Plan/Anthem Blue Cross plan. If you are not enrolled in that plan, you will be allowed to change your enrollment when the Long-Term Disability extension begins.

This extension will not apply at such time that you become covered under another group plan to which an Employer makes a contribution.

If you are granted a Long-Term Disability extension, you are not eligible for COBRA at the conclusion of the extension. During the initial 60-day COBRA election period, you may instead choose to elect COBRA.

PERMANENT DISABILITY EXTENSION – RETIREMENT

If you retire under the Disability Retirement Pension Benefit requirements of the Motion Picture Industry Pension Plan ("Pension Plan"), you will be entitled to Retiree health benefits effective on the date of your retirement certification, regardless of age, if you meet the requirements as described below.

You have a minimum of ten Qualified Years and 10,000 Hours for which contributions have been paid to the Motion Picture Industry Health Plan for Retired Participants, are totally and permanently disabled at the time of your retirement, are not on a Break in Service, and:

1. You are eligible to retire and have retired under the Disability Retirement Pension Benefit provisions of the Pension Plan;
2. You meet the requirements for a Disability Retirement Pension Benefit, but are not entitled to a Social Security Disability Award only because you are over-age. You will be entitled to benefits through the Motion Picture Industry Health Plan for Retired Participants effective on the date of your certification as being totally and permanently disabled by the Plan's Chief Medical Officer; or
3. You meet all of the requirements for such a Disability Retirement Pension Benefit but are not a Participant in the Pension Plan.

COMBINING EXTENSIONS

Short-Term Disability and Bank of Hours

- If you qualify for both a Short-Term Disability extension and a Bank of Hours extension, the Short-Term Disability extension will be granted first, and your Bank of Hours will be held over for future use.
- If you qualify for a Short-Term Disability extension and do not qualify for a Bank of Hours extension, you will be granted the Short-Term Disability extension, and any hours you may have in your bank will be canceled.

Short-Term Disability and Long-Term Disability

- If you do not qualify for a Bank of Hours extension, when the Short-Term extension ends, you may apply for a Long-Term Disability extension for an additional 12 months.

FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act of 1993 (FMLA) provides that most Employers must continue to provide health insurance to eligible Employees during a qualifying family or medical leave as though he or she had been continuously employed.

If you fail to work at least 400 hours in a Qualifying Period due to a family or medical leave covered by FMLA, your leave time, up to 12 work weeks during any 12-month period, may be considered work time for the purpose of maintaining your health benefits if all of the following conditions are met:

1. You were working for a participating Employer covered by FMLA (one which employed 50 or more people for at least 20 calendar weeks during the current or preceding calendar year) at the time of your leave.
2. You were employed by that Employer for at least 1,250 hours of service during the 12 months

immediately preceding your leave. Any time spent on USERRA covered military leave shall also count toward this 1,250-hour requirement. See pages 31, 32 and 34 for information on USERRA.

3. You were employed by that Employer for a total of at least 12 months (not necessarily consecutive) before the commencement of your leave.
4. You were employed at a work site where 50 or more Employees worked within a 75 mile radius at the time you requested your leave.
5. During the Qualifying Period, you took an Employer-approved family leave for the birth of your child or for the placement with you of a child for adoption or foster care, and the leave was not taken on an intermittent or reduced schedule and was taken within one year of the event; or you took a family leave for the care of your parent, spouse or child with a serious health condition; or you took a medical leave for your own serious health condition which rendered you unable to perform your job.
6. You returned to your job after the leave, or, if you did not return, it was due to a continuation, recurrence or onset of a serious health condition or for certain other reasons beyond your control.
7. The Bank of Hours, Short-Term Disability, and Long-Term Disability extensions have been exhausted or do not apply.

If all of the conditions previously stated are met, your Employer will be required to make contributions

on your behalf, and you will be credited with hours for the period of the leave as though you had been continuously employed during the leave. However, your FMLA leave cannot last longer than your employment would have lasted had you stayed on the job.

Example:

If your job was eliminated while you were out on leave (due to the completion of the motion picture or for other reasons), you would only be credited with the hours which you would have worked prior to the job elimination.

Hours reported pursuant to an FMLA leave will be considered in your Bank of Hours calculation. In order to be considered for this crediting of hours under the FMLA, you must notify the Plan's Eligibility Department of the fact that you lost hours due to a qualifying family leave at the time that you receive a Notice of Ineligibility sent to you by the Plan's Eligibility Department. You should notify the Plan Office by returning the Notice of Ineligibility to the Eligibility Department after completing the section of that form that refers to the FMLA leave. In addition, if your FMLA leave was due to a serious health condition as previously described, you must provide certification from a health care provider. Leave under the California Family Rights Act (CFRA) and any other state law will run concurrently with FMLA leave whenever legally permitted.

Note:

If it is determined that FMLA hours have been reported improperly on your behalf for the purpose of obtaining benefits to which you would not otherwise be entitled, your eligibility may be terminated, and you may be held liable for any benefits paid, as well as for other damages.

Your FMLA rights are subject to change. Coverage will be provided as required by law. If the law changes, your rights will change accordingly. For further information regarding FMLA, please contact your Employer.

If a leave for your own serious health condition does not qualify under the FMLA, you may still be able to extend your eligibility under the Short-Term Disability and Long-Term Disability provisions if you were disabled.

- **Disability Extensions:**

TYPE	SHORT-TERM	LONG-TERM	PERMANENT (10/10/DISABILITY)
Definition	Unable to work because of illness or injury requiring a physician's care.	Unable to work at normal occupation or perform similar job functions.	Totally and permanently disabled.
Length of Extension	Six months	Maximum 18 months, but reduced by a Short-Term Disability extension.	Lifetime
Effective Date of Disability	The onset of disability must occur within 180 days of last reported hours.	Disability must exist at the time eligibility terminated.	Must be disabled at the time of retirement.
Qualifications	▸ Onset of disability must occur while eligible for Plan benefits. ▸ Must collect SDI benefits or provide other proof if there is no SDI in your state. ▸ Documentation must be provided within 60 days of the date of award letter. ▸ Granted eight hours for each weekday (excluding holidays and weekends) of paid SDI. ▸ Benefits, applied to actual dates of disability, can be combined with work hours to equal 400. ▸ Cannot have two consecutive Short-Term Disability extensions. ▸ Cannot have more than one extension based on the same disability. ▸ If not eligible for Plan benefits, you cannot use disability hours to requalify.	▸ Proof of disability required. ▸ Certification from Plan's Chief Medical Officer. ▸ Not available to HMO or Oxford Participants, but Participants can change to the MPIHP/Anthem Blue Cross Plan.	▸ Ten Qualified Years & 10,000 Credited Hours, regardless of age. ▸ Retire under Pension Disability requirements. ▸ Social Security Award, or if over age, certification by Plan's Chief Medical Officer.
Benefits	Full benefits	Medical and prescription benefits only. Hospital benefits are not included in this extension, nor are vision, dental or life insurance benefits.	Full benefits
Dependent Coverage	Dependents are covered	Dependents are not covered but have the opportunity to elect COBRA.	Dependents are covered
COBRA	18 or 29 month COBRA period reduced by 6 months	No option to elect COBRA at conclusion of Long-Term Disability	N/A

Dependent Extensions of Eligibility

STUDENT ELIGIBILITY FOR DENTAL AND VISION COVERAGE

If your unmarried child is dependent upon you for primary support and is a full-time student in an accredited school or college, the child may remain eligible for dental and vision coverage until his or her 23rd birthday or graduation, whichever comes first. To be recognized by the Plan as such, a school or college attended must be fully-accredited (approved by the State Department of Education or recognized for veterans' training, and accredited with one of the regional associations granting accreditation to schools throughout the country).

If the school or college is based on a quarter system, the child must attend at least three quarters per year and carry a minimum of ten units per quarter. If the school or college is based on a semester system, the child must attend at least two semesters per year and carry a minimum of 12 units per semester.

If enrolled in a trade, technical or adult education school, the student must be in attendance 25 hours or more per week.

Students attending school to acquire a high-school diploma are required to attend classes 20 hours or more per week.

The student's eligibility for benefits will begin on the first of the month of the session in which the student is enrolled full-time and will cease as of the first of the month following graduation, or at any time the student withdraws from one or more classes prior to the close of a session, bringing the total number of units or hours carried to below full-time.

The Participant is required to supply the Plan Office with the withdrawal date. Students who complete the spring session and have not graduated yet will be covered through August following the spring session that was completed. In no event will eligibility for dental and vision benefits extend beyond the first of the month following the student's 23rd birthday.

Student eligibility for continued coverage is also subject to the Coordination of Benefits rules discussed on pages 36 through 40.

If a student has a physical injury or an illness that prevents him/her from attending school and this injury or illness is certified by a physician, coverage may be continued in six month intervals, not to exceed one year. Learning disabilities, behavioral problems, ADHD, substance abuse, etc., are not qualified reasons for extension of coverage.

REQUIRED DOCUMENTATION FOR STUDENT ELIGIBILITY FOR DENTAL AND VISION COVERAGE

At the beginning of each new session, a Full-Time Student Certification form or a schedule of classes showing the number of units or hours must be submitted to the Plan. If the student withdraws from school, the Participant is responsible for supplying the Plan with the withdrawal date as soon as possible.

To maintain uninterrupted eligibility for a student until age 23, it is the Participant's responsibility to have the student supply the Plan's Eligibility Department with required documentation as described herein. Failure to comply with this requirement will result in the Denial of Claims submitted and a request for reimbursement of Claims paid on behalf of the child. No additional requests for documentation will be forthcoming from the Plan Office.

A Dependent child who ceases to meet the Plan's definition of Dependent may continue coverage by self-payment through COBRA.

DISABILITY OR PHYSICALLY INCAPACITATED DEPENDENTS

Eligible Dependent children whose coverage would otherwise terminate due to attainment of limiting age will continue to be considered eligible Dependents if they have a disability or physical incapacity (for example, cerebral palsy, physical or mental handicap, autism, bipolar disorder) and because of that disability or physical incapacity are incapable of self-sustaining employment and independent care and maintenance, regardless of whether they marry or live separately from you, as long as he or she remain dependent primarily upon you for support and maintenance.

This provision will only apply if the Plan is provided with written evidence of such incapacity by the later of:

1. The 31st day after attainment of the limiting age, or
2. The 31st day after the Participant is notified of the ineligibility of the Dependent.

Children who reach age 26 prior to the Participant's Initial Eligibility for the benefits of the Plan are not entitled to coverage under this provision.

The status and condition of the Dependent may need to be certified periodically by an attending physician. An attending physician is required to complete the Plan's Attending Physician Statement form. This statement from the attending physician must include the diagnosis, the date of the commencement of the disability or physical incapacity and the expected date of recovery. Proof of the continued existence of such incapacity must be furnished to the Plan Office periodically.

The provisions regarding Coordination of Benefits, including Medicare and Medicaid, will apply to your Dependent. Please carefully read the Coordination of Benefits section of your *SPD*.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Pursuant to federal law, the Plan is obligated to honor the terms of a Qualified Medical Child Support Order (QMCSO) which may provide for continued health care coverage for your child/children.

A QMCSO is an order, decree, judgment, or administrative notice (including a settlement agreement) issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, which meets the requirements of Section 609 of ERISA.

SURVIVING SPOUSE ELIGIBILITY

Subject to the Coordination of Benefits rules discussed on pages 36 through 40, coverage is provided for the Participant's eligible surviving Spouse if the Participant has not yet retired, but has qualified for Retiree health benefits. If you have been married for at least two years and you are at least age 62 at the time of your death, your surviving Spouse will continue to be eligible for his/her lifetime, or until "remarriage."

If you have not yet retired, but have qualified for Retiree health benefits, you have been married and covered under the Plan for at least two years, and you die prior to reaching age 62, your eligible surviving Spouse will receive one year of extended coverage for each Qualified Year that you have earned, or until "remarriage" occurs.

If you have been married for less than two years at the time of your death or have not qualified for Retiree health benefits, the Plan will extend coverage for your eligible surviving Spouse for a period of six-months, without cost. At the end of this extended coverage, your Spouse may purchase continuation coverage through COBRA.

SURVIVING DEPENDENT CHILDREN ELIGIBILITY

Subject to the Coordination of Benefit rules discussed on pages 36 through 40, if you have qualified for Retiree health benefits, any eligible children you have at the time of your death will continue to have coverage through the Plan until such time as they cease to qualify by reason of age or loss of full-time student status.

Participant & Dependent Ineligibility

WHEN COVERAGE ENDS

Your coverage will end on the earliest of the following:

1. You lose eligibility under the Plan due to failure to work enough Qualified Hours or failure to qualify for any of the extensions;
2. The Plan is terminated; *or*
3. You fail to pay any required Premium.

Coverage for your Dependent(s) will end on the earliest of the following:

1. The date you, the Participant, loses coverage;
2. The date the Dependent fails to meet the eligibility requirements under the Plan;
3. In the case of a child covered pursuant to a QMCSO, the date that the child is no longer covered by the QMCSO; *or*
4. For unpaid Premiums, the date your Premium payment was due.

NOTICE OF INELIGIBILITY

After the close of each Qualifying Period, all eligible Participants who did not meet the minimum requirement of 400 hours will be sent a Notice of Ineligibility, along with applicable information relevant to extended coverage. These notices are mailed to the permanent address of record approximately six weeks prior to the loss of eligibility.

Notices of Ineligibility are intended to assist you in maintaining your benefits, but the Plan cannot guarantee their delivery. If your own work records show that you may not have worked the minimum required hours during a Qualifying Period, and you do not receive a Notice of Ineligibility, you should contact the Plan Office at once.

PARTICIPANT REQUALIFYING FOR HEALTH COVERAGE AFTER A LAPSE

A Participant may requalify for health coverage through the Plan after a lapse under the following conditions:

1. If less than 30 months of ineligibility have passed, only 400 hours in a Qualifying Period are required.
2. If 30 or more months of ineligibility have passed, 600 hours in one or two consecutive Qualifying Periods are required.

Once a Participant meets the aforementioned eligibility criteria, an enrollment packet will be mailed to him or her six weeks prior to his or her effective date. If a Participant was previously enrolled in an HMO or POS plan, he or she must complete and submit a new Benefit Selection form. Documentation establishing Dependent status will not be required if previously submitted; however, documentation establishing Dependent status will be required for any new Dependents added.

Enrollment – General Information

OPEN ENROLLMENT

The Plan's Open Enrollment period generally occurs during the month of July each year for enrollment effective August 1. During Open Enrollment, you may change your medical/hospital and/or dental coverage.

Note:

Enrollment in the Motion Picture Industry Health Plan/Anthem Blue Cross (MPIHP/Anthem Blue Cross) Plan and the Delta Dental PPO Dental Plan is open all year.

HIPAA SPECIAL ENROLLMENT

If you decline enrollment for yourself or your Dependents, including your spouse, because of other group health coverage and you later lose that other group health coverage, you may be able to enroll yourself or your Dependents in the Plan.

Your loss of other group health coverage qualifies for Health Insurance Portability and Accountability Act of 1996 (HIPAA) special enrollment treatment only if you satisfy both of the following conditions:

- You or your Dependent(s) were covered under another group health plan or health insurance coverage when coverage under the Plan was originally offered to you; and
- You or your Dependent(s) lost your other coverage either because you exhausted your rights to COBRA, you no longer were eligible under that plan, or the Employer stopped contributing toward you or your Dependents' other coverage.

Note:

Loss of coverage does not include a loss due to a failure to pay Premiums on a timely basis or termination of coverage for cause. You must enroll yourself and/or your Dependent(s) within 31 days after the termination of the other coverage.

If you gain a Dependent as a result of marriage, birth, adoption or the commencement of your legal obligation to provide support for a child in anticipation of adoption, you may be able to enroll yourself and your new Dependent if you provide notice and proper documentation and any applicable premium payment to the Plan within 31 days of the applicable event. Coverage will be effective as of the date of the birth or placement

for adoption. Coverage for new spouses will be effective as of the date of the marriage. If you lose other coverage and enroll in the Plan, coverage will be effective retroactive to the date of the birth, adoption, or marriage, whichever is applicable, unless the Participant is ineligible on those dates. If you choose to enroll a Dependent more than 31 days after a qualifying life event, see Adding/Removing Dependents on pages 24 and 25.

In addition, if you have declined coverage for yourself or a Dependent, you will be entitled to enroll yourself or the Dependent in the Plan under the following circumstances:

- Either you or your Dependent is covered under a Medicaid plan or a state child health plan, and coverage for yourself or your Dependent is terminated under that plan as a result of loss of eligibility for coverage, and you request coverage under the Plan within 60 days after the date of that termination.
- If you or your Dependent is determined to be eligible for Premium assistance under Medicaid or the Children's Health Insurance Program (CHIP), as well as eligible under the Plan, you may enroll your Dependent(s) in the Plan if they are not already enrolled.

REQUIRED DEPENDENT DOCUMENTATION FOR ENROLLMENT

In addition to completion of the Beneficiary/Enrollment form, application must be made to the Plan's Eligibility Department to determine eligibility for coverage of all Dependent family members. Copies of birth certificates, marriage certificates, spousal Coordination of Benefits forms (see pages 36 through 40 for additional information) and/or other forms of documentation (e.g., divorce/custody documents) are required to make this determination. It is important that both the Motion Picture Industry Health Plan and Pension Plan are notified of any changes made by the completion of new Beneficiary/Enrollment forms and the submission of required documentation. If your Dependent(s) or beneficiary(ies) change, contact the Plan's Eligibility Department immediately, and you will be sent blank forms to make changes. These forms are also available at www.mpiphp.org.

Note:

Revised Beneficiary/Enrollment forms received on behalf of a deceased Participant will not be accepted.

CHANGE OF ADDRESS

It is very important that you keep the Plan aware of your current address. If you change your address, please notify the Plan's Eligibility Department by using the Change of Address form that can be obtained from the Participant Services Center or the Plan's website. However, please be aware that if you provide change of address information on the Beneficiary Enrollment form or the Benefit Selection form, and you are a Participant in the Motion Picture Industry Pension Plan, you will be providing that change of address information to both the Plan and the Pension Plan, and the records of both plans will be updated to reflect your new address.

If your Dependent(s) have a different address than you, you must notify the Plan as soon as possible by using the Change of Address form. Always let the Plan know when your Dependent(s) have other insurance coverage as the Plan will need that information to determine the order of benefits.

The Social Security Number or Participant Identification Number and signature of the Participant are required on all address changes. For your protection, address changes will not be taken over the telephone.

SELECTION FORM

Upon qualification for Initial Eligibility, you will be sent a selection form to enroll in your choice of medical/hospital and dental plans. If you return the selection form without selecting medical/hospital and dental plans you will be automatically enrolled in the MPIHP/Anthem Blue Cross plan and the Delta Dental PPO plan. Selection forms are also available upon request and at www.mpiphp.org during the Open Enrollment period in July of each year. If you do not return this form by the deadline, you will remain in your previously selected medical/hospital and dental plans.

EXTENSION FORM

Extensions of eligibility are not automatic unless using Bank of Hours. To be considered for an eligibility extension, you must return the extension form, along with any applicable documentation. If you qualify for an extension of eligibility as described previously, you will be sent a Notice of Ineligibility along with information relevant to extending your coverage.

Enrollment – The Process

Step 1

INITIAL ELIGIBILITY PACKET IS SENT TO YOU

Approximately six weeks prior to your eligibility effective date, the Plan will send you a packet containing an *SPD*, a selection form to enroll in your choice of medical/hospital and dental plans, and a Beneficiary/Enrollment form to enroll your Dependent(s) and designate the beneficiary(ies) of your life insurance.

In addition to the above, a statement of hours, indicating the work hours reported on your behalf, will be included in your packet. If you believe that there is any discrepancy between the hours you worked and the hours reported on your statement, you must first attempt to resolve the discrepancy with your Employer(s) before the Plan can take action.

Copies of birth certificates, marriage certificates, spousal Coordination of Benefits forms and/or other forms of documentation are required to enroll your Dependent(s).

No benefit identification cards can be provided and no Claims can be paid until you return all of your required enrollment documents to the Plan and pay any required Premiums.

Step 2

SELECT YOUR COVERAGE

Select a Medical Plan

When you first become eligible for benefits and return the Beneficiary/Enrollment form to the Plan Office, you will be enrolled and covered by MPIHP/Anthem Blue Cross.

You have the option to enroll in Health Net, Kaiser Permanente or the Oxford Health Plans ("Oxford"). If you decide to select Health Net, Kaiser Permanente, or Oxford, your coverage with that plan will be effective the first of the month following the receipt of your completed Beneficiary/Enrollment form. Until your HMO or POS coverage is effective, you will be covered by MPIHP/Anthem Blue Cross.

If you are already covered in Health Net, Kaiser Permanente, or Oxford through some other group or individual plan, you can be enrolled in that plan from the first month of your eligibility with the Plan. Your selected plan will remain the same until you select a different plan during Open Enrollment (July of each year).

Your life insurance, accidental death and dismemberment insurance, dental, vision care, and prescription drug benefits will not be affected by your choice of medical/hospital plan.

With the exception of hearing aids, the member assistance program and The Wellness Program, Participants enrolled in an HMO or POS plan are not eligible for any medical or hospital benefits other than those provided by the HMO or POS

▸ **Medical Plan Options:**

PROVIDER	TYPE OF PLAN	LOCATION OF AVAILABILITY
Motion Picture Industry Health Plan / Anthem Blue Cross	PPO	Throughout the United States and the rest of the world
Health Net	HMO	California Only
Kaiser Permanente	HMO	California Only
Oxford Health Plans	POS	New York, New Jersey & Connecticut

selected by the Participant.

The Board of Directors makes no recommendation of the plans, but make them available so that you may select the plan most suited to your needs.

Select a Dental Plan

When you first become eligible for benefits and return the Beneficiary/Enrollment form to the Plan Office, you will be enrolled and covered by the Delta Dental PPO Dental Plan. If you choose to select the prepaid dental plan, DeltaCare USA, your coverage with that plan will be effective the first of the month following the receipt of your completed enrollment form. Until your prepaid dental coverage is effective, you will be covered by the Delta Dental PPO dental plan. DeltaCare USA is only available in California.

Your selected plan will remain the same unless you select a different plan during Open Enrollment.

Other Coverage You Receive – No Selection Required

When you first become eligible for benefits and return the Beneficiary/Enrollment form to the Plan Office, you will automatically be enrolled in prescription, vision and life insurance coverage. No selection is required. Benefits will not commence and claims will not be paid until your Beneficiary/Enrollment form is received by the Plan Office.

QUICK TIP

WANT TO LEARN MORE ABOUT THE MEDICAL PLANS WE OFFER?

See page 51

Step 3

RECEIVE BENEFIT I.D. CARDS

Medical – MPIHP/Anthem Blue Cross

If you select MPIHP/Anthem Blue Cross, then Anthem Blue Cross will send you a benefit identification card for you and any eligible Dependent(s).

If you need additional cards, please email the Plan's Participant Services Center at service@mpiphp.org, or call toll-fee to (855) 275-4674, from 6 a.m. to 7 p.m. PST, Monday through Friday.

Medical – Health Net, Kaiser Permanente & Oxford Health Plans

If you select an alternate plan, your medical/hospital benefit cards will be issued directly by that plan. Your prescription drug benefit cards will be sent to you by the Plan Office. If you need additional cards, please call:

- **Health Net**
  (800) 522-0088
- **Kaiser Permanente**
  (800) 464-4000
- **Oxford Health Plans**
  (800) 444-6222

Dental

Dental information is provided on the identification cards issued by the Plan Office.

Other Benefits

You will not receive identification cards for the other benefits for which you are enrolled. To use these other benefits, you should refer to your medical identification card and/or use your Social Security Number.

Employer Contributions

CONTRIBUTIONS

Contributions on a Participant's behalf can be accepted by the Plan only when their Employer has submitted all required documents to the Plan Office and they have been approved for participation as an Employer Party by the Plan's Board of Directors.

The Plan recommends that a Participant maintain his or her check stubs, deal memos, etc. in case any questions arise as to the number of hours an Employer has reported on his or her behalf.

If you are not sure whether you are a covered Employee or whether your Employer has been approved for participation in the Plan, contact the Plan and ask to be directed to the Employer Contracts Department.

If you believe there is a discrepancy between the hours you worked or were guaranteed and the hours in the Plan records, it is your responsibility to contact your Employer first for resolution, and if necessary, your Union for assistance. If you cannot resolve the situation with your Employer or Union, contact the Plan and ask to be directed to the Audit and Collections Department.

WORK HOURS

Work Hours are a Participant's hours worked or guaranteed, including hours worked at overtime rates. Contributions for on-call, weekly on-call, and salaried Employees are credited as outlined in the Trust Agreement or the Collective Bargaining Agreement under which he or she is employed, whichever is applicable.

For Employees working under the IATSE Basic Agreement, or any agreement which calls for these same guarantees, the on-call weekly schedule is considered to be a guarantee of the following:

- 12 hours per day during any partial workweek
- 60 hours during any five day workweek
- 72 hours during any six days worked during a given workweek
- 84 hours during any seven days worked during a given workweek

Note:

Contributions for "on-call" Employees for the sixth day not worked on distant location will be based on seven hours and the number of hours for contributions for the seventh day not worked on distant location shall be based on eight hours.

If you work on an hourly or weekly basis, your Union or Guild can tell you the formula used to determine your work hours.

If you are not covered by a Collective Bargaining Agreement (i.e., a Non-Affiliated Employee), the Plan's Employer Contracts Department can tell you the hourly contribution requirements for you to be eligible under the Plan.

DELINQUENT CONTRIBUTIONS

If an Employer has been delinquent in making contributions and has been terminated as an Employer Party to the Plan, no credit will be given for employment after the effective date of the termination.

DELINQUENT CONTROLLED EMPLOYERS

If you are a member (i.e., owner) or officer of an LLC, or an officer or shareholder of a signatory Employer, or the spouse of such member, officer or shareholder (referred to herein as a "Controlling Employee"), and the Employer becomes delinquent in the contributions due to the Plan on your own behalf or

on behalf of any other Employee, your eligibility for benefits may be suspended until such time as the delinquency is resolved. This is the case whether the eligibility is based upon contributions from your own signatory corporation, any other Employer, or based on any extension of eligibility.

If the delinquency is not paid in full or resolved prior to the date on which the Final Notice of delinquency is sent by the Plan, then the eligibility of all Controlling Employees of the Employer shall be delayed during the next Benefit Period. Specifically, eligibility is delayed by one month for each four weeks (or portion thereof) of delinquency during the applicable Qualifying Period, with a minimum of one month of delayed eligibility if a Final Notice is sent.

LOAN-OUT COMPANIES

A Loan-Out Company is defined as a company controlled by the loaned-out Employee who is the only Employee of that company who performs work covered by the applicable Collective Bargaining Agreements. A Loan-Out Company is not allowed to contribute directly to the Plan, regardless of the type of Collective Bargaining Agreement to which it is signatory. If a Loan-Out Company loans out the services of the Controlling Employee to a borrowing Employer which is a participating Employer, the borrowing Employer shall make contributions directly to the Plan on behalf of the loaned-out Employee based upon hours worked or guaranteed.

IMPROPERLY REPORTED HOURS

If it is determined that hours have been reported improperly on your behalf, your eligibility may be terminated, and you may be held liable for any benefits paid, as well as for other damages. In most cases you will receive 30-days advance notice before your coverage is terminated. However, your coverage may be terminated retroactively if there is fraud or intentional misrepresentation or in the case of certain administrative delays in recordkeeping.

RETROACTIVE COVERAGE DUE TO LATE REPORTED HOURS

Hours you work during a Qualifying Period must be reported to the Plan by your Employer in time for the Plan to process the hours and calculate your eligibility for the corresponding Eligibility Period. Late Hours are hours submitted by an Employer after the calculation process has been completed or closed. All hours, including late hours, are credited to the dates on which they were worked, which may result in retroactive eligibility. If late hours change your eligibility status, the Eligibility Department will notify you and, as a result, your eligibility will be retroactive from the start of the corresponding Eligibility Period. If your eligibility is established retroactively, you may submit any medical Claims you have incurred in the corresponding Eligibility Period to the Claims Department for consideration.

GRIEVANCE SETTLEMENT

Following the settlement of a grievance or arbitration award, contributions received on behalf of an individual who was a Participant in the grievance or arbitration shall be credited to that individual from the date the individual was terminated, denied employment, or underpaid if consistent with the resolution of the grievance or arbitration award. The credit will extend from that date until the contributions have all been applied, based upon the standard number of hours that have been worked by, or guaranteed to the individual.

Participant Contributions

PREMIUMS

Some Participants are required to pay quarterly premiums in order to receive their own health coverage. All Participants with Dependents are required to pay applicable premiums.

There are two premium rate groups that Participants fall under; these rate groups are determined in accordance with the Collective Bargaining Agreement of the Employer that is reporting hours to the Plan.

PREMIUM RATE GROUP 1

This rate group applies to eligible Participants who elect to receive Plan health coverage for one or more of their Dependents and have $0.305 per hour of their Motion Picture Industry Individual Account Plan (IAP) contribution re-allocated to the Plan.

Participant-Only Premium

For Participants with no Dependents, there is no monthly premium.

Participant Plus Dependent(s) Premium

For Participants with one Dependent, the Premium is $25 per month, paid quarterly, semi-annually or annually.

For Participants with two or more Dependents, the Premium is $50 per month, paid quarterly, semi-annually or annually.

Single monthly payments will not be accepted.

PREMIUM RATE GROUP 2

This rate group applies to eligible Plan Participants who do not have $0.305 per hour of their IAP contribution re-allocated to the Plan or who do not participate in the IAP.

Participant-Only Premium

For Participants with no Dependents, the Premium is $21 per month, paid quarterly, semi-annually, or annually.

Single monthly payments will not be accepted.

Participant Plus Dependent(s) Premium

For Participants with one Dependent, the Premium is $44 per month, paid quarterly, semi-annually or annually.

For Participants with two or more Dependents, the Premium is $68 per month, paid quarterly, semi-annually or annually.

Single monthly payments will not be accepted.

PREMIUM NOTIFICATION

Participants will receive a Premium Notice up to 60 days prior to each Eligibility Period. The Premium Notice will include the Eligibility Period, Total Amount Due for the Eligibility Period, the Participant's Minimum Payment Amount, payment options and Payment Due Date.

The Premium Notice will also list any eligible Dependent(s) on file for the Participant. The Premium amount will correspond to the number of eligible Dependents listed on the statement. However, if the Participant prefers not to cover their Dependent(s), he or she may complete and return the Dependent Removal section from the payment coupon and the removal will be effective for the quarter billed on the Premium Notice. Alternatively, a Participant may submit a signed and dated written request to remove Dependents and removal will be effective the first of the following month.

FUTURE PREMIUM

Notices will include only enrolled Dependent(s).

Premium Notices are available on the Plan website at www.mpiphp.org by clicking on the"Pay Premium" link and logging in to the Participant's Portal account.

PAYMENT OPTIONS

The Plan offers flexible payment options for Plan Premiums.

Frequency

Participants may pay in quarterly installments using the Minimum Payment Amount, pay the Total Amount Due for the entire six-month Eligibility Period, or prepay annually.

Please note that making an annual payment does not guarantee eligibility. Eligibility is determined by hours worked during applicable Qualifying Periods.

Payment Type

Participants will be able to make Premium payments online, through the mail or in person using credit/debit cards that display the Visa or Mastercard logo, American Express cards, checks, PayPal, money orders and electronic bank account deductions. No cash or partial payments will be accepted.

PAYMENT DUE DATE

Premium payments are due on the day before the Eligibility Period begins. If a Participant chooses to make two quarterly payments, the

second payment will be due on the day before the second quarter of the Eligibility Period begins. A second Premium Notice will be sent approximately 30 days prior to the second quarterly Payment Due Date. Single monthly payments will not be accepted.

Example:

If a Participant's Eligibility Period is January through June, and he or she chooses to pay quarterly, his or her Payment Due Dates will be December 31st and March 31st.

PREMIUMS FOR DUAL COVERAGE

Participants who individually qualify for coverage through the Plan must each pay the applicable Dependent Premium in order to receive dual coverage (with the Plan being both primary and secondary coverage) for themselves and their eligible Dependent children and/or Spouse.

SUSPENSION PERIOD/ TERMINATION OF COVERAGE

Payments must be received by the Payment Due Date. If payment is not received by the Payment Due Date, coverage will be immediately suspended. If payment is received within the calendar month following the Payment Due Date, coverage will be reinstated retroactively to the first day of the Eligibility Period or the first day of the second quarter of the Eligibility Period, whichever is applicable. The Participant is responsible for re-submitting any Claims that occurred during the suspension. If payment is not received within the calendar month following the Payment Due Date, there will be a lapse in coverage.

An individual whose coverage is terminated due to non-payment of Premiums may not be re-enrolled until the beginning of his or her next Eligibility Period, unless the Participant and/or the Dependent is eligible for a Reinstatement of Coverage Exemption.

REINSTATEMENT OF COVERAGE EXEMPTION

Following termination of coverage due to non-payment of Premiums, the Plan will allow a Participant to reinstate his or her eligibility, or that of his or her Dependent(s), prior to the beginning of his or her next Eligibility Period a maximum of one time every three years. The Participant will be required to complete and sign a Reinstatement form and pay the Premium for the full month in which the request is made plus the Premiums for the remainder of the Eligibility Period. Coverage will not be retroactive. The effective date of coverage will be the date both the Reinstatement form and the payment of Premiums are received by the Plan.

Example:

If a Participant's or his or her Dependent's coverage is terminated on January 1, 2019 for non-payment and subsequently approved for reinstatement on March 15, 2019, the Participant would be required to pay the full monthly Premiums for March through June, and the Participant's or the Dependent's coverage would be effective as of March 15th.

ADDING/REMOVING DEPENDENTS

When a Participant enrolls a new Dependent child as a result of marriage, birth, adoption or the commencement of a legal obligation to provide support for a child in anticipation of adoption, coverage may be effective retroactively to the date of the birth, adoption or placement for adoption, whichever, is applicable. The Participant must be eligible at the time and submit all necessary enrollment documents within 30 days of the event. Also, the minimum Premium payment must be submitted by the due date stated on the Premium Notice.

Adding Dependents:

Never enrolled Spouses have the following options:

- **Enrollment retroactive to the marriage date:**
  Will occur if all enrollment documents and the minimum Premium payment are received by the Plan within 30 days of the date of the marriage.
- **Enrollment retroactive to the Participant's effective date:**
  Will occur if all enrollment documents and the minimum Premium payment are received by the Plan within 30 days of the first day of the original Eligibility effective date.
- **Enrollment effective as of the Premium payment receipt date:**
  Will occur if all enrollment documents and Premium payment are received outside of the initial 30-day period.
- **Enrollment effective the beginning of a six-month Eligibility Period:**
  Will occur if all enrollment documents, a written request signed by the Participant, and the minimum Premium payment are received by the Plan prior to the start of that Eligibility Period.

Spouses who have been eligible and enrolled, but failed to meet the Premium payment due date, have

the following options:

- **Enrollment will occur pursuant to the Reinstatement of Coverage Exemption:**
  Enrollment will start at the beginning of the next six-month Eligibility Period.

Children and Spouses who were eligible, but removed at the Participant's request have the following options:

- **Enrollment effective the date following the loss of other group coverage:**
  Will occur if a COBRA notice or other evidence of loss of coverage from the other insurance, and minimum Premium payment, are received by the Plan within 30 days of the loss of other group coverage.
- **Enrollment effective at the beginning of a six-month Eligibility Period:**
  Will occur if a written request signed by the Participant and the minimum Premium payment are received by the Plan prior to the start of that Eligibility Period.
- **Enrollment will occur pursuant to the Reinstatement of Coverage Exemption.**

Never enrolled children have the following options:

- **Enrollment effective on the child's date of birth:**
  Participants will be billed retroactive to the child's date of birth for any periods of eligibility. Any retroactive billing will only be for periods of time when the Participant was eligible for coverage.
- **Enrollment effective the date following the loss of other group coverage:**
  Will occur if the other evidence of loss of coverage or other acceptable documentation and minimum Premium payment are received by the Plan within 30 days of the loss of other group coverage.
- **Enrollment effective at the beginning of a six-month Eligibility Period:**
  Will occur if a written request signed by the Participant and the minimum Premium payment are received by the Plan prior to the start of that Eligibility Period.
- **Enrollment will occur pursuant to the Reinstatement of Coverage Exemption.**

Removing Dependents:

Participants have the option to remove a Dependent by:

- Returning the Premium Notice with the Dependent Removal section completed and signed by the Participant. The effective date of the removal of the Dependent will be the beginning of the Eligibility Period dated on the Premium Notice.
- Submitting a written request signed by the Participant. The effective date of the removal will be the first of the month following receipt by the Plan of the request.

If a Participant removes a Dependent during an Eligibility Period, he or she will receive a prorated refund for any whole month Premium that has previously been paid. If a Participant removes a Dependent, he or she may not re-enroll that Dependent until the following Eligibility Period, unless there is an event that qualifies the Dependent for enrollment in the Plan or the Participant is eligible for a Reinstatement of Coverage Exemption.

RETROACTIVE COVERAGE DUE TO LATE REPORTED HOURS

Participants awarded retroactive coverage due to late reported hours for any Eligibility Periods that include January 2013 or later may pay the Participant and/or Dependent(s) Premiums retroactively to receive the coverage in the associated Eligibility Period.

CREDIT/REFUNDS

If a Participant prepays Premiums using the annual payment option, but later fails to meet the eligibility requirements for a subsequent Eligibility Period, the funds will be held on account to be used to pay Premiums for a future Eligibility Period for up to two years. If the Participant has not re-qualified for coverage within that period, a refund check will be issued automatically. Participants who would prefer to have their prepaid Premiums refunded to them prior to the two years must request a refund by submitting a completed Request for Refund form. No interest will be paid on the refunded premiums.

COBRA

COBRA will not be offered to individuals who lose coverage due to non-payment of Premiums. Under COBRA regulations, loss of coverage due to failure to pay a Premium does not make the individual eligible for COBRA.

COBRA COSTS

If you lose health coverage due to a reduction in hours, you would need to pay the COBRA Premium rate for yourself and your eligible Dependent(s) for a period of time under the Plan's COBRA rules.

Self-Payment For Coverage

This section contains important information about your right to Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation of coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. This section generally explains COBRA, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA was created by federal law. COBRA can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and Dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. This section does not fully describe COBRA or other rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should review other provisions of this *SPD* or contact the Plan. The Plan provides no greater COBRA rights than what COBRA requires — nothing in this section is intended to expand your rights beyond COBRA's requirements.

WHAT IS COBRA COVERAGE?

COBRA is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying life event." Specific qualifying events are listed later in this section. After a qualifying event occurs and any required notice of that event is properly provided to the Plan Office, coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your Spouse, and your children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA.

WHO IS ENTITLED TO ELECT COBRA?

For Participants

COBRA is available to you if coverage would otherwise end because of either:

- Hours of employment are reduced so that you are no longer eligible to participate in the Plan
- Employment ends for any reason other than gross misconduct

For Spouse and Children

COBRA is available to an eligible Spouse and other Dependents if coverage would otherwise end because of any of the following:

- The Participant's hours are reduced so that you are no longer eligible to participate in the Plan.
- The Participant's employment ends for any reason other than gross misconduct.
- The Participant dies, divorces, or becomes entitled to Medicare.
- The child ceases to be eligible for Plan coverage. (For example, he or she reaches the maximum age limit.)

REQUIREMENTS FOR COBRA

The Plan Office is responsible for administering COBRA. In order to have the option to elect COBRA after a divorce or in the case of a child ceasing to be eligible under the Plan, you and/or a family member must notify the Plan Office promptly and in writing no later than 60 days after that event occurs or the date on which coverage would end as a result of that event, whichever is later. For divorced Spouses, the Plan requires a Final Divorce Decree within 60 days of the event.

- That notice should be sent to:

  Motion Picture Industry Health Plan
  Attn: Eligibility Department
  P.O. Box 1999
  Studio City, CA 91614-0999
  (855) 275-4674
  (818) 766-1229 - Fax
  service@mpiphp.org

The Plan Office will then send you information about COBRA.

Note:

Employers do not notify the Plan of these events.

If there is a divorce or if a child ceases to be eligible under the Plan, and notice is not provided in writing to the Plan Office within 60 days of the event or the date on which coverage would end as a result of that event, whichever is later, you will lose your right to elect COBRA. You and your Dependent(s) will also be liable to pay for any claims that have occurred on and after the date of the event.

ELECTING COBRA

Each qualified beneficiary will have an independent right to elect COBRA. Covered Participants and Spouses (if the Spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice will lose his or her right to elect coverage.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. Please note that Medicare will be primary coverage. A qualified beneficiary's COBRA will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage.

COVERAGE PROVIDED THROUGH COBRA

If you choose COBRA, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end. However, you must now pay for that coverage. If there is a change in the health coverage provided by the Plan to similarly-situated active Participants and their families, the same change will be made in your COBRA.

CORE AND NON-CORE BENEFITS

Your right to continued health care coverage includes the "Non-Core Benefits." This package includes medical, hospitalization, prescription drug, behavioral health, wellness, vision, and dental coverage.

However, as a less expensive option, you may elect to continue "Core Benefits," which include medical, hospitalization, behavioral health, wellness and prescription drug coverage only. Neither of these rates includes life insurance. To continue your life insurance coverage, see the Conversion Privilege Feature on page 139 of the *SPD*.

COST OF COBRA

The amount you, your covered Spouse, and/or your covered child(ren) must pay for COBRA will be payable monthly. The Plan charges the full cost of coverage for similarly-situated active Employees and families, plus an additional 2% (for a total charge of 102%). The COBRA charge is different in cases of extended coverage due to disability. See the section entitled COBRA in Cases of Disability.

The Plan Office will notify you of the cost of the coverage and of any monthly COBRA Premium amount charges at the time you receive your notice of entitlement to COBRA. The cost of COBRA may be subject to future increases during the period it remains in effect.

There will be an initial grace period of 45 days to pay the first amount due, retroactive to the date your coverage would have otherwise ended, starting with the date COBRA coverage is elected. If this payment is not made when due, COBRA will not take effect.

After that, payments are due on the first day of each month. There will then be a grace period of 30 days to make these monthly payments. To ensure your COBRA coverage is activated each month, it is recommended to send the payment 5-7 days prior to the due date.

Note:

Eligibility status cannot be verified and will not be paid until a payment is made to the Plan Office. However, Providers will be told that you are in the COBRA election period and that, if you elect and pay for COBRA, your coverage will be retroactive.

If payment of the amount due is not made by the end of the applicable grace period, COBRA continuation coverage will terminate.

DURATION OF COBRA

Your COBRA continuation coverage continues for up to 18, 29 or 36 months depending on the COBRA qualifying event.

Note:

Any Short-Term Disability extension granted after your initial qualifying event will reduce your COBRA period by six months for each such extension. If you elect and are granted a Long-Term Disability extension you waive the right to elect COBRA for yourself once the initial 60-day election period has passed.

18 Months (Participant and Eligible Spouse and Dependents)

COBRA continues for up to 18 months if you would otherwise lose Plan health coverage because:

- Hours of employment are reduced so that you are no longer eligible to participate in the Plan; or
- Employment ends for any reason other than gross misconduct.

29 Months (Participant and Eligible Spouse and Dependents)

COBRA continues for an additional 11 months (up to a total of 29 months) if you or an eligible Dependent is, or becomes, permanently disabled (as determined by the Social Security Administration), within the first 60 days of COBRA and the disability lasts until the end of the 18-month period of continuation coverage. You or your Dependent(s) must notify the Plan Office of the determination no later than 60 days after it was received and before the end of the initial 18-month COBRA period.

36 Months (Eligible Spouse and Dependents Only)

COBRA for your Dependent(s) continues for up to a total of 36 months from the date that any one of the following COBRA qualifying events occurs:

- Your death
- Your divorce
- Your child ceases to be eligible for Plan coverage. (For example, he or she reaches the maximum age limit.)

COBRA IN CASES OF DISABILITY

If you, your spouse, or any of your covered Dependent children are entitled to COBRA for an 18-month period, that period can be extended for the covered person who is determined to be entitled to Social Security Disability Income benefits, and/or for any other covered family members, for up to 11 additional months (for a total of 29 months) if all of the following conditions are satisfied:

1. The disabled covered person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration. The Plan Office must receive a copy of the determination no later than 60 days after the date of the determination.
2. The disability begins or continues during the first 60 days of COBRA and continues at least until the end of the 18-month period of continuation coverage. The Plan Office must receive a copy of the determination before the initial 18-month COBRA period ends.

If the Plan is not notified during the 60-day notice period and within 18 months after the covered Participant's termination of employment or reduction of hours, then there will be no disability extension of COBRA. This extended period of COBRA will end at the earlier of:

- The last day of the month during which the Social Security Administration has determined that you and/or your Dependent(s) are no longer disabled.
- The end of 29 months from the date of the COBRA qualifying event.
- In the case of the disabled individual only, the date the disabled individual first becomes entitled to Medicare after electing COBRA.

COST OF COBRA IN CASES OF DISABILITY

If the 18-month period of COBRA is extended because of disability, the Plan will charge you and your Dependent(s) 150% of the cost of coverage, if extended coverage is elected for the 11-month period following the 18th month of COBRA.

CAL-COBRA

Participants living in California and enrolled in Kaiser Permanente or

Health Net or any other HMO that the Plan may offer in the future may be eligible for an additional 18 months of coverage under "California COBRA," for a total of 36 months, through their HMO. For more information, contact your HMO.

Open Enrollment

The Open Enrollment period occurs every year during the month of July. During that time, you may change your medical/hospital or dental coverage, your coverage type, add or delete qualified beneficiaries, or change your coverage between family and individual. Any changes made during the Open Enrollment period become effective on August 1st of that year.

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

Children Born to or Placed for Adoption with the Covered Participant During COBRA Period

A child born to, adopted by, or placed for adoption with a covered Participant during a period of COBRA is considered to be a qualified beneficiary provided that the covered Participant has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment (must be done within 31 days of the birth/adoption) or Open Enrollment, and it lasts for as long as COBRA lasts for other family members of the Participant. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Example:

If you have five months of COBRA left and you get married, you can enroll your new Spouse for five months of COBRA. COBRA Premiums are not prorated, and you must pay the full Premium rate for the month in which you are adding your Dependent.

To enroll your new Dependent for COBRA, you must notify the Plan Office within 31 days of acquiring the new Dependent. Adding a Spouse or Dependent child may cause an increase in the amount you must pay for COBRA. A child born to or placed for adoption with the Participant while covered under COBRA will be a qualified beneficiary.

Alternate Recipients under Qualified Medical Child Support Orders

A child of the covered Participant who is receiving benefits under the Plan pursuant to a QMCSO received by the Plan during the covered Participant's period of eligibility with the Plan is entitled to the same rights to elect COBRA as an eligible Dependent child of the covered Participant.

Group Health Plan Coverage Loss

If, while you are enrolled in COBRA, your Spouse or Dependent(s) loses coverage under another group health plan, you may enroll your Spouse or Dependent(s) in coverage for the balance of the period of COBRA. Your Spouse or Dependent(s) must have been eligible for COBRA but not enrolled. When COBRA enrollment was offered and declined, your Spouse or Dependent(s) must have been covered under another group health plan or must have had other health insurance coverage.

You must enroll your Spouse or Dependent(s) within 31 days after the termination of the other coverage. Adding your Spouse or a Dependent child may cause an increase in the amount you must pay for COBRA.

The loss of coverage must be due to one of the following:

- Exhaustion of COBRA under

another plan

- Termination as a result of loss of eligibility for the coverage
- Termination as a result of Employer contributions toward the other coverage being terminated

Loss of eligibility does not include a loss due to failure of the individual or Participant to pay Premiums on a timely basis or termination of coverage for cause.

Second Qualifying Event

If you die, get divorced or if a covered child ceases to be a Dependent child under the Plan during an 18-month period of COBRA (as described previously), then your family may have experienced a second "qualifying event." If a second qualifying event occurs, the affected Spouse and/or child can get additional COBRA, up to a maximum of 36 months. If the Participant or Spouse ceases to be eligible for COBRA due to entitlement to Medicare, the remaining Dependent(s) can elect to continue the original allowed COBRA duration.

Example:

Assume you lose your job (the first COBRA qualifying event), and you enroll yourself and your covered eligible Dependents for COBRA. Three months after your COBRA coverage begins, your child turns 26 years old and is no longer eligible for Plan coverage. Your child can continue COBRA for an additional 33 months, for a total of 36 months of COBRA.

Note:

Entitlement to Medicare will not be treated as a second qualifying event in any circumstance in which, if the Participant had remained employed, the Participant would not have lost regular coverage under the Plan upon entitlement to Medicare, which will be the case nearly all of the time.

Medicare Enrollees

Participants enrolled in Medicare who elect COBRA and receive Medicare benefits at a time that they are not actively employed will have their **COBRA coverage as secondary insurance only**. Electing COBRA continuation coverage does not exempt Medicare Eligible Participants from any late enrollment penalties that may apply with Medicare.

In all of these cases, you must make sure that the Plan Office is notified of the second qualifying event within 60 days of the second qualifying event.

- This notice must be sent to:

  Motion Picture Industry Health Plan
  Attn: Eligibility Department
  P.O. Box 1999
  Studio City, CA 91614-0999
  (855) 275-4674
  (818) 766-1229 - Fax
  service@mpiphp.org

If the second qualifying event is a divorce or a child ceasing to be a Dependent child under the Plan and notice is not provided in writing to the Plan Office during the 60-day notice period after such qualifying event, then there will be no extension of COBRA due to a second qualifying event.

In no case are you, the Participant, entitled to COBRA for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA period due to disability). As a result, if you experience a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event, and COBRA may not be extended beyond 18 months from the initial qualifying event. A second qualifying event extension is not available to the covered Participant under the Plan when a covered Participant becomes entitled to Medicare.

TERMINATION OF COBRA SELF-PAYMENT

Once COBRA has been elected, it may be cut short (terminated) on the occurrence of any of the following events:

- The first day of the month for which you do not submit the COBRA Premiums within the required time period.
- The date on which the Plan is terminated.
- The date, after the date of the COBRA election, on which you or your eligible Dependent(s) first become covered by another group health plan.
- The date, after the date of the COBRA election, on which you or your eligible Dependent(s) first become entitled to Medicare (usually age 65).

Your COBRA coverage ends on the earliest of the date that:

- Any of the above-listed events occur; or
- The COBRA period ends (18, 29, or 36 months).

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's

rights, you should keep the Plan Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Office.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA, you should contact the Plan Office. For more information about your rights under ERISA, including COBRA, HIPAA and other laws affecting your health plan, you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website, www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

PLAN CONTACT INFORMATION

- You may obtain information about the Plan and COBRA coverage upon request from:

  Motion Picture Industry Health Plan
  Attn: Eligibility Department
  P.O. Box 1999
  Studio City, CA 91614-0999
  (855) 275-4674
  (818) 766-1229 - Fax
  service@mpiphp.org

Your COBRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

COVERAGE CONVERSION AND OTHER ALTERNATIVES

If you exhaust the option for continuation coverage or do not

wish to extend benefits under COBRA, you may still provide coverage for yourself and your family by conversion to an individual policy. The cost of these benefits depends upon the family members to be covered. If you would like additional information, please contact the medical/hospital plan in which you are currently enrolled.

You may have other options available to you when you lose group health coverage.

Example:

You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower Out-of-Pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

In addition, you may purchase from $500 to $10,000 of life insurance through the Union Labor Life Insurance Company by conversion of your group life insurance without a physical examination. For an application, please contact the Eligibility Department in writing as soon as possible after the loss of eligibility. Your completed application must be received by the Union Labor Life Insurance Company no later than 31 days from the date your coverage is terminated.

Note:

Life insurance conversion options are available to Participants only. If you convert either of the policies listed above, and at some future date you become eligible for Plan benefits, you must cancel your converted policies. The Union Labor Life Insurance Company does not permit a duplication of coverage.

SELF-PAYMENT UNDER USERRA

If you take a military leave for 30 days or less, you will continue to

receive health care coverage for up to 30 days, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you take a military leave for more than 30 days, USERRA permits you to continue coverage for you and your Dependent(s) at your own expense, at a cost of 102%, for up to 24 months, as long as you give your Employer advance notice (with certain exceptions) of the leave, and provided your total leave, when added to any prior periods of military leave, does not exceed five years (not counting periodic training duty, involuntary active duty extensions, or where the initial enlistment lasted more than five years). In addition, your Dependent(s) may be eligible for health care coverage under TriCare. The Motion Picture Industry Health Plan will coordinate coverage with TriCare. TriCare Standard is the new name for the health care option formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

If you take a leave of absence to serve in the Armed Forces, and, at the time of your leave, have worked at least 30 days in the previous 12 months in motion picture employment covered by the Plan, your eligibility will be suspended as of the date you commence your leave, since you and your Dependents are eligible for hospital and medical care through military facilities or military Medicare.

Your coverage will be reinstated on the day you return to work or register for work with your Union or your last Employer as if you had not taken a leave, provided you are eligible for reemployment under the terms of USERRA and provided that you return to employment within:

- 90 days from the date of discharge if the period of service was more than 180 days;
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- At the beginning of the first full regularly-scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended for up to two years.

If you leave your job to perform military service, you have the right to elect to continue your existing Employer-based health plan coverage for you and your Dependents for up to 24 months while in the military.

A copy of your separation papers must be filed with the Plan's Eligibility Department to establish your period of service.

Your reinstated eligibility will be for the remainder of the Benefit Period in which you return and, if necessary, for the following Benefit Period as well. Thereafter, if you fail to earn eligibility for the next Benefit Period, you may continue coverage through self-payment (up to a maximum of 18 months).

Your rights to self-pay under USERRA are governed by the same conditions described in the COBRA section of this *SPD*.

The period for which you are entitled to self-pay under USERRA will decrease by the number of months that your coverage was reinstated as described above. Subsequently, your continued eligibility will depend on working the necessary 400 hours in one Qualifying Period.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA as specified above.

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected illness or injury.

In addition to this provision, in the event of a major mobilization, the Board of Directors have decided that for eligible Participants who are called to active duty, Dependent coverage will be extended until the earliest of the following:

1. The Participant is released from active duty;
2. The date the Participant becomes eligible for benefits under USERRA; *or*
3. This extension of coverage is terminated by the Board of Directors, provided that any required Premiums are paid. A copy of the orders directing you to report to active duty must be filed with the Eligibility Department to establish the date of your service.

Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Retiree Health Benefits Requirements

The Motion Picture Industry Health Plan maintains a separate plan – the Motion Picture Health Plan for Retired Participants ("Retiree Plan") – to provide benefits for you following your retirement from the motion picture industry. Employers make special contributions for this purpose during your working years, and no payment is required from you either as an Employee or a retiree. The following is a brief summary of certain provisions of the Retiree Plan. For more information about the Retiree Plan, please review the separate Summary Plan Description for that Plan.

CERTIFICATION OF RETIREMENT

To establish eligibility through the Retiree Plan, you must contact the Participant Services Center at (855) 275-4674. If you qualify through the Retiree Plan, the Motion Picture Industry Pension Plan ("Pension Plan") will verify the number of hours and Qualified Years you have accrued, and the age at which you will be eligible. Certification will be sent to the Eligibility Department of the Plan; the Eligibility Department of the Plan will send you an enrollment packet.

BASIC REQUIREMENTS

Your eligibility through the Retiree Plan, with the exception of a total and permanent disability retirement, is not dependent upon your qualifying for retirement under the provisions of the Pension Plan. The rules governing the Retiree Plan and the rules governing the Pension Plan are similar but separate. You will qualify for the Retiree Plan provided:

1. You have retired from the motion picture industry;
2. You meet the Qualified Years/hours/minimum age requirements outlined in the next section; and

3. Your retirement from the motion picture industry has been certified by the Pension Plan.

Participants who meet the basic requirements to participate in the Retiree Plan may request a "health-only retirement" without first commencing their benefits under the Pension Plan or the Motion Picture Industry Individual Account Plan. Participants may submit their health-only retirement application form up to six months, but no less than two complete calendar months, prior to their elected health-only retirement date. The month the form is signed is not considered a complete calendar month.

For example, if the Participant chooses to retire on April 1, the form must be submitted no later than January 31. In this example, the two complete calendar months are February and March.

Participants who would like to cancel or change their health-only retirement date, must do so in writing prior to their scheduled retirement date. If a Participant cancels a retirement, he or she will have to reapply at least two months before his or her new retirement date.

Note:

1. "Qualified Year" is any year in which you worked at least 400 hours, for which contributions were made to the Retiree Plan. Please be aware that your Retiree Plan Qualified Years may differ from the Pension Plan Qualified Years if you incurred a "break in service" under the Pension Plan or your Employer contributes to one of the plans.
2. If you believe that you lost one or more Qualified Years as a result of service in the United States military, you may request additional credit toward establishing eligibility for the Retiree Plan. Upon your request, the Plan's Benefits/Appeals Committee will determine whether it is reasonably certain that military service, which qualifies under the terms of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), prevented you from obtaining one or more Qualified Years toward your Retiree Plan eligibility. In that event, the Plan's Benefits/Appeals Committee will credit you with one or more additional Qualified Years. See pages 44 through 46 for instructions for filing an appeal.

EFFECTIVE DATE OF BENEFITS

The effective date of your Retiree Plan benefits is determined by the number of Qualified Years and hours you have, as well as the age at which you retire. While it is possible that you may retire and receive pension benefits at an earlier age, you will not be entitled to Retiree Plan benefits until the effective dates listed below.

If you are a Participant in the Plan and retire under the following terms, you will be enrolled in the Retiree Plan effective on the date of your certification as a retiree. This will require you to request and complete a retirement application at least 2 months before your retirement date. However, if you have qualified for benefits in the Plan, your $10,000 life insurance benefit will remain in effect as long as you would have been eligible in the Plan.

1. With 15 Qualified Years and 20,000 Credited Hours, the earliest that the Retiree Plan will commence is on the first of

the month following your 62nd birthday. To qualify, Participants must have at least three Qualified Years earned after the year of attainment of age 40, and at least one Qualified Year earned in any of the years commencing with Plan Years 2000 through 2015.

2. With 20 Qualified Years and 20,000 Credited Hours, your Retiree Plan benefits will commence the first of the month following your 62nd birthday.
3. With 30 Qualified Years and 55,000 Credited Hours, your Retiree Plan benefits will commence the first of the month following your 61st birthday.
4. With 30 Qualified Years and 60,000 Credited Hours, your Retiree Plan benefits will commence the first of the month following your 60th birthday.

TOTAL AND PERMANENT DISABILITY

You will be entitled to Retiree Plan benefits effective on the date of your retiree certification, regardless of age, if you meet certain requirements.

You have a minimum of 10 Qualified Years and 10,000 hours for which contributions have been paid to the Retiree Plan benefits, you are totally and permanently disabled at the time of your retirement, are not on a Break in Service, and:

1. You are eligible to retire and have retired under the disability pension provisions of the Motion Picture Industry Pension Plan;
2. You meet the requirements for a disability pension, but are not entitled to a Social Security Disability Award only because you are over age. You will be entitled to Retiree Plan benefits effective on the date of your certification as being totally and permanently disabled by the Plan's Medical Review Department; or
3. You meet all of the requirements for such a Disability Retirement Pension benefit, but are not a Participant in the Motion Picture Industry Pension Plan.

DURATION OF ELIGIBILITY

Eligibility for the Retiree Plan may be discontinued if there are not sufficient funds available in it to continue to provide these benefits or if the Retiree Plan is amended to reduce benefits. Retiree Plan benefits are paid from a separate trust fund and there is no guarantee of continued funding of that trust fund. In addition, your eligible Dependents may be entitled to continue coverage upon your death.

BENEFIT CHANGES UPON RETIREMENT

While most of your benefits under the Retiree Plan remain the same as when you were in the Active Plan, there are a few differences of which you should be aware:

- You and any Medicare-eligible Dependents must enroll in Medicare Parts A and B in order to have medical, hospital and prescription drug coverage through the Retiree Plan.
- Mental health and chemical dependency benefits through Optum Behavioral Health change for non Medicare-eligible Participants and their Dependents.
- Prescription drug Co-Payments change to $5, $20 and $30 for retail purchases, and $12, $50 and $75 for mail order purchases.
- Coordination of Benefit rules change to comply with Medicare Advantage and Part D requirements.
- Life insurance is reduced from $10,000 to $2,000. You may convert from $500 to $8,000 of your group life insurance to a private policy with The Union Labor Life Insurance Company without a physical examination. If you are interested in this conversion, contact the Plan Office immediately upon the termination of your active life insurance. See page 139.
- Your Dependents are covered only until age 19 unless they satisfy the requirements for being a full-time student, in which case coverage may continue until attainment of age 23. See page 14 for student requirements.

Note:

The Board of Directors retain the right to change the Plan of benefits in their sole discretion, and any changes made after you retire will apply to you and your eligible Dependent(s).

WORK AFTER RETIREMENT

If you re-qualify for eligibility in the Plan on the basis of hours worked after the date of your retirement certification, you will be transferred to the Plan for full benefits on the first date of the subsequent Eligibility Period. When earned active Employee benefits are exhausted, you will immediately be returned to the Retiree Plan.

Coordination Of Benefits

Like most group medical plans, your benefits through the Plan are subject to a provision against duplication with other Employer group health plans. A process known as order of benefit determination is used to coordinate the benefits of both plans where duplicate coverage exists. This provision does not apply to individual health insurance policies.

PAYMENT PRIORITY

The following rules determine which plan is primary when a Participant is enrolled in two health plans:

1. A plan without a Coordination of Benefits rule is considered primary.
2. If both plans have Coordination of Benefits rules, the following applies:
   - (a) The plan in which you are enrolled as an Employee, rather than as a Dependent, is primary.
   - (b) If you are not legally separated or divorced, you are the natural parents of your children and your children are enrolled in both parents' Employer plan, including the Plan, the Plan uses special rules to determine which plan pays benefits first. The Plan, like most other plans, uses the "Birthday Rule" where the plan covering the parent whose birthday falls first in the calendar year is primary, and the plan of the parent whose birthday falls later in the year is the secondary plan.

     Claims should be submitted to the secondary plan for amounts not paid by the primary plan. If the benefit paid by the primary plan is less than 100% of the eligible expense, the secondary plan may pay a benefit.

     If both parents share the same birthday, the primary plan will be the plan that has covered one parent the longest. The secondary plan will be the plan that has covered the other parent for a shorter period of time.
3. If you are legally separated or divorced, you are the natural parents of your children and your children are enrolled in both parents' Employer plan, including the Plan, the Birthday Rule does not apply. Instead, the benefits will be paid in the following order:
   - (a) The plan of the parent to whom the court specifically assigned financial responsibility for health care expenses.
   - (b) The plan of the parent who has custody.
   - (c) The plan of the Spouse married to the parent who has custody.
   - (d) The plan of the parent who does not have custody.
   - (e) The plan of the Spouse married to the parent who does not have custody.
4. A plan in which you are enrolled as an active Employee, rather than a laid-off or retired Employee, is primary. However, if you are covered as a retiree

or laid-off Employee and also as the Dependent of an active Employee, the plan covering you as a retired or laid-off Employee is primary, unless you are enrolled in Medicare.

5. In most cases, a plan in which you are enrolled as an active Employee or subscriber rather than as a COBRA Participant is primary.
6. If you are the insured in more than one plan, the plan covering the individual for the longest period of time is considered primary.
7. If none of the above rules determines which plan is primary, the Allowable Amounts shall be shared equally between the plans.

When applying Coordination of Benefits, the Plan will not pay more than it would have paid had it been primary.

When you or your eligible Dependent(s) have any other Employer group health plan, the Plan will coordinate with the other group plan. If you reside outside the United States and are covered by a health plan in that country, the Plan will be secondary to that plan for coordination purposes.

PAYMENT OF BENEFITS

When the Plan serves as secondary coverage, benefits will be paid in the following manner. Your other health plan will calculate its payment, and then the Plan will calculate its normal benefit amount. If your other health plan already paid more than the Plan would have paid had the Plan been primary, no additional payment will be paid toward that bill.

If the primary plan paid less than the Plan would have paid had the Plan been primary, the Plan will pay up to the Plan benefit amount less the amount paid by the primary insurance or the remaining Coinsurance, whichever is less.

This method of coordinating payments may result in the same or lower Out-of-Pocket expenses for the patient. This same rule applies to prescription drug coverage if you are eligible for prescription drug coverage under another health plan.

SPOUSE ELIGIBLE FOR COVERAGE THROUGH OWN EMPLOYER

A Participant's Spouse who is eligible for medical and/or prescription coverage through his or her own Employer is not eligible for primary health care coverage through the Plan. The Plan coverage will be coordinated as a secondary plan for your Spouse if the Spouse enrolls in his or her Employer's plan.

It is important to note that if a Participant's Spouse is eligible for any type of health coverage through his or her Employer but did not enroll in such plan, the Plan will not provide any coverage for that Spouse. The Participant's Spouse is required to take the medical-hospital and prescription drug benefit coverage from his or her Employer. The Spouse will continue to be covered for dental and vision benefits through the Plan with the Plan serving as primary coverage.

This rule will apply even if the Spouse is required by his or her Employer to pay all or a portion of the Premium cost for coverage.

This rule does not apply if a Participant's Spouse is not employed or is employed but not eligible for a health insurance plan provided by the Employer. In such instances, the Plan will serve as primary coverage.

Spouse Eligibility Determination Requirements

In order to determine Spouse eligibility for other health insurance coverage, Participants must periodically provide to the Plan the following documentation:

- If the Spouse is unemployed, the Plan will require a sworn declaration attesting to the fact.
- If the Spouse is employed, the Plan will require certification from his or her Employer of any health plan for which he or she is eligible and of enrollment or non-enrollment in such health plan.
- Alternatively, a Participant may indicate that his or her Spouse is covered by another Employer-sponsored health plan. In that instance, the sworn declaration will not be required, but the Employer certification still must be submitted.

If a Participant's Spouse transitions from employed with insurance to unemployed without insurance, the Plan will require a new set of the following:

- Coordination of Benefits forms; and
- A copy of the COBRA notice stating the end date of Spouse's Employer's coverage; or
- A letter from the Spouse's Employer stating the Spouse's last date of employment and other evidence of loss of coverage stating the end date of the Spouse's Employer's coverage.

If a Participant's Spouse transitions from employed with insurance to retired without insurance, the Plan will require the following:

- Coordination of Benefits forms;
- A letter from the Spouse's Employer stating the Spouse's retirement date, availability for retirement health coverage and if retirement health coverage requires a premium; and
- A copy of the COBRA notice or other evidence of loss of coverage stating the end date of Spouse's Employer's coverage.

If the Participant's Spouse is employed but is on leave and the Employer does not offer insurance during that period of leave, the Plan may be considered primary coverage, provided documentation satisfactory to the Plan is received.

If the Participant's Spouse's employment status is "per diem," the Plan will be considered primary.

If, for any reason, a Participant fails to furnish the required spousal information, that Dependent will automatically be excluded from all eligibility, including eligibility for medical, hospital, dental, vision, and prescription drug coverage. The Plan will assume the Spouse has other health coverage. Therefore, it is extremely important that the required information be provided in a timely manner.

ELIGIBILITY AND COORDINATION OF BENEFITS FOR DEPENDENT CHILDREN

If a Spouse enrolls his or her Dependent child(ren) in his or her Employer's health plan, that plan may be considered primary for the child(ren). The determination of which coverage is primary will be made based on whose birthday comes first in the year. If the Spouse's birthday is earlier than the Participant's, his or her insurance will be considered primary. If the Participant's birthday comes first, the Plan will be primary for the

Dependent child(ren).

If a Spouse enrolls in his or her Employer's health coverage and Dependent child(ren) can be enrolled at no additional charge, such Dependents must be enrolled. If they are not enrolled under these circumstances, the Plan will provide no coverage to such Dependent child(ren).

The Plan will provide primary coverage for a Dependent child not enrolled in the Spouse's Employer's health plan only if one of the following occurs:

- The Spouse declines coverage under his or her Employer's plan where coverage of the Dependent child is included in a package Premium payment required to be paid for covering the Spouse under that plan;
- There is an additional cost for covering Dependent children; or
- There is no coverage available for the child(ren) under the Employer's plan.

DUAL COVERAGE

An alternative Coordination of Benefits provision for medical benefits applies to Participants or Dependents who are eligible for both primary and secondary coverage through the Plan when they pay the required Premiums for Dependent coverage.

The following rules apply to Participants who would like the Plan to provide both primary and secondary coverage for each Participant and Spouse:

- Two Participants who enroll in an HMO must both select the same HMO to receive coverage.
- If one Participant enrolls in Oxford, and the other Participant enrolls in the MPIHP/Anthem Blue Cross plan, both the Oxford and MPIHP/Anthem Blue Cross plans will coordinate benefits.
- If both Participants enroll in the MPIHP/Anthem Blue Cross plan and:
  - For covered services provided by an In-Network Provider, then the Plan will pay 100% of the Allowable Amount.
  - The covered service is provided by an Out-of-Network Provider, then the Plan will:

1. Determine the Allowable Amount for the Claim;
2. Determine the primary payment amount as 50% of the Allowable Amount less any applicable Co-Payment;
3. Determine the secondary payment amount as 50% of the Allowable Amount less any applicable Co-Payment; and
4. Pay both the primary and secondary payment amounts, which shall not exceed the Billed Amount.

In general, the Participant will only be responsible for paying the applicable Co-Payments and any amount billed to the Participant by the Provider to cover the difference between the billed charge and the Allowable Amount.

EXCLUSIVE PROVIDER ORGANIZATION, HEALTH MAINTENANCE ORGANIZATIONS, POINT OF SERVICE AND PREFERRED PROVIDER ORGANIZATIONS COORDINATION

If your primary coverage is through an Exclusive Provider Organization (EPO), Health Maintenance Organization (HMO), Point of Service (POS), or Preferred Provider Organization (PPO) plan, the service coverage guidelines of those plans must be followed, otherwise the Plan will not consider services for payment.

For services that are not available through your EPO, HMO, POS or PPO plan, the Plan will only consider payment for those services if it receives a copy of a written denial from your EPO, HMO, POS or PPO plan.

Failure to follow the guidelines of your EPO, HMO, POS or PPO does not constitute a "not-available" service.

MEDICAID COVERAGE COORDINATION

Medicaid is a state plan for medical assistance approved under Title XIX of the Social Security Act of 1965, as amended. If you or your covered Dependents are covered under a state's Medicaid program, the Plan will serve as primary coverage and will pay benefits before Medicaid.

The Plan shall not reduce or deny benefits for you or your covered Dependents to reflect eligibility to receive medical assistance under a state Medicaid program. In addition, the Plan shall reimburse any state Medicaid program for the cost of any items and services provided under the state program that should have been paid for by the Plan and will honor any subrogation rights that a state has to recoup such mistaken payments.

Active Participants Eligible for Medicare Parts A and B

If you are eligible for Medicare benefits (Parts A and B), whether or not you have actually applied for such Medicare benefits, the following rules apply:

1. The Plan is ordinarily the primary payer if:
   - (a) You are currently working for an Employer or are covered by the Plan as a Participant; or
   - (b) You first become eligible for Medicare benefits because you have end-stage renal disease (ESRD), in which case the Plan is the primary payer for the first 30 months you are eligible for Medicare due to ESRD (in most cases, at the end of this period, Medicare will be the primary payer).

Dependents Eligible for Medicare Parts A and B

If your eligible Dependent is eligible for Medicare benefits, whether or not he or she has actually applied for such Medicare benefits, the following rules apply:

1. The Plan is ordinarily the primary payer if:
   - (a) You are currently working for an Employer or are covered by the Plan as a Participant; or
   - (b) Your Dependent first becomes eligible for Medicare benefits because he or she has ESRD, in which case the Plan is the primary payer for the first 30 months your Dependent is eligible for Medicare due to ESRD (in most cases, at the end of this period, Medicare will be the primary payer).
2. If you are over age 65 and you are currently working for an Employer or are covered by the Plan as an Active Participant, the Plan will be the primary payer. You should still enroll in Medicare Part A, but you do not need to enroll in Medicare Part B until you retire.

Retired Participants Eligible for Medicare Parts A and B

If you are retired, you must enroll in Medicare Parts A and B when you reach age 65. Medicare Part A provides inpatient hospital benefits and Medicare Part B pays for necessary physician services, outpatient hospital services, and other medical services and supplies not covered by Part A.

To enroll, you will need to contact your local Social Security Administration office **at least 90 days** before your 65th birthday.

You pay Medicare a monthly Premium for Part B coverage. Your Premiums for Part B coverage are ordinarily deducted from your Social Security Administration benefits, if you receive them.

Again, it is important that you enroll in both Medicare Parts A and B when you become Medicare-eligible.

When enrolled in Medicare Parts A and B at age 65, and eligible for the Retiree Plan, the Anthem Medicare Advantage PPO Plan will provide your health coverage if you are not actively employed.

Third Party Liability

CLAIMS INVOLVING THIRD PARTY LIABILITY

If you or your Dependent's injury or illness was, in any way, caused by a third party who may be legally liable or responsible for the injury or illness, no accident-related benefits will be paid under any coverage of the Plan unless you contractually agree in writing, in a form satisfactory to the Plan, to do all of the following:

1. Provide the Plan with a written notice of any claim made against the third party for damages as a result of the injury or illness;
2. Agree to reimburse the Plan for benefits paid by the Plan from any Recovery (as described and defined below) when the Recovery is obtained from or on behalf of the third party or the insurer of the third party or from your own uninsured or underinsured motorist coverage;
3. Agree to pay interest on the amount owed to the Plan in connection with any Recovery (as described and defined below);
4. Ensure that any Recovery is kept separate from and not co-mingled with any other funds and agree in writing that the portion of any Recovery required to satisfy the lien of the Plan is held in trust for the sole benefit of the Plan until such time as it is conveyed to the Plan;
5. Execute a lien in favor of the Plan for the full amount of the Recovery which is due for benefits paid by the Plan;
6. Periodically respond to information requests regarding the status of any claim against the third party, and notify the Plan, in writing, within 10 days after any Recovery has been obtained; and
7. Direct any legal counsel retained by you or your Dependent or any other person acting on behalf of you or your Dependent to hold that portion of the Recovery to which the Plan is entitled in trust for the sole benefit of the Plan and to comply with provisions of this section and to facilitate the reimbursement of all amounts owed to the Plan (as described and defined below).

If you or your Dependent fails to comply with any of the aforementioned requirements, no benefits will be paid with respect to the injury or illness. If benefits have already been paid, they may be recouped by the Plan.

Reimbursement of benefits paid by the Plan for an injury or illness for which either you or your Dependent has received any Recovery is the liability of the Participant. If reimbursement is requested and not received by the Plan, in addition to any other available remedies, the amount of such benefits (including any applicable interest), as described below, will be deducted from all future benefit payments to or on behalf of the Participant and/or any Dependent, until the full amount of the Overpayment is resolved (see Overpayments section on page 85).

In addition to any other remedy, the Plan may enforce the terms described in this section, and its right to full reimbursement of the amount of benefits paid and where applicable, interest through a court action.

The Plan may also require the filing of periodic reports regarding the

status of your or your Dependent's third-party claim(s) as a condition of continued eligibility for benefits for the injury or illness.

The Plan's Right to Recovery Reimbursement

The term "Recovery" includes any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from your or your Dependent's uninsured or underinsured motorist coverage, related to the illness or injury, without reduction for any attorneys' fees paid or owed by you or your Dependent on behalf of you or your Dependent, and without regard to whether you or your Dependent have been "made whole" by the Recovery. The Plan will not pay any portion of your or your Dependent's legal fees, and the Common Fund doctrine does not apply. Recovery does not include monies received from any insurance policy or certificate issued in your name or the name of your Dependent, other than uninsured or underinsured motorist coverage. The Recovery includes all monies received regardless of how held, and includes monies directly received by you or your Dependent, as well as any monies held in any account or trust on your or your Dependent's behalf, such as an attorney-client trust account or special needs trust. You and/or your Dependent, if applicable shall pay to the Plan from the Recovery an amount equal to the benefits actually paid by the Plan in connection with the illness or injury. If the full amount paid by the Plan is not reimbursed from the Recovery, you as the Participant, (and your Dependent, if applicable) shall continue to owe to the Plan such unpaid amount, up to the full amount of the Recovery. If the benefits paid by the Plan in connection with the illness or injury exceed the amount of the Recovery, neither you, as the Participant nor your Dependent, shall be responsible for any benefits paid in excess of the amount of the Recovery, other than interest as described below.

Your (and where applicable, your Dependent's) acceptance of benefits from the Plan for injuries or illness caused by a third party shall act as a waiver of any defense to full reimbursement of the Plan from the Recovery, including any defense that you and/or your Dependent have not been "made whole" by the Recovery, or that you and/or your Dependent's attorneys' fees and costs, in whole or in part, are required to be paid or are payable from the amount of the Recovery, or that the Plan should pay a portion of the attorneys' fees and costs you and/or your Dependent incur in connection with the claims against the third party.

You and/or your Dependent shall be obligated to pay interest to the Plan on any amounts owed to the Plan in connection with the Recovery which are not paid within ten days after the Recovery is obtained. The interest on any such unpaid amounts will be at the rate of 10% per 12-month period, with a pro rata percentage applicable if payment is made before the end of any 12-month period. The interest shall commence running on the 11th day after the Recovery is obtained and shall be paid from the Recovery. Interest shall continue to accrue until the full amount owed to the Plan is either reimbursed from the Recovery or by you, as the Participant.

WORKERS' COMPENSATION

The Plan does not cover expenses incurred as a result of, or in connection with, any of the following:

1. Injuries sustained while performing any act pertaining to any occupation or employment for remuneration or profit; or
2. Sickness, disease or injuries covered under any Workers' Compensation or Occupational Disease Act or Law.

Under the California Workers' Compensation Act, and the laws of other states, medical treatment for an injury or illness either caused or aggravated by your work activities is the responsibility of your Employer. You must notify your Employer as soon as you are aware of any medical problem or condition that you think has been caused or aggravated by your work by filing form #DWC-1 Employees Claim for Workers' Compensation Benefits in California and comparable forms in other states.

If the Plan determines that your injury or illness is work-related, no benefits related to the injury or illness will be paid or are payable by the Plan. Therefore, if your Employer denies liability for your work-related injury or illness, you may wish to protect your rights by filing a Workers' Compensation Claim as soon as possible.

If you file a Workers' Compensation Claim, the Plan will make a determination as to whether it will advance payment for the medical services rendered in connection with the claimed injury or illness, which would otherwise be covered under the Plan. The Plan will then file a lien Claim on its own behalf

before the Workers' Compensation Appeals Board for reimbursement by your Employer if it is determined that your condition was caused or aggravated by your work.

If you file a Claim for Workers' Compensation Benefits, you must immediately notify the Plan of the case number and the name of your attorney, if you have one.

In the event that you settle a Workers' Compensation Claim, you should attempt to have your Employer agree, as part of the settlement, to pay expenses for future medical treatment of the work-related condition. If the Workers' Compensation settlement does not contain such an agreement, the Plan will make its own determination whether future medical expenses related to your work-related condition are excluded from coverage under items "1" or "2", above.

Benefits from the Plan are not intended to duplicate any benefits which are available under Workers' Compensation Law, whether or not you or your Employer have actually maintained Workers' Compensation insurance.

Participants and Dependents are obligated to complete and submit the necessary Claim forms, consents, releases, assignments and other documents requested so the Plan may pursue its lien rights. Any Participant or Dependent who fails to submit such documents or cooperate with the Plan in processing the lien will not be entitled to benefits under this provision of the Plan until these documents are received by the Plan, or the Participant or Dependent cooperates in the Plan's efforts, as outlined above.

Additionally, any failure on the part of a Participant or eligible Dependent to cooperate with the Plan in pursuing its lien rights that results in a loss to the Plan may result in the Plan deducting the amount of the loss from all future benefit payments for the Participant or eligible Dependents until the amount of the loss is recovered. A loss to the Plan means any action or inaction on the part of the Participant or eligible Dependent that prevents the Plan from obtaining reimbursement for health expenses to which it would otherwise be entitled.

A failure to cooperate could include, but is not limited to, any of the following acts.

A Participant or eligible Dependent, in a timely fashion, fails to:

1. Notify the Plan of the filing of a Workers' Compensation Claim;
2. Provide the Plan with a copy of the Workers' Compensation Claim Form or Application;
3. Complete and return a Questionnaire Form;
4. Notify the Plan of the approval of a Workers' Compensation Award;
5. Provide the Plan with a copy of a Workers' Compensation Award;
6. Notify the Plan of the approval of a Workers' Compensation Compromise and Release;
7. Provide the Plan with a copy of a Workers' Compensation Compromise and Release, Stipulation with Request for Award, and Findings and Award;
8. Cooperate fully with the Plan in litigating its lien rights before the Workers' Compensation Appeals Board;
9. Provide complete and accurate information on the Questionnaire Form; or
10. Provide the Plan with Physicians' notes to substantiate the Plan's lien.

Appeals Procedure

FILING AN APPEAL WITH THE PLAN

If you feel that your Claim or request has not been processed correctly by the Plan, you have 180 days following the process date of the Claim as indicated on the Explanation of Benefits or other initial Adverse Benefit Determination to make a formal request for review by the Board of Directors' Benefits/Appeals Committee. Please submit in writing your reasons, in clear and concise terms, and include any other pertinent medical documents or other documentation that will help the Committee to understand the situation.

- Your request must be addressed to:

  Motion Picture Industry Health Plan
  Attn: Benefits/Appeals Committee
  P.O. Box 1999
  Studio City, CA 91614-0999

The Board of Directors' Benefits/Appeals Committee generally schedules meetings once a month to review files. The Benefits/Appeals Committee's decision shall be final and binding on all parties, including the Participant and any person claiming under the Participant. You will be notified of the Benefits/Appeals Committee's decision in writing. While you may be represented during the course of the appeals process, neither you, nor your representative, may attend meetings of the Benefits/Appeals Committee.

The failure to file such an appeal within 180 days from the process date of the Claim as indicated on the Explanation of Benefits or other initial Adverse Benefit Determination shall constitute a waiver of the right to appeal the decision. Such failure will not, however, prevent the applicant from establishing entitlement at a later date based on additional information and evidence, which was not available at the time the decision denying the Claims, in whole or in part, was made.

Neither the Participant, eligible Dependents, health care Providers, nor their individual representatives may appear in person before the Benefits/Appeals Committee.

If you are receiving previously approved ongoing treatment (e.g., kidney dialysis) for a specific period of time (or number of treatments), and the Plan intends to reduce or terminate such coverage before the end of that period, you will be provided notice of this change sufficiently in advance to allow an appeal and decision on the appeal.

The Plan pays only those benefits established by the Plan's Board of Directors. The Benefits/Appeals Committee shall have the discretion and final authority to interpret and apply the Plan of Benefits, including the Trust Agreement, this Summary Plan Description, any other Plan documents under which the Plan is maintained and any and all rules governing the Plan. The Benefits/Appeals Committee does not have the authority to change Plan benefits. The decision of the Benefits/Appeals Committee shall be final and binding upon all parties, including the Participant and any person claiming under the Participant, subject to the right to bring a civil action under Section 502(a) of ERISA. These provisions apply to and include any and every Claim for benefits under the Plan and any Claim or right asserted against the Plan, regardless of the basis asserted for the Claim.

Q&A:
Time Limits for Appeals Processing

Q: How long does a Participant have to appeal?

A: 180 days following receipt of a notification of Adverse Benefit Determination.

Q: What is the appeal deadline by which the Claimant must be notified of an appeals decision?

A: Appeals will generally be heard at the Benefits/Appeals Committee meeting that follows receipt of the appeal, if it is received more than 30 days in advance of 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 Benefits/Appeals 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. You will be provided notice of the appeals decision within five days of the decision.

FILING APPEALS WITH SELF-INSURED CONTRACTED BENEFIT PARTNERS AND FULLY-INSURED CONTRACTED BENEFIT PARTNERS

The Plan offers Participants a variety of health care options as described on the following pages. For appeals related to MPIHP/Anthem Blue Cross, please follow the appeals procedures explained on the previous page.

A number of other health care options are made available to you through companies with which the Plan contracts. Self-insured contracted benefit partners include Oxford Health Plans, Optum Behavioral Health, Delta Dental PPO, Express Scripts and Vision Service Plan (VSP). First level appeals for health care services made available through these contracted benefit partners are handled by the companies themselves, rather than the Plan. Following the first

▶ **Appeals Time Limits for Plan Contracted Benefit Partners:**

	CLAIMS NOT REQUIRING PREAUTHORIZATION (Post-Service Claims)	CLAIMS REQUIRING PREAUTHORIZATION (Pre-Service Claims)	URGENT CLAIMS REQUIRING PREAUTHORIZATION (Urgent Claims)
How long does a Participant have to appeal?	▶ **180 days** following the process date of the Claim as indicated on the Explanation of Benefits or other initial Adverse Benefit Determination.	▶ **180 days** following the process date of the Claim as indicated on the Explanation of Benefits or other initial Adverse Benefit Determination.	▶ **180 days** following the process date of the Claim as indicated on the Explanation of Benefits or other initial Adverse Benefit Determination.
What is the appeal deadline by which Claimant must be notified of appeals decision?	▶ If one required level of appeal: **60 days** from receipt of the appeal. ▶ If two required levels of appeal: **30 days** from receipt of the appeal for each level. ▶ For time limits for second level appeals reviewed by the Benefits/Appeals Committee, please see page 44.	▶ If one required level of appeal: **30 days** from receipt of the appeal. ▶ If two required levels of appeal: **15 days** from receipt of the appeal for each level. ▶ For time limits for second level appeals reviewed by the Benefits/Appeals Committee, please see page 44.	▶ **72 hours** from receipt of the appeal.*

**In conjunction with such an appeal, a Claimant may submit information by any expeditious method including fax, phone or other electronic means, or in person.*

level appeal through the contracted benefit partner, if there is a decision with which you do not agree, you may file a second level appeal with the Plan's Benefits/Appeals Committee. You must submit your request in writing to the Benefits/Appeals Committee to the address indicated on the previous page.

The Plan also offers the option for enrollment in fully-insured contracted benefit partners, such as Health Net, Kaiser Permanente and DeltaCare USA. The appeals procedures available under these plans are detailed on the following pages in the section describing each plan.

As indicated in the chart on the previous page, the time frames for contracted benefit partners to process your appeals depend on the type of appeal filed.

You should also review the material in the *SPD*, which is specific to the contracted benefit partners as well as the separate materials furnished to you by the benefit partners. A contracted benefit partner may not, however, under current ERISA guidelines, require you to participate in mandatory binding arbitration in connection with an appeal of an Adverse Benefit Determination.

Note:

Provider initiated appeals (i.e., those appeals that are initiated by a Provider rather than a Participant or Dependent) are subject to the same rules set forth above, but will only be considered if the Participant or Dependent has assigned his or her Claim to the Provider.

APPEALS DETERMINATIONS

In appeals determinations, processed by either the Plan or one of its contracted benefit partners, the following information shall be made available:

1. The specific reason or reasons for any adverse determination.
2. Reference to the *SPD* or related provisions on which the determination is based.
3. In the event that a rule or protocol was relied upon, it will be identified and either set forth or stated that it will be provided, at no charge, upon request.
4. If the adverse decision is based on medical necessity, experimental treatment, or similar Exclusion or limitation, a clinical or scientific explanation will be provided or it will be stated that such will be provided, at no charge, upon request.
5. A statement regarding the Claimant's right to bring a civil action under Section 502(a) of ERISA.
6. A statement that the Claimant is entitled to receive, upon request, and at no charge, reasonable access to and copies of documents, records and other information related to the Claim for benefits.

NATURE OF CLAIMS APPEALS PROCESS

The appeals process is an independent one in the sense that it shall take a fresh look at the relevant documents, and not just defer to the conclusion of the initial decision maker. You, the Claimant, have the right to submit any additional documents or information for the appeal, whether or not such information was submitted to the initial decision maker.

In the event that the disposition of an appeal is based on medical necessity, experimental treatment, or similar Exclusion or limit, the appeals process shall utilize a health care professional who has appropriate training and experience in that field of medicine, and who:

1. was not consulted in connection with the initial Adverse Benefit Determination being reviewed; and
2. was not the subordinate of the decision maker in the initial determination.

You also have the right to obtain, upon request, the identity of any medical or vocational experts from whom advice was obtained in connection with an Adverse Benefit Determination. You similarly have the right to obtain in connection with your appeal, at no charge and upon request, reasonable access to and copies of documents relevant to your appeal, as provided under ERISA guidelines.

You also have the right to utilize another person to represent you during the appeals process. If you wish to take advantage of this, you must notify the Plan (or other entity if such other entity is processing your appeal), and you may be required to fill out an appropriate form. The Plan or the contracted benefit partner offering the benefit reserves the right to verify that any such designation is authentic. In the case of an urgent care Claim (requiring Preauthorization) made to a Plan contracted benefit partners, a health care professional with knowledge of the Participant's medical condition may act as the authorized representative of the patient. These time limits may be extended if both the Claimant and the entity processing the appeal agree to do so.

MOTION PICTURE INDUSTRY HEALTH PLAN

BENEFIT OPTIONS

MPI Benefits

HELPING YOU +
YOUR FAMILY LEAD
MORE VIBRANT LIVES

Anthem BlueCross

Health Net®

KAISER PERMANENTE®

UnitedHealthcare® Oxford

OPTUM

DELTA DENTAL®

Ullico

EXPRESS SCRIPTS®

vsp®

healthy MPI
Engage ▸ Educate ▸ Empower

MOTION PICTURE INDUSTRY HEALTH PLAN

MEDICAL PLAN OPTIONS

Notes

Back to Contents

Medical Plan Options

As a Participant, you have an extensive package of benefits available to you, and you have choices within that package. In order to make decisions appropriate to your needs, it is in your best interest to take time to familiarize yourself with your medical and hospital plan options.

The benefit comparison chart provided on the following pages offers information to help you identify the best benefit match for your individual circumstances. It is provided for your information only. The Plan makes no recommendations regarding the use of any of the options offered.

The Plan's Board of Directors retains the right to interpret and apply the Plan, and any interpretation of the Plan is final and binding upon Participants, their Dependents, and Providers of services. The Board of Directors also reserves the right to alter and amend the level and nature of benefits provided.

Employees of the Plan have no authority to alter benefits or eligibility rules. Any interpretations or opinions given by Employees of the Plan are not binding on the Board of Directors and cannot increase or change such benefits or eligibility rules.

In accessing your benefits, please remember that, although a physician may make a recommendation or provide a prescription, this does not, of itself, establish coverage by the Plan. As to the determination of Non-Covered Services and items, the Plan does not imply that the services and items are not beneficial for the

health management of the patient, nor does it wish to interfere with the patient/Provider relationship. Rather, the Plan is being administered in accordance with its terms.

SERVICES PROVIDED IN CALIFORNIA

Participants who live in California can choose to be enrolled in the Motion Picture Industry Health Plan/Anthem Blue Cross (MPIHP/Anthem Blue Cross), Health Net or Kaiser Permanente. Health benefits provided through these plans are summarized in this *SPD*.

Participants who enroll in Health Net or Kaiser Permanente (HMOs) will be covered through MPIHP/Anthem Blue Cross for their first month of coverage through the Plan unless the Participant is already covered in their chosen HMO through some other group or individual plan, or has selected the HMO prior to their initial eligibility date. Other Participants will be moved to Health Net or Kaiser Permanente at the beginning of the second month.

Note:

Participants who have selected one of the HMOs offered by the Plan must use the HMO for mental health and chemical dependency benefits.

SERVICES PROVIDED FOR RESIDENTS OUTSIDE OF CALIFORNIA

Participants residing outside California will be enrolled in the BlueCard Program.

The Oxford Health Plans, a Point of Service plan, is also available as an alternate choice for residents of the Oxford Health Plans' service area of New York, New Jersey and Connecticut.

For those Participants residing in the Oxford Health Plans' service area, during the first month of your initial selection of the Oxford Health Plans, you will likely be covered in the BlueCard Program. The exception is for Participants already covered in the Oxford Health Plans through some other group or individual plan. He or she will be enrolled in the Oxford Health Plans from the first month of eligibility.

A chart comparing the general difference in covered benefits among the four plans offered by the Plan is included in the following pages.

Medical Plan Options

▸ **For more information on the benefits below, please see the Medical Plan Options section beginning on page 59.**

MPIHP/ ANTHEM BLUE CROSS	HEALTH NET (California Only)	KAISER PERMANENTE (California Only)	OXFORD HEALTH PLANS (New York, New Jersey & Connecticut Only)
Out-of-Network Coverage			
▸ Yes, as shown below	▸ Only in an emergency	▸ Only in an emergency	▸ Yes, as shown below
Annual Deductible			
▸ None	▸ None	▸ None	▸ In-Network: None ▸ Out-of-Network: $500 per person up to $1,000 per family
Annual Out-of-Pocket Maximum			
▸ In-Network: $1,000 per person for Coinsurance; does not include Co-Payments ▸ Out-of-Network: Unlimited	▸ $1,500 per person up to $4,500 per family for both Coinsurance and Co-Payment	▸ $1,500 per person up to $3,000 per family for both Coinsurance and Co-Payment	▸ In-Network: $0 ▸ Out-of-Network: $8,000 per person up to $16,000 per family for Coinsurance and Deductible; does not include Co-Payments
Hospital Services Room and Board | Intensive Care | Ancillary Services | Semi-Private Room			
▸ In-Network Facility: Coinsurance is 10% of the Contracted Amount, plus $100 Co-Payment per admission ▸ Out-of-Network Facility: Coinsurance is 50% of the Allowable Amount, plus $100 Co-Payment per admission; Balance Billing may apply	▸ No charge	▸ No charge	▸ In-Network: No charge ▸ Out-of-Network: Deductible plus Coinsurance is 30% ; Balance Billing may apply
Extended Care Room and Board in a Skilled Nursing Facility | Other Services and Supplies			
▸ In-Network: Coinsurance is 10% of the Contracted Amount ▸ Out-of-Network: Coinsurance is 50% of the Allowable Amount; Balance Billing may apply ▸ Plan coverage ends after - 90 days for Participants per stay - 60 days for Dependents per stay ▸ See page 78 for more information	▸ No charge (up to 100 days per calendar year)	▸ No charge (up to 100 days per calendar year)	▸ In-Network: No charge ▸ Out-of-Network: Deductible plus Coinsurance is 30%; Balance Billing may apply

▶ **For more information on the benefits below, please see the Medical Plan Options section beginning on page 59.**

MPIHP/ ANTHEM BLUE CROSS	HEALTH NET (California Only)	KAISER PERMANENTE (California Only)	OXFORD HEALTH PLANS (New York, New Jersey & Connecticut Only)
Emergency Services Within or Outside Service Area			
▶ In-Network: Coinsurance is 10% of the Contracted Amount, plus $100 Co-Payment (If admitted, emergency room Co-Payment will be applied to hospital admission) ▶ Out-of-Network: Coinsurance is 10% of the Allowable Amount, plus $100 Co-Payment (If admitted, emergency room Co-Payment will be applied to hospital admission); Balance Billing may apply	▶ $35 Co-Payment (waived if admitted to a hospital) ▶ All Covered Services, when medically necessary, are available anywhere in the world from any licensed physician, surgeon or general hospital	▶ $35 Co-Payment (waived if admitted to a hospital) ▶ All Covered Services, when medically necessary, are available anywhere in the world from any licensed physician, surgeon or general hospital	▶ $25 Co-Payment (waived if admitted to a hospital) ▶ All Covered Services, when medically necessary, are available anywhere in the world from any licensed physician, surgeon or hospital; Balance Billing may apply
Physician Visits (See page 73 for Comprehensive Physical Exams) Co-Payments apply per office visit and inpatient visit unless otherwise noted			
▶ UCLA-MPTF and TIHN: $5 Co-Payment and 100% coverage for Covered Services ▶ In-Network within MPTF area:* Coinsurance is 10% of the Contracted Amount, plus $30 Co-Payment ▶ In-Network out of MPTF area: Coinsurance is 10% of the Contracted Amount, plus $15 Co-Payment ▶ Out-of-Network within MPTF area:* Coinsurance is 50% of the Allowable Amount, plus $30 Co-Payment; Balance Billing may apply ▶ Out-of-Network out of MPTF area: Coinsurance is 50% of the Allowable Amount, plus $15 Co-Payment; Balance Billing may apply ▶ *See UCLA-MPTF service area ZIP codes on page 64 ▶ See page 65 for more information	▶ $15 Co-Payment for office visits ▶ No charge for inpatient visits and no Balance Billing ▶ Out-of-Network: Not covered	▶ $15 Co-Payment for office visits ▶ No charge for inpatient visits and no Balance Billing ▶ Out-of-Network: Not covered	▶ In-Network: $15 Co-Payment for office visits; no charge for inpatient visits ▶ Out-of-Network: Deductible plus Coinsurance is 30%; Balance Billing may apply
Urgent Care Visits			
▶ Same as Physician Visits ▶ Exer Urgent Care visits $15 Co-Payment and no Coinsurance	▶ $35 Co-Payment	▶ $15 Co-Payment	▶ $15 Co-Payment

▸ **For more information on the benefits below, please see the Medical Plan Options section beginning on page 59.**

MPIHP/ ANTHEM BLUE CROSS	HEALTH NET (California Only)	KAISER PERMANENTE (California Only)	OXFORD HEALTH PLANS (New York, New Jersey & Connecticut Only)
Anesthesia (Note that an anesthesiologist can be Out-of-Network even when the hospital and surgeon are In-Network)			
▸ In-Network: Coinsurance is 10% of the Contracted Amount ▸ Out-of-Network: Coinsurance is 50% of the Allowable Amount; Balance Billing may apply	▸ In-Network: No charge ▸ Out-of-Network: Not covered	▸ In-Network: No charge ▸ Out-of-Network: Not Covered	▸ In-Network: No charge ▸ Out-of-Network: Coinsurance is 30%; Balance Billing may apply
Ambulance Services (including air ambulance)			
▸ Emergency: - In-Network: Coinsurance is 10% of the Contracted Amount - Out-of-Network: Coinsurance is 10% of the Allowable Amount; Balance Billing may apply ▸ Non-emergency and medically necessary: - In-Network: Coinsurance is 10% of the Contracted Amount - Out-of-Network: Coinsurance is 50% of Allowable Amount; Balance Billing may apply ▸ See page 68 for more information	▸ Emergency: No charge ▸ Non-emergency: Prior approval is required	▸ Emergency: No charge ▸ Non-emergency: Prior approval is required	▸ Emergency: No charge ▸ Non-emergency: Prior approval is required ▸ Non-emergency Air Transportation is not covered ▸ Out-of-Network: Balance Billing may apply
Injectable Drugs (Outpatient)			
▸ In-Network: Coinsurance is 10% of the Contracted Amount ▸ Out-of-Network: Coinsurance is 50% of the Allowable Amount; Balance Billing may apply ▸ Covered through Express Scripts, except Allergy Shots. Please see Express Scripts discussion about Specialty Medications on page 143	▸ No Charge for injections, allergy injections or testing (Injections for infertility are paid at 50%) ▸ Covered through Express Scripts	▸ Most injectable drugs, including allergy tests, provided at no charge if administered in the medical office ▸ Covered through Express Scripts	▸ Subject to Physician Visit Co-Payment ▸ Covered through Express Scripts ▸ Out-of-Network: Balance Billing may apply

▸ **For more information on the benefits below, please see the Medical Plan Options section beginning on page 59.**

MPIHP/ ANTHEM BLUE CROSS	HEALTH NET (California Only)	KAISER PERMANENTE (California Only)	OXFORD HEALTH PLANS (New York, New Jersey & Connecticut Only)
Laboratory Tests and Diagnostic Imaging			
▸ In-Network: Coinsurance is 10% of the Contracted Amount ▸ Out-of-Network: Coinsurance is 50% of the Allowable Amount; Balance Billing may apply	▸ No charge	▸ No charge	▸ In-Network: No charge ▸ Out-of-Network: Deductible plus Coinsurance; Balance Billing may apply
Eye Examinations			
▸ $20 Co-Payment for routine eye examinations and corrective lenses are covered through VSP *(see Vision Service Plan section)* ▸ Non-routine see Physician Visit	▸ $15 Co-Payment per visit ▸ Routine exams are also covered through VSP at a $20 Co-Payment *(see Vision Service Plan section)*	▸ $15 Co-Payment per visit ▸ Routine exams are also covered through VSP at a $20 Co-Payment *(see Vision Service Plan section)*	▸ $20 Co-Payment for routine eye examinations and corrective lenses are covered through VSP *(see Vision Service Plan section)* ▸ Non-routine same as Physician Visit
Chiropractic Services			
▸ In-Network: No Charge ▸ Out-of-Network: Maximum Allowable Amount and other limitations apply (see page 69); Balance Billing may apply ▸ Maximum of 20 visits per calendar year for both In and Out-of-Network	▸ $15 Co-Payment per visit ▸ Available through ASH Networks only	▸ $15 Co-Payment per visit ▸ Available through ASH Networks only	▸ In-Network: $15 Co-Payment per visit ▸ Out-of-Network: Coinsurance is 30%, plus Deductible; Balance Billing may apply
Physical Therapy			
▸ Same as Physician Visits ▸ In-Network: Maximum of 16 visits per calendar year; additional visits may be authorized upon review by the Plan's Medical Review Department; criteria for additional visits may include medical necessity and/or occurrence of another injury; visit limit applies to both In and Out-of-Network ▸ Out-of-Network: Maximum Allowable Amounts and other limitations apply (see page 75); Balance Billing may apply	▸ No charge	▸ $15 Co-Payment per visit	▸ In-Network: $15 Co-Payment per visit (through UHC); ▸ Out-of-Network: Coinsurance is 30%, plus Deductible; Balance Billing may apply ▸ Maximum of 90 visits per condition per lifetime for both In and Out-of-Network ▸ Maximum of 60 inpatient days per condition per lifetime for both In and Out-of-Network

▶ **For more information on the benefits below, please see the Medical Plan Options section beginning on page 59.**

MPIHP/ ANTHEM BLUE CROSS	HEALTH NET (California Only)	KAISER PERMANENTE (California Only)	OXFORD HEALTH PLANS (New York, New Jersey & Connecticut Only)
Comprehensive Physical Exams (Annual)			
▶ Applicable Co-Payment and Coinsurance apply ▶ For adults with addresses listed inside of Los Angeles County: Must use a UCLA-MPTF Health Center Provider to be covered, with a $5 Co-Payment and no Coinsurance ▶ For adults with addresses listed outside of Los Angeles County: Annual Exam is covered, see Physician Visits for details ▶ For children (i.e., below age 18): See Physician Visits for details ▶ See page 73 for more information	▶ $15 Co-Payment	▶ $15 Co-Payment	▶ In-Network: No charge ▶ Out-of-Network: Not covered except for children under age 19. The benefit is paid after the Deductible plus Coinsurance of 30%
Home Hospice			
▶ No charge	▶ No charge	▶ No charge	▶ Same as other Home Health Services
Home Health Services Physician Home Visits			
▶ Same as Physician benefit	▶ $30 Co-Payment per visit	▶ No charge; limited to 100 visits per year and three visits per day.	▶ In-Network: $15 Co-Payment ▶ Out-of-Network: Deductible plus Coinsurance of 30%
Home Health Nurse			
▶ No Co-Payments ▶ In-Network: Coinsurance is 10% of the Contracted Amount ▶ Out-of-Network: Coinsurance is 50% of the Allowable Amount; Balance Billing may apply	▶ $10 Co-Payment on and after the 31st calendar day	▶ No charge; same limits as Physician Home Visits	▶ In-Network: $15 for initial visit; only 60 visits per year with maximum of 4 hours per visit ▶ Out-of-Network: Coinsurance is 20%; only 60 visits per year with maximum of 4 hours per visit; Balance Billing may apply

▸ **For more information on the benefits below, please see the Medical Plan Options section beginning on page 59.**

MPIHP/ ANTHEM BLUE CROSS	HEALTH NET (California Only)	KAISER PERMANENTE (California Only)	OXFORD HEALTH PLANS (New York, New Jersey & Connecticut Only)
Telemedicine			
▸ Provided by LiveHealth Online; visit www.livehealthonline.com ▸ $20 Co-Payment	▸ Provided by Teladoc; visit www.Teladoc.com/hn or call (800) 835-2362 ▸ No Co-Payment	▸ For the appointment and advice line, please call (833) 574-2273 ▸ For telephone and video visits, no Co-Payment	▸ Not available at this time
Maternity Benefits			
▸ In-Network: See Physician Visits Co-Payment section for initial visit Co-Payment; No Co-Payment for subsequent care ▸ Out-of-Network: Coinsurance is 50% of the Allowable Amount; Balance Billing may apply ▸ Dependent children and surrogates not covered	▸ $15 Co-Payment per visit ▸ No charge in hospital	▸ $15 Co-Payment per visit ▸ No charge in hospital	▸ In-Network: $15 Co-Payment for initial visit, no charge for subsequent care ▸ Out-of-Network: Covered only in an emergency
Family Planning Services Intrauterine Device (IUD provided in a Physician's office)			
▸ UCLA-MPTF and TIHN: $5 Co-Payment and 100% coverage for Covered Services ▸ In-Network within MPTF area:* Coinsurance is 10% of the Contracted Amount, plus $30 Co-Payment ▸ In-Network out of MPTF area: Coinsurance is 10% of the Contracted Amount, plus $15 Co-Payment ▸ Out-of-Network within MPTF area:* Coinsurance is 50% of the Allowable Amount, plus $30 Co-Payment; Balance Billing may apply ▸ Out-of-Network out of MPTF area: Coinsurance is 50% of the Allowable Amount, plus $15 Co-payment; Balance Billing may apply ▸ *See UCLA-MPTF service area ZIP codes on page 64	▸ $15 Co-Payment for the insertion and removal of the IUD only; the IUD is not covered	▸ $15 Co-Payment	▸ Not covered

▶ **For more information on the benefits below, please see the Medical Plan Options section beginning on page 59.**

MPIHP/ ANTHEM BLUE CROSS	HEALTH NET (California Only)	KAISER PERMANENTE (California Only)	OXFORD HEALTH PLANS (New York, New Jersey & Connecticut Only)
Family Planning Services Vasectomy/Tubal Ligations			
▶ TIHN: $5 Co-Payment and 100% coverage for Covered Services, with a referral ▶ In-Network: Coinsurance is 10% of the Contracted Amount ▶ Out-of-Network: Coinsurance is 50% of the Allowable Amount; Balance Billing may apply	▶ $50 Co-Payment	▶ Outpatient: $15 Co-Payment ▶ Inpatient: No charge	▶ In-Network: No charge, reversal not covered; Balance Billing may apply ▶ Out-of-Network: Coinsurance is 30%, plus Deductible
Pregnancy Termination			
▶ TIHN: $5 Co-Payment and 100% coverage for Covered Services, with a referral ▶ In-Network: Coinsurance is 10% of the Contracted Amount ▶ Out-of-Network: Coinsurance is 50% of the Allowable Amount; Balance Billing may apply ▶ Dependent children not covered	▶ No Charge for medically necessary abortion ▶ $150 for elective abortion	▶ Outpatient: $15 Co-Payment ▶ Inpatient: No charge	▶ In-Network: No charge ▶ Out-of-Network: Coinsurance is 30%, plus Deductible ▶ Maximum Allowable Amount of $350 per abortion for both In and Out-of-Network
Mental Health (Outpatient)			
▶ Mental health benefits are provided through Optum Behavioral Health (see page 86) ▶ In-Network: $5 Co-Payment per visit ▶ Out-of-Network: Coinsurance is 50% of the Allowable Amount; Balance Billing may apply	▶ $15 Co-Payment per visit	▶ $15 Co-Payment per visit ▶ $7 Co-Payment per visit for group therapy	▶ In-Network: $15 Co-Payment per visit ▶ Out-of-Network: Coinsurance is 30%, plus Deductible
Mental Health (Inpatient)			
▶ Mental health benefits are provided through Optum Behavioral Health (see page 86) ▶ In-Network: No charge ▶ Out-of-Network: $100 Co-Payment per admission, then Coinsurance of 50% of the Allowable Amount; Balance Billing may apply	▶ No charge	▶ No charge	▶ In-Network: No charge ▶ Out-of-Network: Coinsurance is 30%, plus Deductible

Motion Picture Industry Health Plan / Anthem Blue Cross

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007
(800) 688-3828
www.anthem.com

Group Number:
277163

Plan Code:
040

As a Participant, you have the option of selecting comprehensive medical and hospital coverage through the Motion Picture Industry Health Plan/Anthem Blue Cross (MPIHP/Anthem Blue Cross) option. You should become familiar with the limitations, as well as opportunities, to save Out-of-Pocket costs by using In-Network Providers.

IN CALIFORNIA

The hospital and the medical PPO network in California is provided by Anthem Blue Cross, and the benefits are administered by MPIHP.

OUTSIDE OF CALIFORNIA

The hospital and the medical PPO network outside California is provided by the BlueCard Program, and the benefits are administered by MPIHP.

Provider Options

MOTION PICTURE INDUSTRY HEALTH PLAN/ANTHEM BLUE CROSS

UCLA–MPTF HEALTH CENTERS & THE INDUSTRY HEALTH NETWORK

Available in Southern California

The Plan has entered into an agreement with UCLA-Motion Picture & Television Fund (UCLA-MPTF) Health Centers to establish The Industry Health Network (TIHN). Providers, including Primary Care Providers, Medical Specialists and Surgeons participating in TIHN have agreed to a special fee schedule for Plan Participants and their eligible Dependents.

The UCLA-MPTF Health Centers service area is described on pages 63 through 64.

Co-Payment Amount

Participants and Dependents will be required to pay a $5 Co-Payment for office visits to UCLA-MPTF Health Centers Primary Care Providers. Participants and Dependents, with a Referral, will be required to pay a $5 Co-Payment for an office visit to Medical Specialists or Surgeons participating in The Industry Health Network (TIHN). Referrals are obtained from the UCLA-MPTF Health Centers Primary Care Providers.

Coinsurance Amount

Participants and Dependents visiting a UCLA-MPTF Health Centers, or a Primary Care Provider, Medical Specialist or Surgeon participating in TIHN for which UCLA-MPTF provided a Referral will have Covered Services paid at 100% of the Contracted Amount.

EXER URGENT CARE

Available in Southern California

Participants can visit an Exer Urgent Care clinic. These clinics are available in Southern California only. For more information on Exer Urgent Care clinics, visit www.exerurgentcare.com.

Co-Payment Amount

Participants will be required to pay a $15 Co-Payment.

Coinsurance Amount

Participants will have Covered Services paid at 100% of the Contracted Amount.

MPIHP/ANTHEM BLUE CROSS - IN-NETWORK PROVIDERS

Available Inside of California

Participants may see a Provider of his or her choice, but if he or she chooses to go to an Anthem Blue Cross In-Network Primary Care Provider, Medical Specialist or Surgeon, he or she will have lower Out-of-Pocket expenses. Please note that Participants who reside in Los Angeles County must have their Comprehensive Physical Exam performed at a UCLA-MPTF Health Center in order for it to be covered.

Co-Payment Amount

Participants who reside in the UCLA-MPTF Health Centers' service area will pay a $30 Co-Payment to see a Primary Care Provider, Medical Specialist or Surgeon.

Participants who reside outside of the UCLA-MPTF Health Centers service area will pay a $15 Co-Payment to see a Primary Care Provider, Medical Specialist or a Surgeon.

Coinsurance Amount

For an In-Network Provider, the Contracted Amount is the contracted rate between Anthem Blue Cross and the In-Network Provider.

Participants visiting an In-Network Primary Care Provider, Medical Specialist or Surgeon will have Covered Services paid at 90% of the Contracted Amount.

THE BLUECARD PROGRAM - IN-NETWORK PROVIDERS

Available Outside of California

The Plan and the BlueCard Program have entered into an agreement to provide Participants with access to quality care with significant Out-of-Pocket savings nationwide. Participants may still see a Provider of his or her choice, but if he or she chooses to go to a BlueCard Program In-Network Provider, he or she may have lower Out-of-Pocket expenses.

Co-Payment Amount

Participants will pay a $15 Co-Payment to see a Primary Care Provider, Medical Specialist or Surgeon. However, be aware, the Co-Payment will be $30 if your address on record at the Plan is in the UCLA-MPTF service area.

Coinsurance Amount

For an In-Network Provider, the Contracted Amount is the contracted rate between the BlueCard Program and the In-Network Provider. Participants visiting a Primary Care Provider, Medical Specialist or Surgeon who is an In-Network Provider of the BlueCard Program will have Covered Services paid at 90% of the Contracted Amount.

OUT-OF-NETWORK PROVIDERS

Available Inside and Outside of California

A Participant may see a Primary Care Provider, Medical Specialist or Surgeon of his or her choice, but if he or she sees an Out-of-Network Provider, he or she will have higher Out-of-Pocket expenses.

Co-Payment Amount

Participants who reside in the UCLA-MPTF Health Centers service area will pay a $30 Co-Payment per visit to see an Out-of-Network Primary Care Provider, Medical Specialist or Surgeon.

Participants who reside outside of the UCLA-MPTF Health Centers service area will pay a $15 Co-Payment per visit to see an Out-of-Network Primary Care Provider, Medical Specialist or Surgeon. See UCLA-MPTF service area on page 64.

Coinsurance Amount for Out-of-Network Providers In California

Coinsurance is 50% of the Allowable Amount for Covered Services.

The Out-of-Network Allowable Amount is based on an analysis of Usual, Customary, and Reasonable (UCR) rates for a specific geographic area based on pricing rates in a FAIR Health data base. The Allowable Amount is set at the 70th percentile,

which means that the UCR rates are greater than or equal to the charges billed for that service/procedure by 70% of the Providers in the geographic area.

Coinsurance Amount for Out-of-Network Providers Outside of California

Coinsurance is 50% of the Allowable Amount for Covered Services.

Anthem Blue Cross has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "Inter-Plan Programs." When you obtain health care services outside of the Anthem Blue Cross service area, the Claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program, and may include negotiated national account arrangements available between Anthem Blue Cross and other Blue Cross and Blue Shield licensees. The amount reimbursed is 50% of the Inter-Plan Program negotiated national account arrangement. Or, in some cases, the Allowable Amount may be the 70th percentile of UCR, in which case reimbursement is 50% of the 70th percentile of the UCR, less the Co-Payment.

TELEMEDICINE

Available Inside the United States and Its Territories

Telemedicine is provided to Participants through LiveHealth Online. The service area includes the United States and its territories. This service may not be used by a Participant or his or her eligible Dependent when he or she is outside of the United States or its territories.

Co-Payment Amount

A Participant will pay a $20 Co-Payment.

Coinsurance Amount

A Participant will have Covered Services paid at 100% of the Allowable Amount.

OTHER SCHEDULES OF ALLOWABLE AMOUNTS

The professional fees noted below are limited to the Contracted Amount, if In-Network, or Allowable Amount, if Out-of-Network.

Assistant Surgeons

An Assistant Surgeon is not covered for all surgical procedures. An Assistant Surgeon is covered for procedures that involve:

- A difficult exposure, dissection and/or closure;
- Procedures in which an Assistant Surgeon is used routinely in the community; or
- Procedures that are technically demanding, where the use of an assistant with the skills of a surgeon is imperative to safeguard the life of the patient.

The Allowable Amount for an Out-of-Network Assistant Surgeon is based on the usual, customary and reasonable charge at the current Centers for Medicare & Medicaid (CMS) percentage in effect at the time the Claim is incurred.

Anesthesiologists

Allowances for anesthesiology are based on anesthesia procedure codes and the duration of anesthesia.

UCLA-MPTF Service Area

UCLA-MOTION PICTURE & TELEVISION FUND HEALTH CENTERS

The Plan's medical/hospital benefits permit you free choice of physicians and hospitals. However, there is a medical group that provides medical care through its health centers that is less expensive to the patient than is possible under the other Plan provisions.

The UCLA-Motion Picture & Television Fund (UCLA-MPTF) Health Centers provide cost savings and access to Providers with a unique understanding of the needs of entertainment industry Participants and their eligible Dependents. The UCLA-MPTF Health Centers treat adults and children age 13 and older. For children under age 13, Participants may opt to visit a Provider at a pediatric physician group through The Industry Health Network (TIHN). See below.

Participants and their eligible Dependents who visit one of the five UCLA-MPTF Health Centers in Los Angeles, or the UCLA Medical Group's Primary Care Clinic in Simi Valley, may be provided a Referral to see a Provider in TIHN, a group of contracted Specialists and ancillary Providers.

Participants and/or Dependents who see a Provider at the UCLA-MPTF Health Centers will be required to pay a $5 Co-Payment. In addition, Covered Services will be paid at 100%.

If you live in a ZIP code within the UCLA-MPTF service area and choose not to visit the UCLA-MPTF Health Centers, you will be required to pay a $30 Co-Payment, plus any applicable Coinsurance.

For help selecting a Provider or to schedule an appointment, please call the UCLA-MPTF Health Centers' customer service phone number on page 64. Be sure to identify yourself as a Plan Participant when you call, and take your insurance card with you to your appointment.

Please note, if you live in the County of Los Angeles and would like a Comprehensive Physical Exam, you must see a Provider at one of the UCLA-MPTF Health Centers. Please see page 73 for important information about Comprehensive Physical Exams.

THE INDUSTRY HEALTH NETWORK

There is a strong cost-saving incentive for Participants to use the UCLA-MPTF Health Centers and obtain referrals to TIHN Providers.

TIHN referrals do not apply to in-patient stays or outpatient facility services, with the exception of physical therapy, speech therapy and occupational therapy.

TIHN has a network of Providers at pediatric physician groups available. For a referral to one of these pediatric physician groups, call (800) 876-8320, Monday through Friday.

Participants who would like to see a TIHN Provider for maternity benefits should first see a Provider through the UCLA-MPTF Health Centers; this Provider will then provide a TIHN referral to an obstetrician.

Participants and/or Dependents who see a TIHN Provider will be required to pay a $5 Co-Payment. In addition, Covered Services will be paid at 100%.

UCLA-MPTF Service Area ZIP Codes

90004	90095	91352
90005	90210	91354
90006	90211	91355
90007	90212	91356
90008	90232	91364
90010	90290	91367
90016	90401	91377
90018	90402	91381
90019	90403	91384
90020	90404	91387
90024	90405	91390
90025	91201	91401
90026	91202	91403
90027	91203	91405
90028	91204	91406
90029	91205	91411
90034	91207	91423
90035	91208	91436
90036	91214	91501
90038	91301	91502
90039	91302	91504
90046	91303	91505
90048	91304	91506
90049	91306	91522
90057	91307	91601
90064	91311	91602
90066	91316	91604
90067	91321	91605
90068	91335	91606
90069	91350	91607
90077	91351	91608

UCLA-MPTF Health Centers

Customer Service: (800) 876-8320 | www.uclahealth.org/mptf

The facilities listed below are not available to Participants who are enrolled in Health Net, Kaiser Permanente or Oxford Health Plans. The Plan makes no recommendations regarding the use of these Providers but merely provides this information for use at your own discretion.

- **Bob Hope Health Center**
  335 North La Brea Avenue
  Los Angeles, California 90036
  General Phone Number:
  (323) 634-3850
  Social Services Department:
  (323) 634-3888
  Physical Therapy:
  (323) 634-3826
- **Toluca Lake Health Center**
  4323 Riverside Drive
  Burbank, California 91505
  General Phone Number:
  (818) 556-2700
  Social Services Department:
  (323) 634-3888
  Physical Therapy:
  (818) 295-3355
  Radiology:
  (818) 295-3320
- **Santa Clarita Health Center**
  25751 McBean Parkway
  Suite 210
  Valencia, California 91355
  General Phone Number:
  (661) 284-3100
  Social Services Department:
  (323) 634-3888
  Physical Therapy:
  (661) 284-3155
- **Westside Health Center**
  1950 Sawtelle Boulevard
  Suite 130
  Los Angeles, California 90025
  General Phone Number:
  (310) 996-9355
  Social Services Department:
  (323) 634-3888
  Physical Therapy:
  (310) 231-3001
- **Calabasas Health Center**
  26585 West Agoura Road
  Suite 330
  Calabasas, California 91302
  General Phone Number:
  (818) 876-1050
  Radiology:
  (818) 876-1011
  Social Services Department:
  (323) 634-3888

MEDICAL OFFICE VISITS

Provider Options | Other than a Comprehensive Physical Exam

IF PATIENT IS LESS THAN 18 YEARS OLD		
OPTIONS	**PLAN PAYS**	**PATIENT PAYS**
VISIT A PROVIDER AT A TIHN PEDIATRIC PHYSICIAN GROUP[1]	▸ 100% of Covered Services	▸ $5 Co-Payment + Any costs for Non-Covered Services
VISIT A PROVIDER AT A UCLA-MPTF HEALTH CENTER For patients 13 years old and older	▸ 100% of Covered Services	▸ $5 Co-Payment + Any costs for Non-Covered Services
VISIT AN ANTHEM BLUE CROSS OR BLUECARD PROVIDER WHO IS IN-NETWORK	▸ 90% of the Anthem Blue Cross/ BlueCard Contracted Amount for Covered Services	▸ 10% of the Anthem Blue Cross/BlueCard Contracted Amount for Covered Services (Coinsurance) + $15 Co-Payment **if the patient lives outside the UCLA-MPTF service area**[2] + Any costs for Non-Covered Services
	▸ 90% of the Anthem Blue Cross/ BlueCard Contracted Amount for Covered Services	▸ 10% of the Anthem Blue Cross/BlueCard Contracted Amount for Covered Services (Coinsurance) + $30 Co-Payment **if the patient lives in the UCLA-MPTF service area**[2] + Any costs for Non-Covered Services
VISIT A PROVIDER WHO IS OUT-OF-NETWORK Not in the Anthem Blue Cross/BlueCard Network	▸ 50% of the Anthem Blue Cross/ BlueCard Allowable Amount or the 70th percentile of UCR for Covered Services	▸ 50% of the Anthem Blue Cross/BlueCard Allowable Amount or the 70th percentile of UCR for Covered Services (Coinsurance) + $15 Co-Payment **if the patient lives outside the UCLA-MPTF service area**[2] + Any Balance Billing, including costs for Non-Covered Services
	▸ 50% of the Anthem Blue Cross/ BlueCard Allowable Amount or the 70th percentile of UCR for Covered Services	▸ 50% of the Anthem Blue Cross/BlueCard Allowable Amount or the 70th percentile of UCR for Covered Services (Coinsurance) + $30 Co-Payment **if the patient lives in the UCLA-MPTF service area**[2] + Any Balance Billing, including costs for Non-Covered Services
IF PATIENT IS 18 YEARS OLD OR OLDER		
VISIT A PROVIDER AT A UCLA-MPTF HEALTH CENTER	▸ 100% of Covered Services	▸ $5 Co-Payment + Any costs for Non-Covered Services
VISIT A PROVIDER AT A TIHN PHYSICIAN GROUP[3]	▸ 100% of Covered Services	▸ $5 Co-Payment + Any costs for Non-Covered Services
VISIT AN ANTHEM BLUE CROSS OR BLUECARD PROVIDER WHO IS IN-NETWORK	▸ 90% of the Anthem Blue Cross/ BlueCard Contracted Amount for Covered Services	▸ 10% of the Anthem Blue Cross/BlueCard Contracted Amount for Covered Services (Coinsurance) + $15 Co-Payment **if the patient lives outside the UCLA-MPTF service area**[2] + Any costs for Non-Covered Services
	▸ 90% of the Anthem Blue Cross/ BlueCard Contracted Amount for Covered Services	▸ 10% of the Anthem Blue Cross/BlueCard Contracted Amount for Covered Services (Coinsurance) + $30 Co-Payment **if the patient lives in the UCLA-MPTF service area**[2] + Any costs for Non-Covered Services
VISIT A PROVIDER WHO IS OUT-OF-NETWORK Not in the Anthem Blue Cross/BlueCard Network	▸ 50% of the Anthem Blue Cross/ BlueCard Allowable Amount or the 70th percentile of UCR for Covered Services	▸ 50% of the Anthem Blue Cross/BlueCard Allowable Amount or the 70th percentile of UCR for Covered Services (Coinsurance) + $15 Co-Payment **if the patient lives outside the UCLA-MPTF service area**[2] + Any Balance Billing, including costs for Non-Covered Services
	▸ 50% of the Anthem Blue Cross/ BlueCard Allowable Amount or the 70th percentile of UCR for Covered Services	▸ 50% of the Anthem Blue Cross/BlueCard Allowable Amount or the 70th percentile of UCR or Covered Services (Coinsurance) + $30 Co-Payment **if the patient lives in the UCLA-MPTF service area**[2] + Any Balance Billing, including costs for Non-Covered Services

[1] A Referral to a TIHN pediatric Provider is required. The Referral lasts until the patient is 18 years old.
[2] Where a patient "lives" is based on his or her address on file with the Motion Picture Industry Health Plan. See pages 63 through 64 for UCLA-MPTF service area.
[3] A Referral to a TIHN Provider is required.

Benefit Limitations

MOTION PICTURE INDUSTRY HEALTH PLAN/ANTHEM BLUE CROSS

COVERED SERVICES

The Plan provides benefits for specific medical services that have been approved by its Board of Directors. In order for a specific medical service to be covered, it must be a service for which the Plan has established a benefit. The service must be medically necessary and reasonable. To determine if a particular service is medically necessary and reasonable, the Plan independently reviews the Claim and makes a decision as to whether the nature of the services provided and the amount charged is appropriate for the specific diagnosis under the indicated clinical circumstances.

MEDICALLY NECESSARY

"Medically necessary" means procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice (for these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors);
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;
3. Not primarily for the convenience of the patient, physician or other health care Provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

During this evaluation process, the Plan relies upon the judgment of its medical professionals, and when appropriate, upon the opinions of Specialists in the field who are engaged on a case-by-case basis to review Claims that are in question. In addition, the Plan's medical consultants look to guidelines and standards established by Medicare and other health insurers to determine if services and charges are reasonable and necessary for the specific diagnosis. Listing every service or item that is not covered by the Plan is not possible.

If there is a dispute as to whether the Plan has correctly denied a Claim in whole or in part on the basis that the service was not reasonable and necessary, the Participant or the Provider of service may request in writing a reevaluation of the Plan's decision through the Claims Appeals Procedures described on pages 44 through 46 of the *SPD*.

Decisions made by the Benefits/Appeals Committee are final and binding upon all parties, including Provider(s) of service.

SECOND SURGICAL/ MEDICAL OPINIONS

If you wish to seek a Second Surgical/Medical Opinion, the Plan will pay its customary reimbursement for the cost of the examination and any x-ray and laboratory tests, as appropriate. Second Surgical/Medical Opinions are not a requirement for coverage.

SERVICES NOT COVERED

The Plan's comprehensive benefits do not cover:

- Any medications, treatments or services which are not reasonable and medically necessary for the specific diagnosis under the given clinical circumstances.
- Experimental and/or investigational services, treatments, medications or devices. See "Non-Covered Services and Items," page 80.
- Any services, items or medications which are not approved by the Food and Drug Administration for the specific diagnosis.

EXPERIMENTAL AND/OR INVESTIGATIONAL EXCLUSION

The term "Experimental and/or Investigational Services, Treatments, Medications or Devices" includes any medical, surgical or other health care treatment or procedure and any medication or device which is determined by the Plan to meet any one of the following criteria:

1. It is not generally accepted by the medical community as proven and effective for the treatment of the specific diagnosis.
2. The scientific assessment of the treatment, procedure, medication or device, or its application for the specific diagnosis has not been completed.
3. Any required governmental approval of the treatment, procedure, medication or device for the specific diagnosis has not been granted at the time the service(s) are rendered or the medication prescribed.
4. The treatment, procedure, medication or device, or its application, for the specific diagnosis has been granted approval only for use in connection with an experimental study.
5. The medication or device has not been approved by the Food and Drug Administration for the specific diagnosis.
6. It is a clinical trial, Medical Research Study, or a program requiring the approval of the treating facility's institutional review board.

YEARLY OUT-OF-POCKET MAXIMUM FOR COMPREHENSIVE MEDICAL BENEFITS

The Plan limits the amount a Participant will have to pay on an annual basis to make up the difference between the percentage of the Allowable Amount paid by the Plan and the percentage of the Allowable Amount that is the patient's responsibility. This Out-of-Pocket Maximum applies on a per patient basis, so there is a separate maximum for you and each of your Dependents.

1. **In-Network:**
   The calendar year Out-of-Pocket Maximum is $1,000 for In-Network Coinsurance expenses for hospital and professional charges combined. Co-Payments and non-covered benefits do not count toward the Out-of-Pocket Maximum.
2. **Out-of-Network:**
   There is no limit on Out-of-Pocket costs if a patient uses Out-of-Network Provider or hospitals, except in an emergency (facilities are capped at $1,000 per emergency).

The Out-of-Pocket Maximum does not apply to denied services; it does not apply to visits or procedures in excess of the maximum number allowed under the Plan of Benefits (for example, acupuncture visits in excess of 20 in a calendar year), nor to any benefit for which the Plan pays 100% of the Allowable Amount.

Professional benefits/services include the following items as described below. Applicable Coinsurance and Co-Payments apply.

ACUPUNCTURE

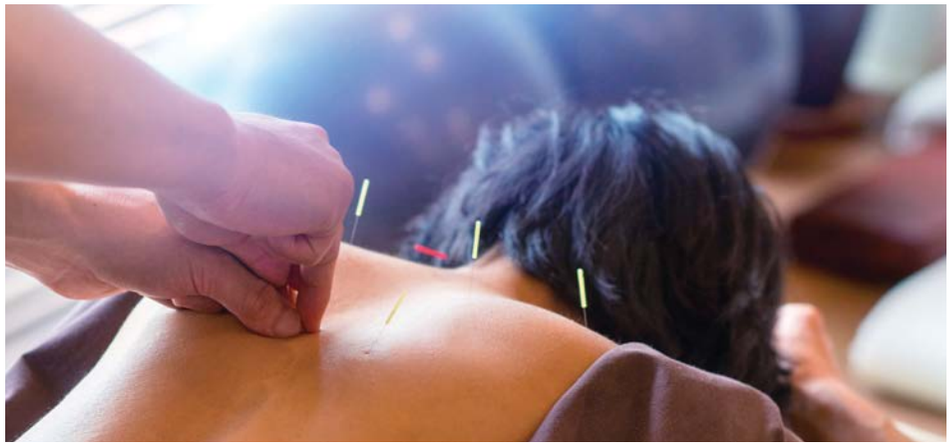
Acupuncture is only covered when services are rendered by a licensed/certified acupuncturist or Provider Laboratory tests or diagnostic studies are not covered when ordered by an acupuncturist. A maximum of 20 acupuncture treatments are covered per calendar year.

For Out-of-Network Providers, the Maximum Allowable Amount for acupuncture treatments is $94.50 per date of service reimbursed at 50%, less an applicable Co-Payment. Balance Billing may apply.

AMBULANCE

Medically necessary ambulance services are covered at 90% of the Allowable Amount (In-Network and Out-of-Network) for emergencies.

Medically necessary ambulance services are also covered at 90% of the Allowable Amount (In-Network and Out-of-Network) for transfer from one hospital to another hospital, provided the treating physician has determined that the transferring hospital is unable to treat the condition and that the receiving hospital is the closest facility with expertise and availability to treat the condition. The transfer must occur by midnight of the next calendar day after the initial emergency room treatment. All other medically necessary ambulance services are covered at 90% of the Contracted Amount if In-Network and 50% of the Allowable Amount if Out-of-Network. Ambulance and air ambulance fees will be covered to transport the patient to the nearest medical facility equipped to treat the emergency condition.



Note:

Ambulance transport for patient/physician convenience is not covered.

ARTIFICIAL DISC REPLACEMENT

Artificial disc replacement for degenerative disc disease of the spine are now covered when the Anthem Blue Cross Clinical Utilization Management Guidelines are met.

BEHAVIORAL HEALTH & SUBSTANCE ABUSE

See Optum section of the *SPD* on page 86.

BIRTH CONTROL DEVICES

The Plan will cover birth control devices placed or inserted in a physician's office. This includes the office visit charge and any other Allowable Amount associated with the birth control procedure or injection.

BIRTHING CENTERS

The Plan will cover birthing centers, provided the facility is accredited by the Commission on Accreditation of Birth Centers. The Plan will cover the services at the applicable rate based on the Provider's network status.

CARDIAC REHABILITATION

Cardiac rehabilitation is covered any time after a cardiac event. A total of 32 cardiac rehabilitation treatments are covered per lifetime, regardless of the specific cardiac condition.

CASE MANAGEMENT

Case Management is a process by which a nurse coordinator works with the patient, the family and the attending Provider to develop an individualized and appropriate treatment plan. This voluntary program is available to provide coordination of treatment in the event of a prolonged or catastrophic illness or injury. It is intended to assure that you and your Dependent(s) are receiving the most appropriate and cost-effective treatment when medical care is necessary. While you are a part of

Case Management, the Plan may pay for certain benefits through the Case Management program that would not otherwise be covered.

Because this program is voluntary, if a treatment plan is suggested by the Case Management Coordinator, you, your family and your Provider must all agree to the recommended plan. The purpose of the program is to benefit the patient. If you or your Provider do not think the suggested treatment plan is to the patient's benefit, you do not have to participate. You will also be advised of any Out-of-Pocket expenses, as appropriate.

All requests for Case Management must be approved by the Plan. For questions email Casemanagement@mpiphp.org.

Case Management benefits are payable at the rate of 100% of the negotiated rate.

CHIROPRACTIC TREATMENT

A maximum of 20 chiropractic treatments are covered per calendar year, regardless of condition or conditions. The Plan will only pay for chiropractic treatment when rendered by a licensed chiropractor. The Maximum Allowable Amount for an Out-of-Network Provider is $54 for the initial office visit, up to $34 per follow-up treatment, and up to $159 per year for x-rays. Follow-up office visit charges are not covered.

You may go to the chiropractor of your choice. However, chiropractic care provided by an Anthem Blue Cross Preferred Provider does not require a Co-Payment for covered services. If your chiropractor is an Out-of-Network Provider, you will be responsible for any remaining Balance Billing after the Plan payment.

The following services are not covered under this benefit:

- Services that constitute the practice of medicine by a chiropractor
- Studio calls
- On-site calls
- Home visits
- Exercise at a gym or similar facility
- Magnetic Resonance Imaging (MRI)/CT scans, diagnostic studies and laboratory tests are not covered when ordered by a chiropractor, even if such scans or tests are administered by a Provider
- Orthotics prescribed by a chiropractor

COLON CANCER SCREENING

A screening colonoscopy is covered every ten years for most individuals age 50 or over, and for some high-risk individuals at an earlier age or more frequently. Generally, an anesthesiologist is not required for the procedure and is not covered without specific medical indications. Alternatively, computed tomographic colonography or virtual colonoscopy and flexible sigmoidoscopy are covered every five years, Cologuard is covered every three years, and stool tests such as the FIT and FOBT are covered annually. Virtual colonoscopy is covered as a screening examination only.

CONTRACEPTION

See "Permanent Surgical Contraception" page 73 and "Birth Control Devices" page 68.

COSMETIC SURGERY

See "Reconstructive/Cosmetic Surgery" page 76.

DENTAL TREATMENT

Your dental plan describes your standard dental benefit and covers your dental care. Dental treatment is not covered under your comprehensive medical benefits. Accidental injuries to natural teeth are also covered by the dental plan you choose if services are provided within 180 days following the date of the accident.

The following medical diagnoses in the areas of the head and face are at times recognized to be appropriately treated by dentists (DDS or DMD) as well as by Providers and are covered under the comprehensive medical plan: myalgia, myositis, migraine, trigeminal neuralgia, sleep apnea, and temporomandibular joint disorder.

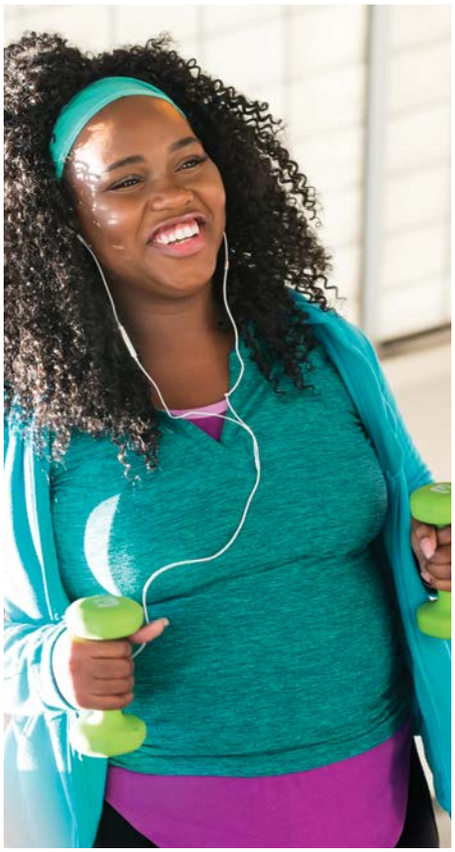
Dental implants may be covered under the medical benefit in cases of trauma, ablative surgery or congenital anomalies.

Oral appliances are not covered for the treatment of malocclusion or bruxism.

See Delta Dental HMO and PPO sections for all other dental benefits.

DERMATOLOGY

The Maximum Allowable Amount for the destruction of any number of non-malignant lesions of the face and body by laser or any other method is $100 per date of service for both In-Network and Out-of-Network Providers. Balance Billing may apply, except in cases where there is a Referral to a TIHN Provider.



DIABETES EDUCATION

Type 1 Diabetes

The Plan will cover counseling sessions with a certified diabetes educator (CDE) for diabetes education for Participants and eligible Dependents with type 1 diabetes.

Type 2 Diabetes

Participants and their eligible Dependents who have type 2 diabetes may receive up to three diabetes education sessions on a calendar year basis with a CDE. This benefit is a substitute for the Nutritional Counseling benefit. Participants who use this benefit may not also use the Nutritional Counseling benefit for the same calendar year.

UCLA offers a course entitled, "Living With Type 2 Diabetes." The course is an American Diabetes Association-certified, self-care class that is designed to help Participants learn important skills and gain knowledge and confidence to manage their diabetes. To sign-up, ask for a Referral from your UCLA-MPTF Health Centers Provider.

Pre-Diabetes

The Plan will cover participation in the Diabetes Prevention Program through Solera and sponsored by Anthem Blue Cross for pre-diabetic Participants and their Dependents who qualify for the program. The program lasts a year and provides education on diet, exercise and healthy lifestyle choices designed to prevent the progression of pre-diabetes to diabetes. To find out more information about this benefit, visit www.solera4me.com/mpi or call (877) 486-0141.

DIABETES SUPPLIES AND INSULIN

Most diabetes supplies and insulin are covered and should be obtained through your prescription drug program.

Coverage for insulin pumps and continuous glucose monitoring devices will be determined based on medical necessity. Preauthorization for insulin pumps and continuous glucose monitoring devices is recommended.

DIAGNOSTIC IMAGING AND LABORATORY TESTS

Diagnostic x-rays, CT scans, MRIs, Position Emission Tomography (PET) scans, and laboratory tests for illness or injury are covered when reasonable and necessary and ordered by the treating licensed Provider, nurse practitioner, midwife or physician assistant. Confirmation of medical necessity for any diagnostic testing may be required at the discretion of the Plan.

MRI/CT scans, diagnostic tests, and laboratory tests are not covered when ordered by a chiropractor or acupuncturist, even if such scans or tests are administered by a Provider.

DURABLE MEDICAL EQUIPMENT

Some medical equipment that is rented or purchased may be a covered benefit of the Plan. Purchase of equipment is limited to once every two years if medically necessary, except in situations where the patient's change in size requires new equipment sooner. Total payment for equipment rental cannot exceed the purchase price of the item. The fact that the item is prescribed by a Provider does not, in and of itself, guarantee coverage and payment.

Requirements and limitations of this benefit are as follows:

1. You must obtain a prescription from the treating Provider.
2. Benefits for medical equipment are subject to review for medical necessity and appropriateness for the condition being treated.

Over-the-counter, general use/convenience items are not covered. Listing every item that is considered general use/convenience items is not possible. The following is a partial list: hydrocollators, vaporizers/humidifiers, whirlpool baths, sun lamps, heating pads, exercise devices, blood pressure devices, shower chairs, grab bars, incontinent supplies/diapers, orthopedic shoes and other items serving as apparel. Such items as over-the-bed tables and traction appliances are not covered, even when prescribed or recommended by a Provider.

FOOD ALLERGY TESTING

Food allergy testing will be covered when medically necessary and when conservative therapies, like the avoidance of foods that trigger allergies, have failed. To be considered for coverage, food allergy testing must be performed by Providers with special training in the field of allergy and immunology. Direct skin tests are the recommended method of testing for patients suspected of having food allergies. There is no limit for Dependent(s) ages 0-5 years old; 80 tests are covered per calendar year for those ages six and above. Additional tests may be authorized upon review by the Plan's Medical Review Department.

FUNDUS PHOTOGRAPHY

Medical photography of the fundus by an ophthalmologist will be covered when medically necessary and by an optometrist only for glaucoma or suspected glaucoma.

GENDER REASSIGNMENT

Gender reassignment services that meet Anthem Blue Cross' guidelines are covered. Preauthorization is recommended.

GENETIC TESTING

Genetic tests that meet Anthem Blue Cross' guidelines for medical necessity are covered. Preauthorization of genetic tests and pre-test genetic counseling is recommended. These guidelines may be found at https://www11.anthem.com/search.html.

HEARING AIDS

Participants and their eligible Dependents may use the services of a qualified hearing aid distributor

but must first have their hearing tested by a qualified audiologist.

The Plan has contracted with the HearUSA network of audiologists and hearing aid dispensers. Through HearUSA, Participants and their Dependents are eligible for deep discounts on hearing aids resulting in a lower Out-of-Pocket expense. Anthem Blue Cross audiologists and hearing aid dispensers are considered In-Network. HearUSA audiologists and hearing aid dispensers are treated at the In-Network benefit level.

The Maximum Allowable Amount for this benefit is up to $1,386.00 per aid. For In-Network, the Plan will pay 90% of the Maximum Allowable Amount. For Out-of-Network, the Plan will pay up to 50% of the Maximum Allowable Amount. This benefit covers one hearing aid per ear, once every three years.

HEAVY METAL TESTING

Heavy metal testing for lead, mercury, arsenic and copper is covered when ordered with the diagnosis of certain types of neuropathy or anemia. Heavy metal testing for any other reason is not a Plan benefit.

HOME HOSPICE CARE

Hospice is a palliative approach to health care that focuses on managing pain and treating other symptoms to improve the quality of life for those individuals faced with a terminal illness. Hospice also offers emotional and spiritual comfort and support to patients and their families during this time.

Hospice teams include Providers, nurses, social workers and ministers of various faiths, all working collaboratively to meet the unique needs of the patient and family. These professionals may also bring in others to provide home care and other support services to allow patients to stay at home with loved ones.

Qualifications for eligibility for the home hospice benefit include Participants and their Dependents who satisfy all of the following:

- Are currently eligible for Plan benefits;
- Have no other home hospice coverage available (this includes Medicare or any other health plan that has a hospice benefit);
- Are not enrolled in Health Net, Kaiser Permanente or Oxford Health Plans;
- Have a treating Provider who indicates that the patient is likely to have less than six months' life expectancy; and
- Indicate their desire to have hospice services provided in the home.

Hospice services provided in the home through the Plan are a covered benefit. There are no Out-of-Pocket expenses associated with home hospice care.

HOME INTRAVENOUS THERAPY

Home intravenous therapy for administration of FDA-approved drugs is covered when medically necessary. Nursing care services for the administration of intravenous drugs are covered.

IMMUNIZATIONS/ VACCINATIONS

Routine preventive immunizations are covered according to the current Center for Disease Control (CDC) guidelines, in effect on the date of service. Vaccinations for the purpose of the Participant's travel for work are covered; this benefit does not apply to Dependents. This benefit does not apply to Dependents. Documentation establishing the Participant's travel for work must be provided to the Plan. Current CDC vaccine recommendations can be found at www.cdc.gov. If the vaccination is associated with an office visit or prescription, then the visit or prescription Co-Payment will apply. Preventive immunizations administered at pharmacies are also covered.

LENS REPLACEMENT FOLLOWING CATARACT SURGERY

Coverage of a new standard spectacle lens for the surgically-treated eye after undergoing cataract surgery is a covered benefit. This benefit does not include new frames. See vision benefits beginning on page 147 for additional information on frame coverage.

MAMMOGRAPHY

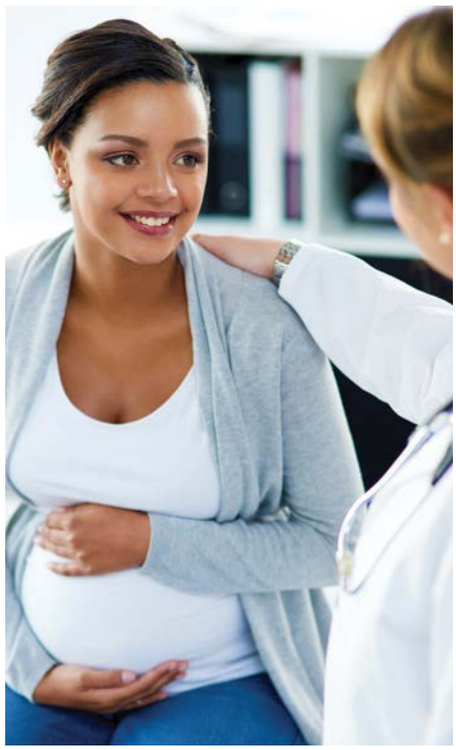
One routine/screening mammography per calendar year will be covered, in accordance with nationally recognized guidelines in effect. Diagnostic mammography for a specific medical condition is a covered benefit.

MATERNITY BENEFITS

The maternity benefit is the same for single or multiple births. Benefits are payable for normal and Cesarean section delivery, including ante and postpartum care.

Maternity benefits are payable only after delivery or termination of pregnancy (including charges for prenatal visits). Only Claims for the initial office visit, laboratory charges and medically indicated consultations and diagnostic tests may be submitted prior to delivery; all other Claims must be submitted after delivery. Should you lose your eligibility with the Plan prior to delivery, the prenatal visits will be considered for payment.

To avoid delays in coverage for your newborn baby, remember to provide a copy of the birth certificate to the Plan Office as soon as possible after your baby is born. Birth records from your hospital are acceptable. It is the parents' responsibility to provide it.



Without a birth certificate, the Plan has no basis to pay Claims.

Note:

No maternity benefits are available for Dependent children or surrogates.

MEMBER ASSISTANCE PROGRAM

A member assistance program (MAP) is available through Optum Behavioral Health ("Optum") for all Participants, Dependents and household members. MAP offers counseling services with a mental health provider referral, advice on work-related concerns and improving relationships, assistance with parenting and caregiving, legal, financial and retirement advice. To find out more information, visit www.liveandworkwell.com or call (888) 661-9141.

MENTAL HEALTH AND CHEMICAL DEPENDENCY

The Plan has arranged for mental health and chemical dependency benefits through Optum, a United Health Group company, for eligible Participants and covered Dependents. Please see the Optum section on page 86.

NURSING CARE

Services must be ordered by the treating Provider. Nursing care is covered under the following conditions:

1. The patient must medically require skilled nursing services

that cannot be adequately and safely performed by the patient's family, friends or aides.

2. Nursing services may be available under Case Management.

Custodial care is not covered. Private-duty nursing is not covered when services are rendered in an acute care facility or skilled nursing facility.

NUTRITIONAL COUNSELING

The Plan will cover up to three Nutritional Counseling sessions each calendar year for Participants and eligible Dependents. The benefit applies to any medical diagnosis when the counseling is prescribed by a Provider and provided by a registered dietitian. See "Diabetes Education," on page 70.

NUTRITIONAL SUPPORT

For any Participant or eligible Dependent who is physically incapable of swallowing, gastric tube feeding is a covered benefit upon receipt of Provider-verified inability to take food by mouth. The benefit covers at-home feedings only.

Any other nutritional replacement supplements, vitamins and minerals, including baby formula, are not covered.

PERMANENT SURGICAL CONTRACEPTION

The Plan will cover vasectomy and tubal ligation for permanent surgical contraception. Reversal of permanent contraception is not a covered benefit.

PHYSICAL EXAMINATIONS/ COMPREHENSIVE PHYSICAL EXAMS

Frequency

Newborn through Age 17
The Plan covers unlimited well child visits for eligible Dependent children who are newborn through age 4. The Plan covers physical examinations once per calendar year for eligible Dependent children ages 5 through 17.

Age 18 and Older
The Plan covers Comprehensive Physical Exams (CPE) for Participants and their eligible Dependents once per calendar year.

Service Location Requirements

Newborn through Age 12
Participants may use a Provider of their choice for well child visits/physical exams for their eligible Dependents who are newborn through age 12. Alternatively, Participants may contact TIHN at (800) 876-8320 for a Referral to a pediatrician so that they will have a $5 Co-Payment for pediatric office visits.

Age 13 through Age 17
Participants may use UCLA-MPTF Health Centers or the Provider of their choice for annual physical exams for their eligible Dependents ages 13 through 17.

UCLA-MPTF Health Centers only see patients who are age 13 or older for both wellness and general primary care.

Age 18 and Older
If you or a Dependent are age 18 or older and the last home address you have provided to the Plan on or before the date of your CPE is in Los Angeles County, you must use the UCLA-MPTF Health Centers for the CPE to be covered by the Plan.

If the last home address you have provided to the Plan on or before the date of your CPE is outside of Los Angeles County, you may go to the Provider of your choice for your CPE. **If you and any of your enrolled Dependents have different addresses, you must notify the Plan of any address changes in writing.**

A CPE performed by a Provider at

COMPREHENSIVE PHYSICAL EXAMS (CPE)

Provider Options | Patients may receive a Comprehensive Physical Exam once per calendar year.

IF PATIENT IS LESS THAN 18 YEARS OLD		
OPTIONS	**PLAN PAYS**	**PATIENT PAYS**
VISIT A PROVIDER AT A TIHN PEDIATRIC PHYSICIAN GROUP[1]	▸ 100% of Covered Services	▸ $5 Co-Payment + Any costs for Non-Covered Services
VISIT A PROVIDER AT A UCLA-MPTF HEALTH CENTER For patients 13 years old and older	▸ 100% of Covered Services	▸ $5 Co-Payment + Any costs for Non-Covered Services
VISIT AN ANTHEM BLUE CROSS OR BLUECARD PROVIDER WHO IS IN-NETWORK	▸ 90% of the Anthem Blue Cross/ BlueCard Contracted Amount for Covered Services	▸ 10% of the Anthem Blue Cross/BlueCard Contracted Amount for Covered Services (Coinsurance) + $15 Co-Payment **if the patient lives outside the UCLA-MPTF service area[2]** + Any costs for Non-Covered Services
	▸ 90% of the Anthem Blue Cross/ BlueCard Contracted Amount for Covered Services	▸ 10% of the Anthem Blue Cross/BlueCard Contracted Amount for Covered Services (Coinsurance) + $30 Co-Payment **if the patient lives in the UCLA-MPTF service area[2]** + Any costs for Non-Covered Services
VISIT A PROVIDER WHO IS OUT-OF-NETWORK Not in the Anthem Blue Cross/BlueCard Network	▸ 50% of the Anthem Blue Cross/ BlueCard Allowable Amount or 70th percentile of UCR for Covered Services	▸ 50% of the Anthem Blue Cross/BlueCard Allowable Amount or 70th percentile of UCR for Covered Services (Coinsurance) + $15 Co-Payment **if the patient lives outside the UCLA-MPTF service area[2]** + Any Balance Billing, including costs for Non-Covered Services
	▸ 50% of the Anthem Blue Cross/ BlueCard Allowable Amount or 70th percentile of UCR for Covered Services	▸ 50% of the Anthem Blue Cross/BlueCard Allowable Amount or 70th percentile of UCR for Covered Services (Coinsurance) + $30 Co-Payment **if the patient lives in the UCLA-MPTF service area[2]** + Any Balance Billing, including costs for Non-Covered Services
IF PATIENT IS 18 YEARS OLD OR OLDER		
VISIT A PROVIDER AT A UCLA-MPTF HEALTH CENTER	▸ 100% of Covered Services	▸ $5 Co-Payment + Any costs for Non-Covered Services
VISIT AN ANTHEM BLUE CROSS OR BLUECARD PROVIDER WHO IS IN-NETWORK	▸ $0	▸ All costs will be the patient's responsibility **if the patient lives in the County of Los Angeles[2]**
	▸ 90% of the Anthem Blue Cross/ BlueCard Contracted Amount for Covered Services	▸ 10% of the Anthem Blue Cross/BlueCard Contracted Amount for Covered Services (Coinsurance) + $15 Co-Payment **if the patient lives outside the County of Los Angeles[2]** + Any costs for Non-Covered Services
VISIT A PROVIDER WHO IS OUT-OF-NETWORK Not in the Anthem Blue Cross/BlueCard Network	▸ $0	▸ All costs will be the patient's responsibility **if the patient lives in the County of Los Angeles[2]**
	▸ 50% of the Anthem Blue Cross/ BlueCard Allowable Amount or 70th percentile of UCR for Covered Services	▸ 50% of the Anthem Blue Cross/BlueCard Allowable Amount or 70th percentile of UCR for Covered Services (Coinsurance) + $15 Co-Payment **if the patient lives outside the County of Los Angeles[2]** + Any Balance Billing, including costs for Non-Covered Services

[1] A Referral to a TIHN pediatric Provider is required. The Referral lasts until the patient is 18 years old.

[2] Where a patient "lives" is based on his or her address on file with the Motion Picture Industry Health Plan. See pages 63 through 64 for UCLA-MPTF service area.

a UCLA-MPTF Health Centers will be paid at 100% of the Contracted Amount and a $5 Co-Payment will apply.

For Participants who live outside Los Angeles County, a CPE performed by In-Network Providers will be paid at 90% of the Contracted Amount, and a $15 Co-Payment will apply. Out-of-Network Providers will be paid at 50% of the Allowable Amount and a $15 Co-Payment will apply. Balance Billing may also apply.

PHYSICAL/OCCUPATIONAL/ AQUATIC/OSTEOPATHIC MANIPULATIVE THERAPIES (OUTPATIENT)

Physical therapy, occupational therapy, aquatic therapy and osteopathic manipulative therapy (outpatient) are covered when rendered by a registered physical therapist, an occupational therapist, a doctor of osteopathy or a Provider.

Therapy rendered by interns and therapy aides, working under the direct and on-site supervision of a registered therapist, may be covered when therapy notes are signed by the supervising registered therapist.

A maximum of 16 physical/ occupational/aquatic/osteopathic manipulation therapy treatments are covered per calendar year. Additional treatments for the same diagnosis will be reviewed for possible coverage based on medical information provided by the treating Provider through the Preauthorization process. If a Participant uses all of the 16 covered visits for one injury or surgery and sustains an entirely different injury or surgery later in a calendar year, additional visits for the second incident may be approved upon request and review by the Medical Review Department.

The initial visit/evaluation is allowed separately and is not included in the 16 treatment limitation. Reevaluation for the same injury or surgery treated during a calendar year is not covered. An additional initial visit/evaluation for an entirely different injury or surgery sustained later in a calendar year is covered and is allowed separately.

The Maximum Allowable Amount the Plan will pay per treatment for an In-Network Provider is 90% of the Allowable Amount.

The Maximum Allowable Amount the Plan will pay per treatment for an Out-of-Network Provider is up to $94.50, payable at 50%, less your $15 or $30 Co-Payment.

The therapy must be prescribed by a Provider, with duration and interval of therapy noted on the prescription. Your Provider or therapist should submit this information with the initial billing.

The Plan will not consider Claims for therapy elected by the patient.

PODIATRY

Podiatry services to the feet, including orthotics, are covered when rendered by a licensed podiatrist or a Provider.

Orthotics

Dependent Children, Age 16 and Under
Orthotics are covered once yearly, if medically indicated.

Participants and Dependents, Age 17 or Older
Orthotics are covered once every two years, if medically indicated.

Prostheses and Braces

See "Durable Medical Equipment," page 70.

Dependent Children, Age 16 and Under
Prostheses and braces replacements are covered once yearly, if medically

indicated. See "Durable Medical Equipment," page 70.

Participants and Dependents, Age 17 and Older
Prostheses and braces replacement are covered once every two years, if medically indicated. See "Durable Medical Equipment," page 70.

RECONSTRUCTIVE/ COSMETIC SURGERY

Cosmetic Surgery is not a covered benefit. The Plan only covers services for reconstructive surgery when medically indicated for the:

1. Treatment of non-industrial illness;
2. Correction of a congenital malformation;
3. Reconstruction due to accidental injury; and
4. Reconstructive surgery following a mastectomy for breast cancer.

Medical necessity is often in question and must be established for surgeries involving the abdominal wall, breast, eyelid, external ear, nose, and scar revision.

The Plan will include, under Covered Expenses, expenses associated with reconstructive surgery following a mastectomy for breast cancer. This benefit will include expenses related to reconstructive surgery on the other breast to achieve symmetry, the cost of prostheses and the costs for treatment of physical complications at any stage of the mastectomy, including lymphedema.

Any Claim for benefits connected with reconstructive surgery may be denied unless it is determined that the information available clearly establishes the surgery as medically necessary.

Preauthorization is not required but strongly recommended for all non-emergency reconstructive surgeries. Confirmation of coverage should be obtained prior to surgery. This means the following documentation should be submitted to Anthem Blue Cross by the Provider:

1. A Preauthorization Request form;
2. A letter of medical necessity; and
3. Medical records to explain and support the service requested.

A determination of authorization from Anthem Blue Cross should be received prior to surgery. If you do not receive a copy of this determination, contact Anthem Blue Cross at (800) 274-7767.

SCLEROTHERAPY

Sclerotherapy is a covered procedure for the treatment of varicose veins when medically indicated. Benefits will be based upon the documentation. The Maximum Allowable Amount the Plan will pay for an Out-of-Network Provider is up to $94.50 per leg, payable at 50%. Balance billing will apply.

SPEECH THERAPY

A maximum of 32 speech therapy treatments are covered per calendar year if ordered by the treating Provider under the conditions that follow. Please visit www.mpiphp.org for a copy of the Speech Therapy Questionnaire that must be completed by the treating speech pathologist. The initial visit/evaluation is allowed separately and is not included in the 32 treatment limitation.

For Participants and Dependents of All Ages

Speech therapy benefits only apply to individuals who have experienced a stroke or other neurologic disease, or who have had an injury or surgery affecting speech or swallowing. Speech therapy must be rendered by a licensed speech pathologist.

For Dependent Children, Age 16 and Under

Speech therapy is also covered for the following diagnoses: developmental speech delay, stuttering, autism, apraxia and dysarthria.

TELEMEDICINE

Telemedicine allows a Participant and/or his or her Dependent(s) to visit with a Provider by phone or through online video communication using a computer, smartphone or tablet. Participants will pay a $20 Co-Payment and will not be required to pay additional Coinsurance. This benefit is offered through LiveHealth Online. The service area includes the entire United States. This service may not be used by a Participant and/or his or Dependent(s) when outside of the United States. Access LiveHealth Online at www.livehealthonline.com.

TERMINATION OF PREGNANCY

Elective termination of pregnancy (abortion) is covered. It is not covered for Dependent children who are seeking to terminate a pregnancy.

TRANSPLANTS

Transplants are preauthorized by Anthem Blue Cross. The donor search is not a covered benefit. Once the donor is selected, the Plan will cover related expenses. For more information, or for transplant Preauthorization information, contact Anthem Blue Cross at (800) 274-7767.

URGENT CARE

Participants in southern California can visit an Exer Urgent Care clinic and pay a $15 Co-Payment and covered services will be paid at 100%. Otherwise, urgent care visits are covered as a Physician Visit.

WEIGHT CONTROL

Services rendered in connection with weight control are not covered. The fact that a Provider may recommend weight control and prescribe medication or surgery for weight loss due to a medical condition does not establish coverage. Surgical procedures for weight loss are also not a covered benefit. Weight loss medications are not a covered benefit. The Wellness Program does offer some educational classes related to weight loss. See page 150.

WIGS/HAIR PIECES

Participants and their eligible Dependents over the age of 16 who have hair loss due to chemotherapy, radiation therapy or who have another medical condition of the scalp causing hair loss are eligible for reimbursement for one wig/hair piece costing up to $240 per lifetime.

For eligible Dependents age 16 or under, provided the circumstances noted above are all still applicable, the Plan will cover two wigs/hair pieces, up to $240 per wig/hair piece or a total of $480 per lifetime.

The wig/hair piece must be prescribed by a Provider; the Participant must submit the Provider-executed Wig/Prosthesis Certification form attesting to the fact that the prescribed wig is essential to the patient's mental health. For reimbursement, a claim form, the Provider prescription and an itemized bill or receipt must be submitted to Anthem Blue Cross.

Facilities

MOTION PICTURE INDUSTRY HEALTH PLAN/ANTHEM BLUE CROSS

HOSPITALS

The Plan has contracted with Anthem Blue Cross to obtain reduced costs through Anthem Blue Cross In-Network hospitals in California and with the BlueCard program throughout the United States.

For Covered Services incurred at an In-Network hospital, the Plan will pay 90% of the Contracted Amount, less a $100 Co-Payment upon admission.

For Covered Services incurred at an Out-of-Network hospital, the Plan will pay 50% of the Allowable Amount, less a $100 Co-Payment upon admission. Balance Billing may apply.

For Covered Services incurred at an Out-of-Network hospital as the result of an emergency hospital admission (admitted through the emergency room), the Plan will pay 90% of the Allowable Amount, less a $100 Co-Payment upon admission. Coinsurance can be used to satisfy your $1,000 In-Network, Out-of-Pocket Maximum. Balance Billing may also apply.

Be sure to verify in advance whether the hospital is an Anthem Blue Cross In-Network hospital or contracted through the BlueCard Program. To obtain this information:

Services Rendered in California:

- **Motion Picture Industry Health Plan**
  (855) 275-4674
  www.anthem.com/ca

Services Rendered Outside of California:

- **Anthem Blue Cross**
  (800) 810-2583
  www.anthem.com

Hospital Services Not Covered

The following is a list of some services that are not covered by the Plan:

- Industrial illness or injury, including any illness or injury arising out of and in the course of your employment.
- Hospitalization for Cosmetic Surgery, except for restoration of congenital malformation or for the repair of accidental injury which occurred while covered, or for reconstructive surgery following a mastectomy.
- Hospitalization for a Dependent child's pregnancy.
- Hospitalization for Custodial Care.
- Hospitalization not reasonable and necessary for the treatment of a covered illness or injury.
- Hospitalization in connection with any treatment or procedure which is not covered under the Comprehensive Medical Benefit of the Plan.

Admissions to Hospital - Rendered in California

For hospital admissions for you or your eligible Dependent(s), present your benefit card. If you do not have your benefit card with you at the time, provide the following information:

- Anthem Blue Cross Group Number: 277163
- Plan Code: 040

- Certificate Number: "MPI" plus the Participant Identification Number
- Social Security Number

Admissions to Hospital - Rendered Outside of California

Claims for services rendered outside of California should be submitted to the local Blue Cross/Blue Shield office. For BlueCard Program Providers nationwide, call (800) 810-2583.

Childbirth

The Plan complies with federal law that prohibits the restriction of benefits for a mother or newborn child in connection with childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section.

Emergency Room Care

Covered emergency room charges, including all related Provider charges and all Covered Services performed in the emergency room, are paid at 90% of the Allowable Amount(s), less a $100 Co-Payment, if not admitted. If admitted directly to the hospital from the emergency room, the $100 emergency room Co-Payment is waived. However, the $100 hospital admission Co-Payment will apply.

If an Out-of-Network emergency room is used, covered emergency room charges, including all related Provider charges and all covered services performed in the emergency room, are paid at 90% of the Allowable Amount(s), less a $100 Co-Payment, if not admitted. If admitted directly to the hospital from the emergency room, the $100 emergency room Co-Payment is waived. However, the $100 hospital admission Co-Payment will apply.

Coinsurance can be used to satisfy your $1,000 In-Network, Out-of-Pocket Maximum. Balance Billing may also apply.

Urgent care centers, even if they are located on the grounds of a hospital, are paid at the Provider visit level of benefit.

Inpatient Care

Benefits for Inpatient Care include:

- Room Charge (semi-private)
- Intensive Care
- Nursery Expenses
- Other charges, including, but not limited to, supplies, medication, diagnostic x-rays and laboratory tests, operating rooms, anesthesia supplies, physical therapy, occupational therapy, speech therapy, and inhalation therapy required in connection with the conditions being treated.

SKILLED NURSING/ EXTENDED CARE FACILITY

The benefits described under Inpatient Care are available in an Anthem Blue Cross contracted skilled nursing/extended care facility or Medicare-approved extended care facility if admitted within 30 days of a minimum three day stay in a licensed general hospital.

The maximum covered length of stay is 90 days for a Participant and 60 days for an eligible Dependent.

This benefit does not renew until the patient is out of the hospital or skilled nursing facility for 60 days.

In no event will the terms "Convalescent Hospital" or "Extended Care Facility" include any institution or part thereof which is used primarily as a rest facility (including nursing facility or facility for the aged). Custodial Care is not covered.

AMBULATORY SURGICAL CENTERS

To determine whether an Ambulatory Surgical Center is contracted with Anthem Blue Cross, contact Anthem Blue Cross in advance of your procedure:

Services Rendered in California:

- **Motion Picture Industry Health Plan**
  (855) 275-4674
  www.anthem.com/ca

Services Rendered Outside of California:

- **Anthem Blue Cross**
  (800) 810-2583
  www.anthem.com/ca

The reimbursement for Out-of-Network surgery centers, including facility and supplies, is paid at 100% of the Allowable Amount up to a maximum benefit of $350.

Non-Covered Services + Items

Non-Covered Services and items include, but are not limited, to the following:

- After hour fees
- Air purifiers/air filter systems
- Apparel (items that serve as apparel, except wigs)
- Artificial insemination or related services
- Autopsy
- Biofeedback therapy
- Breast implants
  (See page 76 for exceptions.)
- Calcium scoring for coronary heart disease (ultra-fast CT scan, etc.)
- Chelation therapy
- Chemical exfoliation (chemical peel)
- Christian Science telephone consultations/treatments classes, training courses
- Circulating water pump during or after surgery
- Cold therapy units (cold packs)
- Collagen injections
- Colonics
- Corneal surgery to correct refraction errors and all related services (lasers and radial keratotomy included)
- Cosmetic surgery
  (See page 76 for exceptions.)
- Custodial Care
- Dental services, routine
  (See page 119 for Dental Benefits.)
- Dermabrasion
- Diagnostic tests not related to an illness or injury
- Diet analysis
- Donor search
- E-mail correspondence consultations
- Electrolysis
  (except for gender reassignment surgery)
- Embryo freezing
- Exercise devices/programs
- Experimental/investigational services, treatments, medications or devices
- Extracorporeal shock wave therapy
  (except for kidney stones)
- Eye examinations, refractions
  (refer to VSP benefit on page 147)
- Facials
- Facility fees
- Gait analysis
  (except for pre- and post-op assessment of patients with cerebral palsy)
- Gait training
  (except by physical therapist)
- Gastric bypass or any other surgical procedure for obesity
- General use/convenience items
- Genetic determination of sex of fetus
- Grab bars
- Hair analysis
- Hair dressers
- Hair loss treatment
- Hair transplants
- Health club memberships
- Heating pads
- Heavy metal testing
  (except lead, mercury, arsenic and copper when ordered for the diagnosis of certain types of neuropathy or anemia)
- Herbalists
- Home blood pressure devices
- Home uterine activity monitoring (HUAM)
- Homeopathic medicine/ treatments
- Home or studio/set visits by chiropractors
- Hospice, inpatient
- Humidifiers
- Hydrocollators
- Hypnotherapy
- Incontinence supplies/diapers
- Infertility/
  In Vitro fertilization (IVF)*
  (any services related to infertility)

- Insurance forms (fees for completion/duplication of medical records)
- Interpreters
- Learning disability
- Lice treatment
- Lost or stolen prescriptions
- Massage therapy (any services rendered by masseur/masseuse)
- Maternity benefits for Dependent children
- Maternity benefits for surrogates
- Measures which constitute the practice of medicine by a chiropractor
- Medical photography, except fundus photography
- Medical social worker (services rendered by)
- Medication for services or procedures not covered
- Mineral analysis
- Missed appointments
- Naturalists
- Naturopathic medicine
- Nursing assistants (CNA/HHA), nursing aides
- Nutritional supplements, vitamins, minerals, including pediatric formula (not to be confused with "Nutritional Support")
- Office visit charges for a wellness exam or physical exam and a medical diagnosis exam on the same day by the same Provider
- On-site calls/studio calls
- Operating room technicians
- Orthopedic shoes
- Orthoptic treatment (vision therapy)
- Over-the-bed tables
- Over-the-counter items
- Over-the-counter medication
- Patient advocate fees
- Post-operative care (included in fee for surgery)
- Prolotherapy
- Reports (preparation of records, medical reports for school, job, legal, etc.)
- Retin-A (except for the treatment of acne, acne vulgaris and Darier's disease.)
- Routine physical examinations for insurance, licensing, employment, school, camp or other non-preventive purposes
- Services rendered or prescribed by a family member
- Shower chairs
- Sperm freezing/storage
- Stimulators TENS units (other stimulators will be reviewed for medical necessity)
- Strapping
- Sun lamps
- Third party liability, any services related to an illness/injury for which a third party is legally responsible. See page 41.
- Traction appliances
- Tubal ligation revision
- Vaporizers
- Urinary drug testing
- Vasectomy revision
- Vitamins, minerals or food supplements (except that the following vitamins and minerals will be covered when prescribed by a Provider and medically necessary: injectable B12 for pernicious anemia, significantly higher doses of Vitamin D and folic acid for some deficiency conditions, activated Vitamin D/calcitriol for renal failure and some endocrine disorders, Vitamin K to treat clotting disorders, some prescription prenatal vitamins and fluoride containing medications and intravenous iron to treat severe iron deficiency anemia)
- Weight control services, drugs, surgeries
- Whirlpool baths/equipment
- Work-related conditions

**Infertility is defined as:*

(a) *the inability to conceive a child by a couple who has had regular sexual relations without contraception for one year, excluding persons who have had elective sterilization, or*

(b) *the inability to carry a pregnancy to live birth, usually based on more than one miscarriage, or*

(c) *a licensed medical physician diagnosing a condition as infertility.*

Preauthorizations

MOTION PICTURE INDUSTRY HEALTH PLAN/ANTHEM BLUE CROSS

PREAUTHORIZATION RECOMMENDATIONS

Payment for Plan benefits is based on, among other considerations, medical necessity of the service or procedure. In an effort to eliminate any possible delay or prevent any Participant from obtaining the medical services that he or she requires, MPIHP/Anthem Blue Cross does not require Preauthorization for any covered benefit. Please refer to the Evidence of Coverage provided by Kaiser and Health Net or Summary of Coverage provided by Oxford to determine their Preauthorization requirements.

An MPIHP/Anthem Blue Cross Claim will not be denied on the basis that it was not preauthorized, but it may not be covered due to other benefit limitations or exclusions or lack of medical necessity.

While Preauthorizations are not required, they are recommended. Some services may not be a Plan benefit or meet the requirement of medical necessity.

- To verify Plan coverage of services, please have your Provider submit a Preauthorization request to:

  Motion Picture Industry Health Plan
  Attn: Medical Review Department
  P.O. Box 1999
  Studio City, CA 91614-0999

The following services are examples of instances when you would be strongly advised to obtain Preauthorization before receiving services:

1. Reconstructive surgery;
2. Genetic testing;
3. Pain procedures;

4. Outpatient Monitored Anesthesia Care;
5. Investigative or experimental testing and treatment; and
6. Physical and occupational therapy over allotted 16 visits per calendar year.

INSTRUCTIONS FOR SUBMITTING PREAUTHORIZATION REQUESTS

Preauthorizations should include a letter of medical necessity from the patient's Provider(s) and supporting medical records.

- To download Preauthorization forms, visit www.mpiphp.org.
- Please fax completed forms to (818) 766-6532 or mail to:

  Motion Picture Industry Health Plan
  Attn: Medical Review Department
  P.O. Box 1999
  Studio City, CA 91614-0999

The letter should include the Participant's name and Participant's Identification Number and the procedure or test being contemplated. The letter should also include Provider information such as the Provider's name, specialty, contact information, NPI number and/or Tax ID number.

Approval or denial of Preauthorization requests will be communicated by mail.

Submission of Claims

SUBMISSION AND PAYMENT OF CLAIMS

Services Rendered In California

Claims for services should be submitted within 90 days from the date services were rendered for an illness or injury, but no later than 15 months from the date of service or, in Coordination of Benefits situations, 15 months from the date the primary payer paid. Failure to file in a timely manner will result in the denial of your Claim.

- Claims should be addressed as follows:

  Anthem Blue Cross
  Attn: Claims Department
  P.O. Box 60007
  Los Angeles, CA 90060-0007

Please make sure the Participant's Social Security Number or MPI identification number appears on all pages of Claim forms and correspondence.

Following the processing of your Claim, the Plan will send the patient an Explanation of Benefits (EOB) statement. All reimbursement Claim checks not paid directly to the Provider of the service will be addressed directly to the patient.

A request for review of any adverse decision on a Claim must be made within 180 days of the date on the EOB.

The fee for a Claims history summary is $1 per Claim, and the fee for a duplicate EOB is $1 per Claim. You may visit the Plan's website to download a free copy of your EOB.

Services Rendered Outside of California

Claims for services rendered outside of California should be submitted to the local Blue Cross office.

REQUIRED COMMUNICATIONS FOR ADVERSE BENEFIT DETERMINATIONS ABOUT A CLAIM

An Adverse Benefit Determination in response to a Claim will include the following:

1. The specific reason or reasons for any adverse determination.
2. Reference to the *SPD* or related provisions on which the determination is based.
3. In the event that a rule or protocol was relied upon, it will be identified and provided upon request.
4. If the adverse decision is based on medical necessity, experimental treatment, or similar Exclusion or Limitation, a clinical or scientific explanation will be provided upon request.
5. A statement regarding the Claimant's right to bring a civil action under Section 502(a) of ERISA.
6. If applicable, a description of any additional material or information that would be needed to perfect the Claim, and why that material or information is needed.
7. A description of the Claims appeals procedure.
8. A Claimant is entitled to receive upon request and free of charge copies of all documents, records and other information related to the Claim.

REQUEST FOR ADDITIONAL INFORMATION ABOUT A CLAIM

As part of the Claims process, you may be requested by the Plan to provide additional information. Please do so promptly to avoid any undue delay in the processing of your Claim.

ADDITIONAL REQUEST FOR REVIEW OF A CLAIM

You may have additional questions

or concerns about the processing of a Claim. If so, please complete a Claim Review Request form; this form may be downloaded at www.mpiphp.org.

You also have the right to obtain, upon request, the identity of any medical or vocational experts from whom advice was obtained in connection with an Adverse Benefit Determination.

BALANCE BILLING

When a Participant uses an Out-of-Network Provider for covered services, the Provider can bill the Participant for the difference between the billed charges and the benefit amount. Charging this difference is referred to as Balance Billing.

WORK-RELATED INJURY/ILLNESS

In order to establish possible work-related injury/illness, third party

Q&A:
Time Limits for MPIHP to Process Claims

Q: What is the general deadline for initial determination?

A: Generally, Claims must be processed 30 days from the Plan's receipt of the completed Claim.

The Plan has 45 days from the Plan's receipt of the Claim in cases where "disability" must be determined by the Plan (as opposed to a neutral third party such as the Social Security Administration or California State Disability Insurance).

Q: Are there any extensions?

A: Yes. One 15-day extension, if the Plan determines it is necessary due to matters beyond the control of the Plan and informs the Claimant of the extension within the initial 30-day time frame.

In the case of a Claim where "disability" must be determined by the Plan (as opposed to a neutral third party such as the Social Security Administration or California State Disability Insurance), the Plan has a 30-day extension from the Plan's receipt of the Claim, with the possibility of an additional 30-day extension.

Q: What is the deadline if additional information is needed?

A: If an extension is necessary because the Claimant failed to provide necessary information, the notice of extension will specify the information needed. The Claimant will be given at least 45 days to respond. The running of time for the initial Claims determination is suspended until the end of the prescribed response period or until the information is received, whichever is earlier. At that point, the decision will be made within 15 days.

liability, Coordination of Benefit, or to clarify the reason for seeking services, you may be requested by the Plan Office to complete a questionnaire. Please do so promptly to avoid any undue delay in the processing of your Claim.

FOREIGN CLAIMS

Comprehensive benefits through the Plan apply anywhere in the world.

Services rendered outside of the United States must be submitted on a Blue Cross International Claim form. This form is available on the Plan's website at www.mpiphp.org. It is important to have the foreign Provider include all supporting medical information along with the bill.

- Send the completed form to:

  Blue Cross/
  Blue Shield Global Core
  Service Center
  P.O. Box 2048
  Southeastern, PA 19399 USA

For medical services incurred while on a cruise ship, please submit a copy of itemized statements to Anthem Blue Cross.

- To download a Claim form, visit www.mpiphp.org.

OVERPAYMENTS

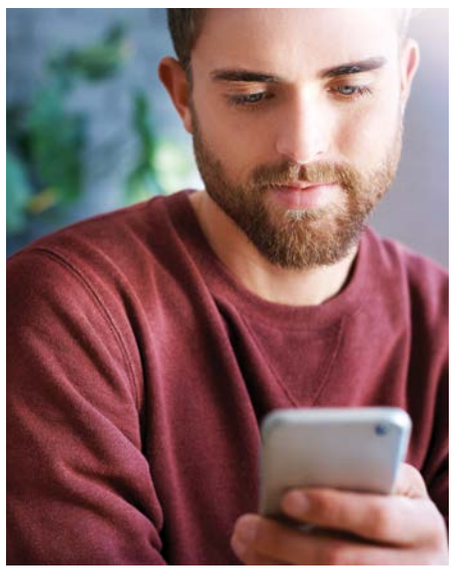
Every effort is made to assure prompt and accurate payment of Claims. If the Plan discovers its payment(s) was incorrect, the Participant is responsible for refunding the overpaid amount. You will receive written notification if a refund is required.

In the event the Plan makes a benefit Overpayment, the Participant, in addition to the amount of the Overpayment itself, shall owe the Plan interest on the Overpayment amount if it was caused, in whole or in part, by the Participant:

1. Providing false or incomplete information; or
2. Failing to provide information within the time frames required under the terms of the *SPD*.

Interest on any non-reimbursed portion of the Overpayment shall be at the rate of 10% per 12-month period, with a pro rata percentage applicable if payment is made before the end of any 12-month period. The interest shall commence running upon the date of the Overpayment and interest shall continue to be due until the full amount owed to the Plan is paid back.

In addition to all other remedies, including any arrangements made with the Plan, if a full refund (including interest, if applicable) is not received within 30 days after the Plan's request, the amount of Overpayment (including interest, if applicable) will be deducted from all future benefit payments for you or your eligible Dependent(s) until the Overpayment and any interest has been recovered.



BILLING ERRORS

If you suspect you have been subject to billing errors, immediately do the following:

- Call the Provider and confirm the accuracy of the billing.
- Send a copy of your EOB, along with a letter explaining the discrepancy, to:

  Motion Picture Industry Health Plan
  Attn: Claims Department
  P.O. Box 1999
  Studio City, CA 91614-0999

STOP PAYMENT OR REPLACEMENT OF A BENEFIT CHECK

Any request for Stop Payment of a benefit check (30 days after the issue date) issued by the Plan must be in writing and a $5 payment for each request to the Plan is required for processing. A $5 per check payment will also be required for copies of canceled checks. This fee applies to Participants and Providers. Requests for Stop Payments may not be made prior to 30 days after the check was issued.

Any request for the re-issuance of a stale-dated (expired) check issued by the Plan must be made in writing and a $5 payment for each request to the Plan is required for processing. Requests must be made within seven years of the original check issuance date. Upon verification that the check has neither cleared the Plan's bank, nor already been reissued, the Plan will issue a replacement check. This policy applies to Participants and Providers.

Please visit, www.mpiphp.org to download and complete the Check Trace form.

Behavioral Health

Optum Behavioral Health
A United Health Group Company
(888) 661-9141
www.liveandworkwell.com

Online Access Code:
MPIPHP

HOW OPTUM BEHAVIORAL HEALTH BENEFITS WORK

Optum Behavioral Health is only available to Participants enrolled in the MPIHP/Anthem Blue Cross Plan. To access Behavioral Health care, you can contact Optum at (888) 661-9141, 24 hours a day. Participants are encouraged to contact Optum to see if their Provider is an Optum contracted Provider or if there is an In-Network Provider who is right for them.

HOW TO OBTAIN BEHAVIORAL HEALTH SERVICES

To get Behavioral Health Services, you should first call Optum at (888) 661-9141. Customer Service Agents and Licensed Care Advocates are available 24 hours a day. When you contact Optum Customer Service, an Optum agent will verify eligibility and conduct a brief telephone screening to review the problems or symptoms you are having, inquire about past or current treatment and identify appropriate Referrals. The agent will then provide you with information on an In-Network Provider near your home or work that meets your needs. For many therapies, since the Providers are the same, your treatment can begin by using your Member Assistance Program (MAP) benefit which waives your

Co-Payment. If the service you want to Preauthorize is non-routine, then the agent can provide you with the necessary authorization. If your need is urgent or an emergency, you will be immediately connected to a licensed care manager for assessment and Referral.

ACCESSING AN OUT-OF-NETWORK PROVIDER

You also have the option of seeing an Out-of-Network Provider.

Note:

Your share of the cost for an Out-of-Network Provider may be substantially higher than for an authorized In-Network Provider. We strongly recommend that you get Preauthorization for the non-routine services listed on page 88. It is best to call Optum and find out if your Provider is already in the Optum network and if your service is considered non-routine.

An Optum Claim will not be denied on the basis that it was not preauthorized, but it may not be covered due to other benefit limitations or exclusions or lack of medical necessity.

WHAT HAPPENS IN AN EMERGENCY?

If you are unable to contact Optum, get help or treatment immediately. This means you should call "911" or go directly to the nearest medical facility for treatment. It is recommended that you contact Optum within 48 hours of your emergency or as soon as is reasonably possible after your condition is stable. You, or someone acting on your behalf, may call Optum at (888) 661-9141 to confirm that your Provider is In-Network and your service is routine.

WHO ARE OPTUM IN-NETWORK PROVIDERS?

Optum's In-Network Providers include hospitals, group practices and individual professionals. All In-Network Providers are carefully screened and must meet strict Optum licensing and program standards. For a listing of Optum In-Network Providers, go to www.liveandworkwell.com; access code: MPIPHP, or call toll-free to (888) 661-9141.

WHAT IF I GET A BILL?

You should not get a bill from your Optum In-Network Provider because Optum's In-Network Providers have been instructed to send all their bills directly to Optum for payment. You may, however, have to pay a Co-Payment to the Optum Provider each time you receive services. You could also get a bill from an emergency room Provider if you used emergency care. If this happens, send Optum the original bill or Claim as soon as possible and keep a copy for yourself. You are responsible only for the amount of your Co-Payment, as described in the Schedule of Benefits. Optum will not pay for Out-of-Network bills or Claims that are more than one year old.

- Mail bills or Claims to:

  Optum Behavioral Health
  Attn: Claims Department
  P.O. Box 30755
  Salt Lake City, UT 84130

COVERED SERVICES

Behavioral Health Services must be incurred while the Participant is eligible for coverage under the Plan.

Optum will pay for the following Behavioral Health Services furnished in connection with treatment as outlined in the Schedule of Benefits:

1. **Inpatient Hospital Benefits/ Acute Care and Partial Hospital Benefits**
2. **Inpatient Provider Care**
3. **Provider Care:**
   Diagnostic and treatment services, including consultation and treatment.

4. **Ambulance:**
Use of an ambulance (land or air) for emergencies including, but not limited to, ambulance or ambulance transport services provided through the "911" emergency response system is covered without Preauthorization when the Participant reasonably believes that the behavioral health condition requires emergency services that require ambulance transport services. Use of an ambulance for a non-emergency is covered when specifically authorized by Optum.

5. **Laboratory Services:**
Diagnostic and therapeutic laboratory services. Please contact Optum for additional details.

6. **Inpatient Prescription Drugs:**
Inpatient prescription drugs are covered only when prescribed by an Optum In-Network Provider while the Participant is confined to a facility for Behavioral Health Treatment.

7. **Injectable Psychotropic Medications:**
Injectable psychotropic medications are covered if prescribed by an Optum In-Network Provider for Behavioral Health Treatment.

8. **Non-Routine Services:**
We strongly recommend that you get Preauthorization when using an Out-of-Network Provider for the following services:

a. Psychological testing

b. Intensive Outpatient program treatment

c. Outpatient electro-convulsive treatment

d. Neuro-Psychological testing

e. Methadone maintenance

f. Extended Outpatient treatment visits beyond 45-50 minutes in duration with or without medication management

EXCLUSIONS AND LIMITATIONS

The services and benefits for care and conditions as described below are excluded from coverage under this Plan and are therefore not covered by Optum:

1. All services not specifically included in the Optum Covered Services section on the previous page
2. Services received prior to the Participant's start date of coverage, after the time coverage ends or at any time the Participant is ineligible for coverage
3. Services or treatments which, in the judgment of Optum, are not medically necessary
4. Any confinement, treatment, service or supply that is provided under Workers' Compensation law or similar laws
5. Any confinement, treatment, service or supply obtained through or required by a governmental agency or program

- **Schedule of Benefits:**

IN-NETWORK MENTAL HEALTH BENEFITS	OUT-OF-NETWORK MENTAL HEALTH BENEFITS	IN-NETWORK SUBSTANCE USE DISORDER BENEFITS	OUT-OF-NETWORK SUBSTANCE USE DISORDER BENEFITS
Inpatient Per Admission Fees + Coinsurance			
▸ No Charge	▸ $100 Per Admission Fee ▸ 50% Coinsurance of the Allowable Amount Applies After the Per Admission Fee	▸ No Charge	▸ $100 Per Admission Fee ▸ 50% Coinsurance of the Allowable Amount Applies After the Per Admission Fee
Outpatient Visit Fees + Coinsurance			
▸ $5 Co-Payment Per Visit	▸ 50% Coinsurance of the Allowable Amount	▸ $5 Co-Payment Per Visit	▸ 50% Coinsurance of the Allowable Amount

6. Treatment for a reading disorder, mental handicap, motor skills disorder, or a communication disorder
7. Treatments which do not meet national standards for mental health professional practice
8. Non-organic therapies, including but not limited to, the following: bioenergetics therapy, confrontation therapy, crystal healing therapy, educational remediation, Eye Movement Desensitization and Reprocessing (EMDR), guided imagery, marathon therapy, primal therapy, Rolfing, sensitivity training, Transcendental Meditation, Lovaas Discrete Trial Training and Facilitated Communication
9. Organic therapies, including but not limited to, the following: aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, and rapid anesthesia opiate detoxification
10. Treatments designed to regress the Participant emotionally or behaviorally
11. Personal enhancement or self-actualization therapy and other similar treatments
12. Routine, custodial, and convalescent care, long-term therapy and/or rehabilitation (Individuals should be referred to appropriate community resources such as school district or regional center for such services.)
13. Any services provided by non-licensed Providers
14. Pastoral or spiritual counseling
15. Dance, poetry, music or art therapy except as part of a Behavioral Health Treatment Program
16. Thought field therapy
17. School counseling and support services, home based behavioral management, household management training, peer support services, recreation, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, wraparound services, emergency aid to household items and expenses, and services to improve economic stability and interpretation services
18. Applied Behavioral Analysis
19. Genetic counseling
20. Community Care Facilities that provide 24-hour non-medical residential care
21. Weight control programs and treatment for addictions to tobacco, nicotine or food (except as provided through The Wellness Program and/or covered by Express Scripts)

▶ **Comparison of Behavioral Health Options:**

OUT-OF-NETWORK OUTPATIENT THERAPY	IN-NETWORK OUTPATIENT THERAPY
Provider Options	
▶ May choose any behavioral health Provider.	▶ Must choose from the 65,000 behavioral health Providers in the Optum network.
Preauthorization Requirements	
▶ Preauthorization for non-routine services is strongly recommended – call (888) 661-9141. The Plan will pay 50% of the fee based on the 70th percentile of the UCR charge.	▶ Preauthorization for non-routine services is recommended and is performed by the In-Network Provider.
Financial Responsibility	
▶ The Participant will be held responsible for whatever portion of the charges is not paid by the Plan.	▶ Participant financial responsibility is limited to: - $5 Co-Payment Per Visit - No Coinsurance

22. Counseling for adoption, custody, family planning or pregnancy in the absence of a DSM-V diagnosis
23. Sexual therapy programs, including therapy for sexual addiction, the use of sexual surrogates, and sexual treatment for sexual offenders/perpetrators of sexual violence
24. Private room and/or private duty nursing unless Optum determines that they are medically necessary
25. All non-prescription and prescription drugs, except those prescribed by an Optum Provider as part of a Participant's inpatient treatment at an Optum participating facility
26. Surgery or acupuncture
27. Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not medically necessary
28. Neurological services and tests, including, but not limited to, EEGs, Pet scans, beam scans, MRIs, skull x-rays and lumbar punctures
29. Treatment sessions by telephone or computer Internet services
30. Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations, or career counseling
31. Nutritional supplements, vitamins, minerals, counseling
32. Speech and occupational therapy
33. Methadone treatment (except as covered by Express Scripts)
34. Biofeedback, including EEG and neurofeedback
35. Gambling disorder
36. Drug testing

RESPONDING TO YOUR CONCERNS

Optum's first priority is to meet your needs and that means providing responsive service. If you ever have a question or problem, your first step is to call Optum's Customer Service Department for resolution.

- If you feel the situation has not been addressed to your satisfaction, you may submit a formal complaint over the telephone by calling Optum's toll-free number.
- If you feel your Claim or request has not been processed correctly by Optum, within 180 days following the receipt of your Explanation of Benefits or other initial Adverse Benefit Determination, you may file a first level appeal in writing to:

  Optum Behavioral Health
  Attn: Appeals Department
  P.O. Box 2839
  San Francisco, California 94126
  Phone: (800) 505-8826
  Fax: (800) 984-7584

- If you feel that your first level appeal was not correctly decided by Optum, you have 180 days following receipt of notification of Optum's decision to file a second level appeal with the Plan's Benefits/Appeals Committee in accordance with the procedures set forth on page 44. Please submit in writing your reasons, in clear and concise terms, and include any other pertinent documents or other documentation that will help the Committee to understand the situation. The decision of the Benefits/Appeals Committee will be final and binding upon all parties, including the Participants and any person claiming under the Participant, subject to the right to bring a civil action under Section 502(a) of ERISA.

Health Net

Health Net
P.O. Box 9103
Van Nuys, CA 91409-9103
(800) 522-0088
www.healthnet.com

Group Number:
61880A

The Motion Picture Industry Health Plan for Active Participants (the "Plan") is pleased to offer you and your eligible Dependent(s) coverage through Health Net.

If you select Health Net for your hospital and medical benefits, you are covered for hospital and medical benefits only through a Health Net Participating Physician Group (PPG) or Independent Physicians Association (IPA). Most covered services are provided to you at no cost. Your member assistance, dental, life insurance, prescription drug, vision and wellness benefits under the Plan remain in effect.

If you are newly eligible for benefits through the Plan and want to select Health Net as your medical plan, you must complete the Health Net portion of your Benefit Selection form and return it to the Plan Office. Upon enrollment and return of your selection forms, your Health Net benefit identification cards will be issued to you directly by Health Net.

If you select Health Net for your health benefits, the Evidence of Coverage you receive upon enrollment with the Plan or with this *SPD* will become part of your *SPD*.

Participants enrolled in Health Net, their spouse's and children are free to select more than one medical group per household. This means that you can choose one physician group and Primary Care Provider (PCP) for yourself, and select another physician group and PCP for your spouse or other members of your family, and members can change physician groups once per month, for any reason.

ANNUAL OUT-OF-POCKET MAXIMUM FOR CERTAIN SERVICES

For services subject to the maximum, you will not pay any more cost-sharing during a calendar year if the Co-Payments and Coinsurance you pay for those services add up to one of the following amounts:

- **For self-only enrollment (a family of one member):** $1,500 per calendar year
- **For a family of two members:** $3,000 per calendar year
- **For a family of three or more members:** $4,500 per calendar year
- **Deductible or Lifetime Maximum:** None

BEHAVIORAL HEALTH TREATMENT FOR AUTISM

Professional services for behavioral health treatment, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Participant and/or Dependent diagnosed with the severe mental illnesses or pervasive developmental disorder or autism is covered. The treatment must be prescribed by a licensed Provider or developed by a licensed Psychologist, and must be provided under a documented treatment plan prescribed, developed and approved by a qualified autism service Provider providing treatment to the Participant and/or Dependent for whom the treatment plan was developed. The treatment must be administered by the qualified autism service Provider, or by qualified autism service professionals and/or paraprofessionals who are supervised and employed by the treating qualified autism service Provider.

CHIROPRACTIC CARE

Chiropractic care is available through Health Net. For additional information contact ASH Plans at (800) 678-9133 (TTY/TDD: 711).

HEARING AIDS

Health Net Participants and their eligible Dependents considering hearing aids may obtain them through the Plan. You must first have a hearing test by a qualified audiologist, which will be paid through Health Net.

For In-Network Providers, the Maximum Allowable Amount is $1,386 per ear, paid at 90%.

Out-of-Network Providers are payable at 50% of $1,386, per ear, Hearing aids are replaceable once every three years.

To find an In-Network Provider, visit www.hearusa.com or www.anthem.com.

Additionally, Health Net provides a discount through TruHearing, but those Providers may be Out-of-Network.

LIMITATIONS AND EXCLUSIONS

Health Net does not cover:

1. Any services not authorized by the Participant's and/or Dependent's selected PPG or IPA in accordance with procedures established by the PPG or IPA and Health Net
2. Cosmetic surgery
3. Reversals of voluntary surgically induced sterility
4. Experimental or investigational procedures as defined by Health Net
5. Routine physical examinations for insurance, licensing, employment, school, camp or other non-preventive purposes
6. Dental services (see Participant's selected dental plan for coverage)
7. Disorders of the jaw joint or surgical procedures to enlarge, reduce or realign the jaw, except as determined to be medically necessary
8. Personal or comfort items
9. Custodial or domiciliary care
10. Treatment for chronic alcoholism or other substance abuse (Detoxification and the treatment of associated medical conditions are covered)
11. Treatment for nervous or mental disorders as a registered bed patient
12. Private-duty nursing for registered bed patients in a hospital or long-term care facility
13. Non-eligible institutions
14. Outpatient prescription drugs or medications *(see Express Scripts)*
15. Disposable supplies for home use
16. Orthotics which are not custom made to fit the body
17. Contact lenses or corrective eyeglasses *(see VSP)*
18. Conception by artificial means; any and all procedures that involve the harvesting or manipulation (physical, chemical or by any other means) of the human ovum to treat infertility;

any service, procedure or process that prepares the Participant and/or Dependent to receive conception by artificial means includes zygote intrafallopian transfer (ZIFT) and any other procedures; collection, preservation or purchases of sperm or ova (artificial insemination is covered when a female or her male partner is infertile)

19. Any services or supplies not specifically listed in the Participant's Evidence of Coverage as covered services or supplies
20. Services received before coverage begins or after termination of coverage, except as specifically stated under Extension of Benefits in the member's Evidence of Coverage

GRIEVANCE, APPEALS, INDEPENDENT MEDICAL REVIEW AND ARBITRATION

Grievance Procedures

If you are not satisfied with efforts to solve a problem with Health Net or your Participating Physician Group, you must first file a grievance or appeal against Health Net by calling the Member Services Department at (800) 522-0088 or by submitting a Member Grievance form through the Health Net website at www.healthnet.com.

- You may also file your complaint in writing by sending information to:

  Health Net Member Services
  Attn: Appeals and Grievance Department
  P.O. Box 10348
  Van Nuys, CA 91410-0348

- If your concern involves the Mental Disorders and Chemical Dependency program, call Managed Health Network (MHN) at (888) 426-0030, or write to:

  Managed Health Network
  Attn: Health Net Team
  1600 Los Gamos Drive, Suite 300
  San Rafael, CA 94903

If your concern involves the chiropractic program, contact Health Net directly. Please include all information from your Health Net identification card and the details of the concern or problem.

Health Net will:

- Confirm in writing within five calendar days that it received your request.
- Review your complaint and inform you of its decision in writing within 30 days from the receipt of the grievance. For conditions where an immediate and serious threat to your health exists, including severe pain or the potential for loss of life, limb or major bodily function, Health Net must notify you of the status of your grievance no later than three days from receipt of the grievance.

For urgent grievances, Health Net will immediately notify you of the right to contact the California Department of Managed Health Care. There is no requirement that you participate in Health Net's grievance process prior to applying to the California Department of Managed Health Care for review of an urgent grievance.

If you continue to be dissatisfied after the grievance procedure has been completed, you may contact the California Department of Managed Health Care for assistance or to request an Independent Medical Review or initiate binding arbitration, as described as follows. Binding arbitration is the final process for the resolution of disputes.

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

You may request an Independent Medical Review (IMR) of disputed health care services from the California Department of Managed Health Care ("Department") if you believe that health care services under your Health Net Plan have been improperly denied, modified or delayed by Health Net or one of its Contracting Providers. A "Disputed Health Care Service" is any health care service eligible for coverage and payment under your Health Net Plan that has been denied, modified or delayed by Health Net or one of its Contracting Providers, in whole or in part because the service is not medically necessary. The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR.

Health Net will provide you with an IMR application form and Health Net's grievance response letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the Disputed Health Care Service.

Eligibility

Your application for an IMR will be reviewed by the Department to confirm that it meets all the eligibility requirements of the law for IMR.

1. Your application for an IMR will be reviewed if:
   - (a) Your Provider has recommended a health care service as medically necessary;
   - (b) You have received urgent or emergency care that a Provider determined to have been medically necessary; or
   - (c) In the absence of the Provider recommendation described in 1.a. above, you have been seen by a Health Net Member Provider for the diagnosis or treatment of the medical condition for which you seek an IMR.
2. The Disputed Health Care Service has been denied, modified or delayed by Health Net or one of its Contracting Providers, based in whole or in part on a decision that the health care service is not Medically Necessary; and
3. You have filed a grievance with Health Net and the disputed decision is upheld by Health Net or the grievance remains unresolved after 30 days. Within the next six months, you may apply to the Department for IMR, or later if the Department agrees to extend the application deadline. If your grievance requires expedited review, you may bring it immediately to the Department's attention. The Department may waive the requirement that you follow Health Net's grievance process in extraordinary and compelling cases.

If your case is eligible for an IMR, the dispute will be submitted to a medical Specialist who will make an independent determination of whether or not the care is medically necessary. You will receive a copy of the assessment made in your case from the IMR. If the IMR determines the service is medically necessary, Health Net will cover the Disputed Health Care Service. If your case is not eligible for an IMR, the Department will advise you of your alternatives.

For non-urgent cases, the IMR organization designated by the Department must provide its determination within 30 days of receipt of the application for review and the supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three business days.

For more information regarding the IMR process or to request an application form, please call the Health Net Member Services Department at (800) 522-0088.

INDEPENDENT MEDICAL REVIEW OF INVESTIGATIONAL OR EXPERIMENTAL THERAPIES

Health Net does not cover experimental or investigational drugs, devices, procedures or therapies. However, if Health Net denies or delays coverage for your requested treatment on the basis that it is experimental or investigational, and you meet the eligibility criteria set out below, you may request an IMR of Health Net's decision from the California Department of Managed Health Care. The Department does not require you to participate in Health Net's grievance system prior to seeking an IMR of a decision to deny treatment on the basis that it is experimental or investigational.

Eligibility

1. You must have a life-threatening or seriously debilitating condition.
2. Your Provider must certify to Health Net that you have a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving your condition or are otherwise medically inappropriate and there is no more beneficial therapy covered by Health Net.
3. Your Provider must certify that the proposed experimental or investigational therapy is likely to be more beneficial than available standard therapies or, as an alternative, you submit a request for a therapy which, based on documentation you present from the medical and scientific evidence, is likely to be more beneficial than available standard therapies.
4. You have been denied coverage by Health Net for the recommended or requested therapy.
5. If not for Health Net's determination that the recommended or requested treatment is experimental or investigational, it would be covered.

If Health Net denies coverage of the recommended or requested therapy, and you meet the eligibility requirements, Health Net will notify you within five business days of its decision and your opportunity to request external review of Health Net's decision through an IMR. Health Net will provide you with an application form to request an IMR of its decision.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for an IMR. You have the right to provide information in support of your request for an IMR. If your Provider determines that the proposed therapy should begin promptly, you may request expedited review, and the experts on the IMR panel will render a decision within seven days of your request. If the IMR panel recommends that Health Net cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the denial of the recommended or requested therapy. For more information, please call the Health Net Member Services Department at (800) 522-0088.

Binding Arbitration

Sometimes disputes or disagreements may arise between you (including your enrolled family members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of its Evidence of Coverage or regarding other matters relating to or arising out of your Health Net membership. Typically, such disputes are handled and resolved through the Health Net Grievance, Appeal, and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, Health Net uses binding arbitration, except as provided below, as the final method for resolving all such disputes, whether stated in tort, contract or otherwise and whether or not other parties such as employer groups, health care Providers or their agents or employees are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to becoming a Health Net member, you agree to submit all disputes you may have with Health Net, except those described below, to final and binding arbitration. Likewise, Health Net agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and Health Net are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby, the parties agree to forgo any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C.§1, et seq., will govern

arbitrations under this process. In the event that the total amount of damages claimed is $200,000 or less, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000. In the event that the total amount of damages is over $200,000, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to Health Net at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Participants who are enrolled in the Plan, which is subject to ERISA, 29 U.S.C.§1001, et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "Adverse Benefit Determinations" made by Health Net to mandatory binding arbitration. Under ERISA, an "Adverse Benefit Determination" means a decision by Health Net to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and Health Net may voluntarily agree to arbitrate disputes about these "Adverse Benefit Determinations" at the time the dispute arises.

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this Evidence of Coverage, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law.

At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that state or federal law provides for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the Arbitration. Each party also will be responsible for its own attorneys' fees. In cases of extreme hardship to a Participant, Health Net may assume all or a portion of a Participant's share of the fees and expenses of the arbitration. Upon written notice by the Participant requesting a hardship application, Health Net will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided below.

- For a more complete description of benefits, please refer to the Health Net Evidence of Coverage.

Health Net of California
Attn: Litigation Administrator
P.O. Box 4504
Woodland Hills, CA 91365-4505

Reminder:

Your Claims review and Appeals will ordinarily be handled based on the general guidelines and time frames provided on page 44, with your Claims and Appeals submitted to Health Net. However, in addition to reading this Health Net section of your *SPD*, you must also review the Health Net Evidence of Coverage furnished to you for further details. In addition, benefits available under Medicare may be handled somewhat differently, as described in your Evidence of Coverage.

▶ **Partial list of Health Net benefits:**

PROFESSIONAL SERVICES	YOU PAY
Visits to physician, physician's assistant or nurse practitioner in PPG or IPA	$15 per visit
Newborn office visits	$15 per visit
Periodic health evaluations	$15 per visit
Teledoc visits	$0 per visit
Emergency services (waived if admitted to a hospital)	$35 per visit
Annual well-woman visit* (self-to a gynecologist associated with member's PPG or IPA)	$15 per visit
Vision and hearing exams	$15 per visit
Specialist's consultations	$15 per visit
Provider's visit to member's home (at discretion of the Provider)	$30 per visit
Provider's visit to hospital or skilled nursing facility	$0
Immunizations in relation to foreign travel or occupational requirements	20% per immunization
Other immunizations	$0
Allergy injection services & Allergy serum	$0
Injections for infertility	50% per visit
All other injections	$0
Surgeon/Assistant Surgeon in hospital or PPG or IPA	$0
Administration of anesthetics	$0
X-ray and laboratory procedures	$0
Short-term neuromuscular rehabilitation therapy (includes physical, speech, occupational and inhalation therapy which will result in significant improvement of the condition)	$0
CARE FOR CONDITIONS OF PREGNANCY	**YOU PAY**
Prenatal care and postnatal office visits	$15 per visit
Provider's visit to a hospital in relation to care for the mother and newborn	$0
Normal delivery, caesarean section	$0
Complications of pregnancy, including medically necessary abortions	$0
Elective abortions	$0
Genetic testing of fetus	$0
Circumcision of newborn males	$0
FAMILY PLANNING	**YOU PAY**
All infertility services (all services that diagnose, evaluate or treat infertility)	50%
Sterilization of females	$150
Sterilization of males	$50

CARE FOR MENTAL DISORDERS	YOU PAY
Outpatient mental health (Services must be provided by a contracted Provider)	$15 per visit
Inpatient mental health (Services must be Preauthorized)	$0
OTHER SERVICES	**YOU PAY**
Medical social services	$0
Patient education	$0
Ambulance	$0
Air ambulance	$0
Durable Medical Equipment	$0
Prosthetic device (internal or external)	$0
Blood, blood plasma, blood derivatives and blood factors	$0
Nuclear medicine	$0
Organ and bone marrow transplants (nonexperimental and non-investigational)	$0
Chemotherapy	$0
Renal dialysis	$0
Home health services (Co-Payment begins on the 31st day of care)	$10 per visit
Hospice services	$0
HOSPITALIZATION	**YOU PAY**
Unlimited days of care in a hospital semi-private room or intensive care unit with Ancillary Services	$0
Room and board in a skilled nursing facility (limited to 100 days per calendar year)	$0
Hospitalization for infertility services	50%
Maternity care	$0
Acute Inpatient Care for alcohol and drug abuse (detoxification only)	$0
Emergency services within or outside the Health Net service area professional services	$0
Emergency room services**	$35 per visit
Urgent care center services**	$35 per visit
Hospital inpatient services	$0
Hospital outpatient services	$0

** Covered services are medical history and diagnosis, physical exams, including breast and pelvic exams, and pap smears. Additional visits or tests require PPG or IPA authorization.*

*** The Co-Payment will not be required if the patient is admitted as a hospital inpatient directly from the emergency room or urgent care center.*

Kaiser Permanente

KAISER PERMANENTE®

Kaiser Permanente
P.O. Box 704
Downey, CA 90242-7004
(800) 464-4000
www.kaiserpermanente.org

Group Number:
100275-00

The Motion Picture Industry Health Plan for Active Participants (the "Plan") is pleased to offer you and your eligible Dependent(s) coverage through Kaiser Permanente.

If you select Kaiser Permanente for your hospital and medical benefits, you are covered for hospital and medical benefits only through a Kaiser Permanente facility. Your member assistance, dental, life insurance, prescription drug, vision and wellness benefits under the Plan remain in effect.

To enroll in the Kaiser Permanente plan, you must complete the Kaiser Permanente portion of your Benefit Selection form and return it to the Plan Office. Upon enrollment, your benefit identification cards will be issued to you directly by Kaiser Permanente, along with comprehensive information regarding its services and facilities. You may contact Kaiser Permanente for an advance copy of information to assist you in your selection of medical/hospital plans. If you select Kaiser Permanente for your health benefits, the Evidence of Coverage (*Your Guidebook*) you receive with your enrollment information will become part of your *SPD*.

ANNUAL OUT-OF-POCKET MAXIMUM FOR CERTAIN SERVICES

For services subject to the maximum, you will not pay any more cost sharing during a calendar year if the Co-Payments and Coinsurance you pay for those services add up to one of the following amounts.

- **For self-only enrollment (a family of one member):** $1,500 per calendar year
- **For any one member in a family of two or more members:** $1,500 per calendar year
- **For an entire family of two or more members:** $3,000 per calendar year
- **Deductible or Lifetime Maximum:** None

BEHAVIORAL HEALTH TREATMENT FOR AUTISM

Kaiser Permanente covers behavioral health treatment for pervasive developmental disorder or autism (including applied behavior analysis and evidence-based behavior intervention programs) that develops or restores, to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism and that meet all of the following criteria:

- The treatment is prescribed by a Kaiser Permanente Provider, or is developed by a Plan Provider who is a psychologist.
- The treatment is provided under a treatment plan prescribed by a Kaiser Permanente Provider who is a qualified autism service Provider.
- The treatment is administered by a Kaiser Permanente Provider who is one of the following:
  - A qualified autism service provider
  - A qualified autism service professional supervised and employed by the qualified autism service provider
  - A qualified autism service paraprofessional supervised and employed by a qualified autism service provider
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the member being treated.
- The treatment plan is reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate.
- The treatment plan requires the qualified autism service provider to do all of the following:
  - Describe the member's behavioral health impairments to be treated
  - Design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the member's progress is evaluated and reported
  - Provide intervention plans that utilize evidence based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism
  - Discontinue intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate
- The treatment plan is not used for either of the following:
  - For purposes of providing (or for the reimbursement of) respite care, day care, or educational services
  - To reimburse a parent for participating in the treatment program

Effective as of the date that federal proposed final rulemaking for essential health benefits is issued, Kaiser Permanente will cover services under this "Behavioral Health Treatment for Autism" section only if they are included in the essential health benefits that all health plans will be required by federal regulations to provide under section 1302(b) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act.

CHIROPRACTIC CARE

Chiropractic care is available through American Specialty Health (ASH) for Participants and eligible Dependents enrolled in Kaiser Permanente.

You may self-refer to an approved ASH chiropractor for a $15 per visit Co-Payment, for a maximum of 20 visits per calendar year.

- Providers submit Claims to:

  American Specialty Health Networks, Inc.
  P.O. Box 509002
  San Diego, CA 92150-9002

For the name of an approved ASH chiropractor near you, please visit www.ashlink.com/ash/kp or call (800) 678-9133.

Please note, Kaiser Permanente does not cover the following services:

- Studio calls
- On-site visits
- Home visits
- Exercise at a gym or similar facility
- Use of a non-network chiropractor

MRI/CT scans, diagnostic tests and laboratory tests are not covered when ordered by a chiropractor, even if they are administered by a Provider. No more than 20 chiropractic treatments are covered per calendar year, regardless of condition or conditions.

Kaiser Permanente does not make any recommendations regarding the use of chiropractors affiliated with ASH, but merely provides this information for use at your own discretion.

HEARING AIDS

Participants and their eligible Dependents considering hearing aids may obtain them through the Plan. You must first have a hearing test by a qualified audiologist, which will be paid through Kaiser Permanente.

For In-Network Providers, the Maximum Allowable Amount is $1,386 per ear, paid at 90%.

Out-of-Network Providers are payable at 50% of $1,386, per ear.

Hearing aids are replaceable once every three years.

To find an In-Network Provider, visit www.hearusa.com or www.anthem.com.

KAISER PERMANENTE SOUTHERN CALIFORNIA PLAN HOSPITALS AND MEDICAL OFFICES

At most of the Kaiser Permanente facilities, you can usually receive all of the covered services you need, including specialty care, pharmacy

and lab work. You are not restricted to a particular Kaiser Permanente facility, and you are encouraged to use the facility that will be most convenient for you:

- All Kaiser Permanente hospitals provide inpatient services and are open 24 hours a day, seven days a week.
- Emergency services are available from Kaiser Permanente hospital emergency departments as described in *Your Guidebook*.
- Same-day, urgent care appointments are available at many locations. (Please refer to *Your Guidebook* for urgent care locations in your area.)
- Many Kaiser Permanente medical offices have evening and weekend appointments.
- Many Kaiser Permanente facilities have a Member Services Department.

The following is a list of Kaiser Permanente hospitals and medical offices in Kaiser Permanente's Southern California service area. Additional Kaiser Permanente medical offices are listed on Kaiser Permanente's website at www.kp.org. This list is subject to change at any time without notice.

- **Aliso Viejo**
  Medical Offices
- **Anaheim** (3 locations)
  Hospital and Medical Offices
- **Bakersfield** (5 locations)
  Hospital and Medical Offices
- **Baldwin Park**
  Hospital and Medical Offices
- **Bellflower**
  Medical Offices
- **Bonita**
  Medical Offices
- **Brea**
  Medical Offices
- **Camarillo**
  Medical Offices
- **Carlsbad**
  Medical Offices
- **Chino**
  Medical Offices
- **Claremont**
  Medical Offices
- **Colton**
  Medical Offices
- **Corona**
  Medical Offices
- **Cudahy**
  Medical Offices
- **Culver City**
  Medical Offices
- **Diamond Bar**
  Medical Offices
- **Downey**
  Hospital and Medical Offices
- **El Cajon**
  Medical Offices
- **Escondido** (3 locations)
  Hospital and Medical Offices

Kaiser Permanente

- **Fontana**
  Hospital and Medical Offices
- **Garden Grove**
  Medical Offices
- **Gardena**
  Medical Offices
- **Glendale**
  Medical Offices
- **Harbor City**
  Hospital and Medical Offices
- **Huntington Beach**
  Medical Offices
- **Indio**
  Hospital and Medical Offices
- **Inglewood**
  Medical Offices
- **Irvine** (2 locations)
  Hospital and Medical Offices
- **Joshua Tree**
  Hospital
- **La Mesa**
  Medical Offices
- **La Palma**
  Medical Offices
- **Lancaster**
  Hospital and Medical Offices
- **Long Beach**
  Medical Offices
- **Los Angeles** (3 locations)
  Hospitals and Medical Offices
- **Lynwood**
  Medical Offices
- **Mission Hills**
  Medical Offices
- **Mission Viejo**
  Medical Offices
- **Montebello**
  Medical Offices
- **Moreno Valley**
  Hospital and Medical Offices
- **Murrieta**
  Hospital
- **Oceanside**
  Medical Offices
- **Ontario**
  Medical Offices
- **Oxnard**
  Medical Offices
- **Palm Desert**
  Medical Offices
- **Palm Springs**
  Hospital and Medical Offices
- **Palmdale**
  Medical Offices
- **Panorama City**
  Hospital and Medical Offices
- **Pasadena**
  Medical Offices
- **Rancho Cucamonga**
  Medical Offices
- **Redlands**
  Medical Offices
- **Riverside**
  Hospital and Medical Offices
- **San Bernardino**
  Medical Offices
- **San Diego** (6 locations)
  Hospital and Medical Offices
- **San Dimas**
  Medical Offices
- **San Juan Capistrano**
  Medical Offices
- **San Marcos**
  Medical Offices
- **Santa Ana** (2 locations)
  Medical Offices
- **Santa Clarita**
  Medical Offices
- **Simi Valley**
  Medical Offices
- **Temecula**
  Medical Offices
- **Thousand Oaks** (2 locations)
  Medical Offices
- **Torrance**
  Medical Offices
- **Upland**
  Medical Offices
- **Victorville**
  Medical Offices
- **Ventura**
  Hospital and Medical Offices
- **West Covina**
  Medical Offices
- **Whittier**
  Medical Offices
- **Wildomar**
  Hospital and Medical Offices
- **Woodland Hills** (2 locations)
  Hospital and Medical Offices
- **Yorba Linda**
  Medical Offices

DISPUTE RESOLUTION

Grievances

Kaiser Permanente is committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with Kaiser Permanente member services representatives at most Kaiser Permanente facilities, or you can call Kaiser Permanente's Member Service Call Center.

You can file a grievance for any issue. Following are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received.
- You received a written Denial of Services from the Medical Group

or a "Notice of Non-Coverage" and you want Kaiser Permanente to cover the services.

- A Kaiser Permanente Provider has said that services are not medically necessary and you want Kaiser Permanente to cover the services.
- You were told that services are not covered and you believe that the services should be covered.
- You received care from a non-Kaiser Permanente Provider that Kaiser Permanente did not authorize (other than emergency care, post-stabilization care, or out-of-area urgent care), and you want Kaiser Permanente to pay for the care.
- Kaiser Permanente did not decide fully in your favor on a Claim for services described in the "Emergency Services and Urgent Care" section of your Evidence of Coverage (*Your Guidebook*), and you want to appeal Kaiser Permanente's decision.
- You are dissatisfied with how long it took to get services, including scheduling an appointment, in the waiting room, or in the exam room.
- You want to report unsatisfactory behavior by Providers or staff, or dissatisfaction with the condition of a facility.

Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about services you received. You must submit your grievance orally or in writing within 180 days of the date of the incident that caused your dissatisfaction as follows:

- If Kaiser Permanente did not decide fully in your favor on a Claim for services described in the "Emergency Services and Urgent Care" section, and you want to appeal a Kaiser Permanente's decision, you can submit your grievance in one of the following ways:
  - To the Claims Department at the following address:

    Kaiser Foundation Health Plan, Inc.
    Attn: Special Services Unit
    P.O. Box 7136
    Pasadena, CA 91109
  - By calling Kaiser Permanente's Member Service Call Center at (800) 464-4000 or (800) 390-3510
    TTY users call (800) 777-1370.
- For all other issues, you can submit your grievance in one of the following ways:
  - To the Member Services Department at Kaiser Permanente Facility (please refer to *Your Guidebook* for addresses).
  - By calling Kaiser Permanente's Member Service Call Center at (800) 464-4000
    TTY users call (800) 777-1370
  - Through Kaiser Permanente's website at www.kp.org.

Kaiser Permanente will send you a confirmation letter within five days after it receives your grievance. Kaiser Permanente will send you its written decision within 30 days after it receives your grievance. If Kaiser Permanente does not approve your request, it will tell you the reasons and will inform you about additional dispute resolution options.

Note:

If Kaiser Permanente resolves your issue to your satisfaction by the end of the next business day after it receives your grievance orally, by fax, or through its website, and a member services representative notifies you orally about the decision, Kaiser Permanente will not send you a confirmation letter or a written decision unless your grievance involves a coverage dispute, a dispute about whether a service is medically necessary, or an experimental or investigational treatment.

Expedited Grievances

You or your Provider may make an

oral or written request that Kaiser Permanente expedite its decision about your grievance if it involves an imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major bodily function. Kaiser Permanente will inform you of its decision within 72 hours (orally or in writing).

If the request is for a continuation of an expiring course of treatment, and you make the request at least 24 hours before the treatment expires, Kaiser Permanente will inform you of its decision within 24 hours.

You or your Provider must request an expedited decision in one of the following ways, and you must specifically state that you want an expedited decision:

- Call Kaiser Permanente's Expedited Review Unit toll-free at (888) 987-7247 and TTY users call (800) 777-1370, which is available Monday through Saturday from 8:30 a.m. to 5:00 p.m. After hours, you may leave a message, and a representative will return your call the next business day.
- Send your written request to:

  Kaiser Foundation Health Plan, Inc.
  Attn: Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170

- Fax your written request to Kaiser Permanente's Expedited Review Unit toll-free at (888) 987-2252.
- Deliver your request in person to your local Member Services Department at a facility.

If Kaiser Permanente does not approve your request for an expedited decision, it will notify you, and it will respond to your grievance within 30 days. If Kaiser Permanente does not approve your grievance, it will send you a written decision that provides you with the reasons and informs you about additional dispute resolution options.

Note:

If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care directly at any time without first filing a grievance with Kaiser Permanente.

Supporting Documents

It is helpful for you to include any information that clarifies or supports your position. You may want to include supporting information with your grievance, such as medical records or Provider opinions. When appropriate, Kaiser Permanente will request medical records from Kaiser Permanente Providers on your behalf. If you have consulted with a non-Kaiser Permanente Provider and are unable to provide copies of relevant medical records, Kaiser Permanente will contact the Provider to request a copy of your medical records. Kaiser Permanente will ask you to send or fax it a written authorization so that it can request your records. If Kaiser Permanente does not receive the information it requests in a timely fashion, it will make a decision based on the information it has on file.

Who May File

The following persons may file a grievance:

- You may file for yourself.
- You may appoint someone as your authorized representative by completing Kaiser Permanente's authorization form. Authorization forms are available from your local Member Services Department at Kaiser Permanente facility or by calling Kaiser Permanente's Member Service Call Center. Your completed authorization form must accompany the grievance.
- You may file for your Dependent under age 18; except that your Dependent(s) must appoint you as his or her authorized representative if your Dependent has the legal right to control release of information that is relevant to the grievance.
- You may file for your ward if you are a court appointed guardian, except that your ward must appoint you as their authorized representative if your ward has the legal right to control release of information that is relevant to the grievance.
- You may file for your conservatee if you are a court appointed conservator.
- You may file for your principal if you are an agent under a currently effective health care proxy, to the extent provided under state law.
- Your Provider may request an expedited grievance as described under "Expedited Grievance" in the "Dispute Resolution" section.

Department of Managed Health Care Complaints

The California Department of Managed Health Care ("Department") is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll-free at (800) 464-4000 and TTY users call (800) 777-1370 and use your health plan's grievance process before contacting the California Department of Managed

Health Care. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the California Department of Managed Health Care for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The California Department of Managed Health Care also has a toll-free telephone number - (888) HMO-2219 and a TDD line - (877) 688-9891 for the hearing and speech impaired.

The California Department of Managed Health Care's website, www.hmohelp.ca.gov, has complaint forms, IMR application forms and instructions online.

BINDING ARBITRATION

For all Claims subject to this "Binding Arbitration" section, both Claimants and respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to Claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved Claims that accrued before the effective date of the Evidence of Coverage (*Your Guidebook*). Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of Arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The Claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to the Evidence of Coverage (*Your Guidebook*) or a Member Party's relationship to Kaiser Permanente. ("Health Plan"), including any Claim for medical or hospital malpractice (a Claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, Services, irrespective of the legal theories upon which the Claim is asserted.
- The Claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties.
- The Claim is not within the jurisdiction of the Small Claims Court.
- If your Group must comply with the Employee Retirement Income Security Act (ERISA requirements, the Claim is not a benefit-related request that constitutes a "benefit Claim" in Section 502(a)(1)(B) of ERISA.

Note:

Benefit Claims under this section of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor regulation prohibiting mandatory binding arbitration of this category of Claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these Claims will automatically become subject to mandatory binding arbitration without further notice.

As referred to in this "Binding Arbitration" section, "Member Parties" include:

- A member
- A member's heir, relative, or personal representative
- Any person claiming that a duty to him or her arises from a member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- KP Cal, LLC
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., or Southern California Permanente Medical Group Provider
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of Claims brought by one or more Member Parties
- Any Employee or agent of any of the foregoing "Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts

a Claim as described above. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a Claim is asserted.

Initiating Arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the Claim against the respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorney, if any; and the names of all respondents. Claimants shall include all Claims against respondents that are based on the same incident, transaction, or related circumstances in the Demand for Arbitration.

Serving Demand for Arbitration

Health Plan, Kaiser Foundation Hospitals, KP Cal, LLC, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Attn: Legal Department
393 E. Walnut St.
Pasadena, CA 91188

Service on that Respondent shall be deemed completed when received. All other respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing Fee

The Claimants shall pay a single, non-refundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of Claims asserted in the Demand for Arbitration or the number of Claimants or respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the respondents. The Fee Waiver form sets forth the criteria for waiving fees and is available by calling Kaiser Permanente's Member Service Call Center.

Number of Arbitrators

The number of arbitrators may affect the Claimant's responsibility for paying the neutral arbitrator's fees and expenses.

If the demand for arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the demand for arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of Arbitrator's Fees and Expenses

Kaiser Permanente will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator ("Rules of Procedure"). In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a Claim regardless of the nature of the Claim or outcome of the arbitration.

Rules of Procedure

Arbitrations shall be conducted according to the Rules of Procedure developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Kaiser

Permanente's Member Service Call Center.

General Provisions

A Claim shall be waived and forever barred if:

1. on the date the Demand for Arbitration of the Claim is served, the Claim, if asserted in a civil action, would be barred as to the respondents served by the applicable statute of limitations;
2. Claimants fail to pursue the arbitration Claim in accord with the Rules of Procedure with reasonable diligence; or
3. the arbitration hearing is not commenced within five years after the earlier of:

   a. the date the Demand for Arbitration was served in accord with the procedures prescribed herein; or

   b. the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the Claim.

A Claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any Claims for professional negligence or any other Claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section.

▶ **The following is a partial list of Kaiser Permanente benefits and exclusions:**

PROFESSIONAL SERVICES	YOU PAY
Routine preventive care: – Physical exams – Well-child visits (through age 23 months) – Family planning visits – Scheduled prenatal care visits and first postpartum visit – Eye exams for refraction – Hearing tests – Flexible sigmoidoscopies	$15 per visit
Primary and specialty care visits	$15 per visit
Urgent care visits	$15 per visit
Physical, occupational and speech therapy	$15 per visit
OUTPATIENT SERVICES	**YOU PAY**
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Allergy injection visits	No charge
Allergy testing visits	$15 per visit

Kaiser Permanente

OTHER SERVICES	YOU PAY
Most vaccines (immunizations)	No charge
X-rays and lab tests	No charge
Health education: Individual visits	$15 per visit
Health education: Group educational programs	No charge
HOSPITALIZATION SERVICES	**YOU PAY**
Room and board, surgery, anesthesia, x-rays, lab tests and drugs	No charge
EMERGENCY HEALTH COVERAGE	**YOU PAY**
Emergency department visits (This cost sharing does not apply if admitted directly to the hospital as an inpatient). See "Hospitalization Services," above.	$35 per visit
AMBULANCE SERVICES	**YOU PAY**
Ambulance services	No charge
MENTAL HEALTH SERVICES	**YOU PAY**
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs	No charge
Outpatient individual and group visits	$15 per individual visit $7 per group visit
CHEMICAL DEPENDENCY SERVICES	**YOU PAY**
Inpatient detoxification	No charge
Outpatient individual visits	$15 per visit
Outpatient group visits	$5 per visit
HOME HEALTH SERVICES	**YOU PAY**
Home health care (up to 100 visits per calendar year)	No charge
FACILITY OPTION	**YOU PAY**
Skilled nursing facility care (up to 100-days per benefit period)	No charge
Hospice Care	No charge

There are exclusions, limitations and reductions to benefits. Please see your Kaiser Permanente Evidence of Coverage (Your Guidebook) for details. This is just a summary of your Kaiser Permanente benefits and should not be considered a legal document. For a complete disclosure of your Kaiser Permanente benefits, please consult your Disclosure Form and Evidence of Coverage (Your Guidebook).

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost sharing, Out-of-Pocket Maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete explanation, please refer to the "Benefits and Cost Sharing" and "Exclusions, Limitations, Coordination of Benefits, and Reductions" sections of your Evidence of Coverage (Your Guidebook).

Specific information on benefits not included on this chart can be obtained from Kaiser Permanente directly. The services and items in this chart are covered benefits only if, in the judgment of a Kaiser Permanente Provider, they are medically necessary to present, diagnose or treat a medical condition. A service or item is medically necessary only if a Kaiser Permanente Provider determines that its omission would adversely affect a member's (i.e., Participant's or Dependent's) health.

Oxford Health Plans

UnitedHealthcare®
Oxford

Oxford Health Plans, Inc.
One Penn Plaza
8th Floor
New York, NY 10119
(800) 444-6222
www.oxfordhealth.com

The Oxford Health Plans ("Oxford") are available to Participants who live in the tri-state area of New York, New Jersey and Connecticut.

If you select Oxford for your hospital and medical benefits, you are covered for hospital and medical benefits through the Oxford Freedom Network plan. Most covered services are provided to you at minimal or no cost. Your member assistance, dental, life insurance, prescription drug, vision and wellness benefits under the Plan remain in effect.

To enroll, you must complete the Oxford portion of your Benefit Selection form and return it to the Plan Office. Upon enrollment and return of your selection forms, your Oxford benefit identification cards will be issued to you directly by Oxford. Since the Provider list is subject to change, you may contact Oxford at any time for an updated copy. If you select Oxford for your

health benefits, you will receive a separate Summary Plan Description Supplement for Oxford which will become part of this *SPD*.

Oxford members, their spouses and children are free to select more than one medical group per household. This means that you can choose one physician group and Primary Care Provider (PCP) for yourself, and select another physician group and PCP for your spouse or other members of your family, and members can change physician groups once per month, for any reason.

In addition to traditional health care services, Oxford offers its members some unique benefits, such as discounts at WellQuest's numerous state-of-the-art health and fitness centers, discounts on select offerings at more than 400 premier day spas in the U.S. and more than 280 resort locations worldwide, and free registration at Weight Watchers.

HEARING AIDS

Oxford Participants and their eligible Dependents considering hearing aids must obtain them through Oxford. You must first have a hearing test by a qualified audiologist, which will be paid through Oxford. Hearing aids are covered limited to a single one-time purchase of up to $1,500 every three years per date of purchase for both ears (not for each ear) including repair and replacements.

- **In-Network:**
  Covered at 100%
- **Out-of-Network:**
  Subject to Deductible and Coinsurance
- **Co-Payment:**
  None

MAXIMUMS AND LIMITATIONS

Unless otherwise indicated, the following maximums and limitations apply to both the In-Network and Out-of-Network benefits combined. All reimbursements for Out-of-Network benefits are subject to Oxford's Allowable Amount.

1. **Diabetic Supplies**
   Diabetic supplies will only be supplied in amounts consistent with the Participant's or Dependent's treatment plan as developed by the attending Provider. Only basic models of blood glucose monitors are covered unless the Participant or Dependent has special needs relating to poor vision or blindness.
2. **Elective Termination of Pregnancy**
   Oxford covers one procedure per Participant, per contract year. Oxford pays a maximum benefit of $350 per procedure.
3. **Treatment of Infertility**
   Oxford covers only one cycle of advanced infertility treatment. This includes one egg harvesting and two transfers during a two-year period. The maximum benefit is $10,000 per Participant, per lifetime. This benefit is available only In-Network.
4. **Rehabilitative Therapy Services (Physical, Speech and Occupation Therapy)**
   Inpatient:
   One consecutive 60-day period per condition, per lifetime;
   Outpatient:
   90 visits per condition, per lifetime
5. **Transplants**
   In-Network coverage is available only at facilities specially approved and designated by Oxford to perform these procedures.
6. **Home Health Services**
   60 visits per contract year; a visit of up to four hours is one visit.

7. **Exercise Facility Reimbursement**
   Oxford will reimburse a Participant $200 per six-month period. Oxford will reimburse the Participant's Spouse $100 per six-month period. The Participant or Dependent Spouse must complete 50 visits within the six-month period.
8. **Skilled Nursing Facility Services**
   Unlimited days per calendar year.
9. **Hospice Services**
   210 days per lifetime.
10. **Bereavement Counseling for the Participant's or Dependent's Family**
    Five sessions either before or after the death of the Participant or Dependent.

Supplemental Rider Information

1. **Mental Health Services**
   Inpatient: unlimited;
   Outpatient: unlimited
2. **Alcoholism and Substance Abuse Rehabilitation**
   Detoxification: unlimited
3. **Chiropractic Services**
   Benefits are unlimited; subject to medical necessity

PREAUTHORIZATION

All admissions to health care facilities and certain diagnostic tests and therapeutic procedures must be preauthorized by Oxford before you are admitted or receive treatment.

For In-Network Benefits

Preauthorization begins with a call to Oxford's Medical Management Department by your PCP, your network Provider of obstetrical and gynecological care or the Network Specialist involved. One of Oxford's Medical Management professionals will examine the case, consult with your Provider and discuss the clinical findings. If all agree that the requested admission, test or procedure is appropriate, the Preauthorization is provided. This comprehensive evaluation ensures that the treatment you receive is appropriate for your needs and is delivered in the most cost-effective setting.

Your network Provider is responsible for obtaining any required Preauthorization and is aware of when Preauthorization is required. However, if you wish to double-check that your network Provider has contacted Oxford about your case, please feel free to call Oxford's Customer Service at (800) 444-6222 and inquire.

For Out-of-Network Benefits

You are responsible for obtaining any required Preauthorization by calling (800) 444-6222. Oxford will review all such admissions and/or procedures.

Ambulatory procedures (or hospital admissions, except in an emergency) require Preauthorization at least 14 days before the scheduled service date. Upon receipt of all necessary information, Oxford will notify you by telephone and in writing within three business days of its determination.

Failure to Preauthorize

If you fail to obtain Preauthorization for an Out-of-Network benefit, when Preauthorization is required, you will be subject to a reduction in benefits. You must pay 50% of the costs for such service or supply.

DEDUCTIBLE

The applicable per calendar year Deductibles for treatment received Out-of-Network are:

- Individual: $500
- Family: $1,000

Out-of-Pocket Limits

The maximum amount you must pay in any calendar year for Out-of-Network covered services is: $8,000 (including Deductible) for an individual and $16,000 (including Deductible) for a family. Once you have met your Out-of-Pocket Maximum in a calendar year, Oxford pays 100% of Out-of-Network covered services for the remainder of the calendar year.

Remember, only Coinsurance and the amounts paid to meet your Deductible count toward the Out-of-Pocket Maximum. Co-Payments for In-Network benefits, amounts in excess of the Usual Customary and Reasonable, amounts paid for Non-Covered Services, and any amounts paid as a penalty do not count toward the Out-of-Pocket Maximum. Coinsurance paid for any covered service obtained under a supplemental rider, excluding state mandated offers, will not be applied toward the Out-of-Pocket Maximum.

MAXIMUM LIFETIME BENEFIT

- Per Participant: Unlimited
- Per Dependent: Unlimited

COMPLAINT PROCEDURE

- If you have a complaint or have a question about your benefits, call Oxford toll free at (800) 444-6222.
- If you feel your Claim or request has not been processed correctly by Oxford, within 180 days following the receipt of your Explanation of Benefits or other initial Adverse Benefit

Determination, you may file a first level appeal in writing to:

Oxford
P.O. Box 30432
Salt Lake City, UT 84130-0432

- If you feel that your first level appeal was not correctly decided by Oxford, you have 180 days following receipt of notification of Oxford's decision to file a second level appeal with the Plan's Benefits/Appeals Committee in accordance with the procedures set forth on page 44. Please submit in writing your reasons, in clear and concise terms, and include any other pertinent documents or other documentation that will help the Benefits/Appeals Committee of the Plan to understand the situation. The decision of the Benefits/Appeals Committee of the Plan will be final and binding upon all parties, including the Participants and any person claiming under the Participant, subject to the right to bring a civil action under Section 502(a) of ERISA.

- **The following is a partial list of Oxford's benefits and exclusions:**

FINANCIAL	IN-NETWORK	OUT-OF-NETWORK*
Annual Deductible	None	$500 individual/$1,000 family
Coinsurance	None	30%
Lifetime Maximum	None	None
Financial Accumulation Period	Calendar Year	Calendar Year
Out-of-Network Reimbursement	Not Applicable	70th Percentile of Usual, Customary and Reasonable and 30% Coinsurance
Annual Out-of-Pocket Maximum	None	$8,000 individual/$16,000 family (includes Deductible)
Primary Care Provider election	Required	Not Required
Hospital Preauthorization	Yes	Yes
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK***
Adult	No Charge	In-Network Benefit Only
Infant and Pediatric	No Charge	Deductible & 30% Coinsurance
Well Woman Exams (Annual CPE)	No charge for two exams annually	In-Network Benefit Only
Mammograms	No Charge	Deductible plus 30% Coinsurance One per year; age limits apply
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK***
Provider's and Surgeon's Services	No Charge	Deductible & 30% Coinsurance
Semi-Private Room and Board	No Charge	Deductible & 30% Coinsurance
All Drugs and Medication	No Charge	Deductible & 30% Coinsurance

OUTPATIENT CARE	IN-NETWORK	OUT-OF-NETWORK*
Primary Care Provider Office Visits	$15 Co-Payment per visit	Deductible & 30% Coinsurance
Specialists Office Visits*	$15 Co-Payment per visit	Deductible & 30% Coinsurance
Outpatient Facility Surgery*	No Charge	Deductible & 30% Coinsurance
Laboratory Services Participating**	No Charge	Deductible & 30% Coinsurance
MRIs, MRAs, PET Scan, CT Scan, Ultrasound**	No Charge	Deductible & 30% Coinsurance
Radiology Services**	No Charge	Deductible & 30% Coinsurance
EMERGENCY CARE	**IN-NETWORK**	**OUT-OF-NETWORK***
Ambulance Service when Medically Necessary**	No Charge	No Charge
At Hospital Emergency Room	$25 Co-Payment; Waived if Admitted	$25 Co-Payment; Waived if Admitted
Urgent Care Center	$15 Co-Payment per visit	Deductible & 30% Coinsurance
MATERNITY CARE	**IN-NETWORK**	**OUT-OF-NETWORK***
Routine Prenatal and Postnatal Care**	No Charge	Deductible & 30% Coinsurance
Hospital Services for Mother and Child**	No Charge	Deductible & 30% Coinsurance
SKILLED NURSING FACILITY	**IN-NETWORK**	**OUT-OF-NETWORK***
Unlimited**	No Charge	Deductible & 30% Coinsurance
HOSPICE CARE (210 DAYS PER LIFETIME)	**IN-NETWORK**	**OUT-OF-NETWORK***
Inpatient Care**	No Charge	Deductible & 30% Coinsurance
Home Hospice Care**	$15 Co-Payment per visit	Subject to 20% Coinsurance
HOME HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK***
Home Care Visits – 60 Visits per Calendar Year**	$15 Co-Payment per visit	Subject to 20% Coinsurance
Provider House Calls**	$15 Co-Payment per visit	Deductible & 30% Coinsurance
SUBSTANCE USE DISORDER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK***
Inpatient Rehabilitation**	No Charge	Deductible & 30% Coinsurance
Outpatient Rehabilitation	$15 Co-Payment per visit	Deductible & 30% Coinsurance
Office Visits	$15 Co-Payment per visit	Deductible & 30% Coinsurance

MENTAL HEALTH CARE	IN-NETWORK	OUT-OF-NETWORK*
Inpatient Care**	No Charge	Deductible & 30% Coinsurance
Outpatient Care	$15 Co-Payment per visit	Deductible & 30% Coinsurance
Office Visits	$15 Co-Payment per visit	Deductible & 30% Coinsurance
ALLERGY CARE	**IN-NETWORK**	**OUT-OF-NETWORK***
Testing and Treatment**	$15 Co-Payment per visit	Deductible & 30% Coinsurance
CHIROPRACTIC CARE	**IN-NETWORK**	**OUT-OF-NETWORK***
Chiropractic Care when Medically Necessary**	$15 Co-Payment per visit	Deductible & 30% Coinsurance
SHORT-TERM REHAB & HABILITATIVE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK***
Inpatient: limited to 60 consecutive days per condition per lifetime**	No Charge	Deductible & 30% Coinsurance
Outpatient: limited to 90 combined visits per Calendar Year**	$15 Co-Payment per visit	Deductible & 30% Coinsurance
DURABLE MEDICAL EQUIPMENT	**IN-NETWORK**	**OUT-OF-NETWORK***
Unlimited** (precertification required for items over $500)	No Charge when ordered by an Oxford participating Provider	Deductible & 30% Coinsurance
HEARING AIDS	**IN-NETWORK**	**OUT-OF-NETWORK***
Limited to a single purchase (including repair/ replacement) of up to $1,500 every 3 years	No Charge	Deductible & 30% Coinsurance
MEDICAL SUPPLIES	**IN-NETWORK**	**OUT-OF-NETWORK***
Medical Supplies when Medically Necessary**	Out-of-Network Benefit Only	Deductible & 30% Coinsurance
EXERCISE FACILITY	**IN-NETWORK**	**OUT-OF-NETWORK***
Participant	$200 reimbursement per 6-month period (see requirements below)	$200 reimbursement per 6-month period (see requirements below)
Spouse	$100 reimbursement per 6-month period (see requirements below)	$100 reimbursement per 6-month period (see requirements below)

ELECTIVE TERMINATION OF PREGNANCY (ONE PROCEDURE PER CALENDAR YEAR)	IN-NETWORK	OUT-OF-NETWORK*
Specialist Office Visits**	$15 Co-Payment per visit	Deductible & 30% Coinsurance
Outpatient Facility Services**	No Charge	Deductible & 30% Coinsurance
ADVANCE INFERTILITY TREATMENT ($10,000 PER LIFETIME)	**IN-NETWORK**	**OUT-OF-NETWORK***
Specialist Office Visits**	$15 Co-Payment per visit	In-Network Benefit Only
Inpatient Facility Services**	No Charge	In-Network Benefit Only
Outpatient Facility Services**	No Charge	In-Network Benefit Only
FAMILY PLANNING SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK***
Family Planning Services Therapeutic and Elective Abortion	Maximum Allowance of $350 per abortion	Deductible plus 30% Coinsurance, Maximum Allowance of $350 per abortion, once per year
Intrauterine Device (IUD)	IUD device not covered	IUD device not covered
Tubal Ligation	No charge, reversal not covered	Deductible plus 30% Coinsurance, reversal not covered
Vasectomy	No charge	Deductible plus 30% Coinsurance
PHYSICAL THERAPY	**IN-NETWORK**	**OUT-OF-NETWORK***
Physical Therapy	Outpatient (through Optum/UHC): $15 Co-Payment for 90 visits per condition per lifetime Inpatient: No charge for 60 days per condition per lifetime	Deductible plus 30% Coinsurance Outpatient: 90 days per condition per lifetime Inpatient: 60 days per condition per lifetime

**In-Network visits to an Oxford participating Specialist requires an authorized referral from the Member's PCP.*

***These services require Preauthorization through Oxford. Members must call Oxford at (800) 444-6222 at least 14 days in advance of treatment to request Preauthorization.*

PAYING YOUR HEALTH CARE PREMIUM IS NOW AT YOUR FINGERTIPS!

Paying Premiums Is Easy

USING YOUR COMPUTER OR SMART PHONE

TO DO SO, TAKE THE FOLLOWING STEPS:

- To pay using the mobile app, download the MPI app from the Apple app store or Google Play. Create log-in credentials for yourself if you have not done so already. Then, log-in and select the money/premium icon. Lastly, consider and set your payment options.
- To pay using the website, visit www.mpiphp.org. Select “Pay Premium” from the top of the website. Create log-in credentials for yourself if you have not done so already. Then, log-in and select the premium icon. Lastly, consider and set your payment options.

GET IT ON Google Play | Download on the App Store | Get it from Microsoft

MPI MOTION PICTURE INDUSTRY PENSION & HEALTH PLANS™

Back to Contents

MOTION PICTURE INDUSTRY HEALTH PLAN

DENTAL PLAN OPTIONS

Notes

Dental Services

OPTIONS AVAILABLE

- Participants who reside in California may enroll in Delta Dental PPO or DeltaCare USA, a prepaid dental plan.
- Participants who reside outside of California may only enroll in Delta Dental PPO.

INITIAL ELIGIBILITY

When you first become eligible, you will be automatically enrolled in the Delta Dental PPO Plan for the first month of coverage. Your eligibility packet will include a Benefit Selection form to use if you wish to switch to the prepaid plan. If you become eligible at the beginning of any given month, you must return the Benefit Selection form no later than the end of that same month in order for your enrollment in the prepaid plan to be effective the beginning of the following month.

If you select DeltaCare USA, upon enrollment in that plan, DeltaCare will send you a dental identification card.

CONTINUOUS ELIGIBILITY

If you are continuously eligible, you do not need to re-enroll in a dental plan every Eligibility Period. Your selected plan will remain the same unless you select a different plan during Open Enrollment. Open Enrollment information will be mailed to you prior to July 1 each year.

PLAN COSTS

If you remain in the Delta Dental PPO plan, you may use the dentist of your choice, anywhere in the world. You are responsible for the balance of the charges over the Plan's share of the Usual, Customary and Reasonable rate for Out-of-Network dental Providers.

The prepaid dental plan, DeltaCare USA, pays a portion of the Premium each month to the dental office that you have selected from their network of dentists. By "prepaying" for these services, you receive the necessary care when needed at no charge to you for most covered services. You are responsible for any applicable fees listed in the Co-Payment schedule.

If you select the prepaid plan, you may only use the dentist you select.

The Plan Office does not process dental Claims covered by your dental plan. Any questions regarding payment for dental services covered by your selected dental plan should be referred directly to the dental plan involved.

PLAN SELECTION

To help you with your selection, the following pages contains a brief summary of benefits. You may contact the dental plans directly for advance information.

▶ **Comparison of Dental Plans:**

DELTA DENTAL PPO (Available Worldwide)	DELTACARE USA HMO (Available in California Only)
Dentists Available	
▶ The dentist of your choice, anywhere in the world. Using Delta Dental PPO dentists may reduce your Out-of-Pocket expense.	▶ Must use selected DeltaCare affiliated dentists only; dentists are located throughout California
Costs to You for Most Services	
▶ You pay 20% of the Usual, Customary and Reasonable Rate	▶ No cost to you
Deductible	
▶ $25 annually per person, up to a maximum of $50 per family	▶ No Deductible
Annual Maximum	
▶ $2,000 per person, per calendar year	▶ No annual maximum
Orthodontics	
▶ Eligible Dependent children only Pay 50% of Usual, Customary and Reasonable Rates ▶ $1,000 lifetime maximum	▶ Eligible Dependents: - Children: $1,100 / Adults: $1,500 - Start-up Fee: $ 250

Delta Dental PPO

Delta Dental PPO
Dental Plan
P.O. Box 997330
Sacramento, CA 95899
(888) 335-8227
www.deltadental.com

Group Number:
3229 (inside California)
0739 (outside California)

ENROLLMENT

You and your enrolled Dependent(s) will be enrolled in the Delta Dental PPO plan if you complete your enrollment form and do not elect DeltaCare USA HMO.

SELECTING A DENTIST

Delta Dental is contracted with more than 127,000 dentists nationwide, and more than 60,000 dentists participate nationwide in the Delta Dental PPO plan. You are free to choose any dentist for treatment, but it is to your advantage to choose a Delta Dental dentist and a greater advantage to choose a Delta Dental PPO dentist. This is because his or her fees are approved in advance by Delta Dental. If you go to a non-Delta Dental dentist you may be Balanced Billed.

For assistance in selecting a Delta Dental dentist, call (800) 427-3237.

A list of Delta Dental dentists is also available using Delta Dental's website: www.deltadentalins.com.

DEDUCTIBLES

You must pay the first $25 of covered services for each enrollee in your family in each calendar year, up to a limit of $50 per family for Participants and their Dependents.

YOUR BENEFIT COVERAGE

Your dental program covers several categories of benefits when the services are provided by a licensed dentist, and when they are necessary and customary under the generally accepted standards of dental practice. After you have satisfied any Deductible requirements, Delta Dental will provide payment for these services at the percentage indicated, up to a maximum of $2,000 for each enrollee in each calendar year.

COVERED FEES

It is to your advantage to select a dentist who is a Delta Dental dentist, since a lower percentage of the dentist's fees may be covered by this program if you select a dentist who is not a Delta Dental dentist.

Payment to a Delta Dental dentist will be based on the applicable percentage of the lesser of the fee actually charged or the accepted Usual, Customary and Reasonable (UCR) rate that the dentist has on file with Delta Dental.

Payment to a dentist outside of California who agrees to be bound by Delta Dental's rules in the administration of the program will be based on the applicable percentage of the lesser of the fee actually charged or the customary fee for corresponding services for a Delta Dental dentist in California.

The Plan's payment to a California dentist who is not a Delta Dental dentist will be based on the applicable percentage of the lesser of the fee actually charged or the fee which satisfies the majority of Delta Dental's dentists.

EXTENSION OF BENEFITS

All benefits cease on the date coverage terminates except that Delta Dental will pay for single procedures or orthodontic procedures which were commenced while you were eligible.

CHOOSING YOUR DENTIST

Delta Dental shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, Delta Dental cannot ensure your dentist's use of precautions against the spread of such diseases, nor can Delta Dental compel your dentist to be tested for HIV or to disclose test results to Delta Dental or to you. Delta Dental informs its panel dentists about the need for clinical precautions as recommended by recognized health authorities on this issue, but if you have any questions about your dentist's health status or use of recommended clinical precautions, you should discuss them with your dentist.

SAVING MONEY ON YOUR DENTAL BILLS

You can keep your dental expenses down by:

- Comparing the fees of different dentists;
- Using a Delta Dental dentist;
- Having your dentist obtain a predetermination from Delta Dental for any treatment over $300;

- Visiting your dentist regularly for checkups;
- Following your dentist's advice about regular brushing and flossing;
- Not putting off treatment until you have a major problem; and
- Learning the facts about over-billing. Under this program, you must pay the dentist your deductible, applicable percent, any amount over the Annual Maximum, and any Balance Billed Amount (only if you used an Out-of-Network dentist). You may hear of some dentists who offer to accept insurance payments as "full payment." You should know that these dentists may do so by overcharging your program and may do more work than you need, thereby increasing program costs. You can help keep your dental benefits intact by avoiding such schemes.

YOUR FIRST APPOINTMENT

At your first appointment, be sure to inform your dentist of the following:

- Primary Enrollee's Social Security Number or Participant's Identification Number (which must also be used by Dependents)
- Primary Enrollee's date of birth
- Information about any other dental coverage you have

DEFINITIONS

Allowable Amount

For an In-Network dentist, it is the lower of the contracted rate or the billed charge. For an Out-of-Network dentist, it is the lower of the UCR rate or the billed charge.

Annual Deductible

The amount you must pay for dental care each year before Delta Dental's benefits begin.

Attending Dentist's Statement

A form used by your dentist to request payment for dental treatment or predetermination for proposed dental treatment.

Benefits

Those dental services available under the Contract and which are described in this Delta Dental summary.

Contract

The written agreement between the Plan and Delta Dental to provide dental benefits. The Contract, together with this *SPD*, form the terms and conditions of the benefits that are provided to you.

Covered Services

Those dental services to which Delta Dental will apply benefit payments, according to the Contract.

Delta Dental Dentist

A dentist who has a signed agreement with Delta Dental as customary and reasonable. He or she agrees to charge Delta Dental patients these accepted fees.

Delta Dental PPO Dentist

A Delta Dental dentist with whom Delta Dental has a written agreement to provide services at the In-Network level and who agrees to charge Delta Dental patients the PPO fees.

Delta Dental Premier Dentist

A Delta Dental dentist with whom Delta Dental has a written agreement to provide services at the In-Network level and who agrees to charge Delta Dental patients the Premier fees.

Dues

The money the Plan pays to Delta Dental each month for your and your Dependent's dental coverage.

Effective Date

The date the program starts.

Eligible Dependent

Any Dependent of an eligible Employee who is eligible to enroll in benefits in accordance with the conditions of eligibility outlined in this *SPD*.

Eligible Participant

Any group member or Employee who is eligible to enroll for benefits in accordance with the conditions of eligibility outlined in this *SPD*.

Enrollee

An eligible Participant or eligible Dependent enrolled to receive benefits.

Maximum

The greatest dollar amount Delta Dental will pay for covered procedures in any calendar year or lifetime for orthodontic benefits.

Single Procedure

A dental procedure to which a separate procedure number has been assigned by the American Dental Association in the current version of Current Dental Terminology (CDT).

Usual, Customary and Reasonable (UCR)

A Usual rate is the amount which an individual dentist regularly charges and receives for a given service or the fee actually charged, whichever is less. A Customary fee is within the range of Usual fees charged and

received for a particular service by dentists of similar training in the same geographic area. A Reasonable fee can be Usual and Customary, or Delta Dental may agree that a fee that falls above Customary is justified by a superior level or complexity (difficulty) of treatment to that customarily provided.

CANCELING THIS PROGRAM

Delta Dental may cancel this program only on an anniversary date (period after the program first takes effect or at the end of each renewal period thereafter), or any time your group does not make payment as required by the Contract. If the program is canceled, you and your Dependents have no right to renewal or reinstatement of your benefits.

If you believe that this program has been terminated or not renewed due to your health status or requirements for health care services (or that of your Dependents), you may request a review by the Director of the California Department of Managed Health Care.

If the Contract is terminated for any cause, Delta Dental is not required to predetermine services beyond the termination date or to pay for services provided after the termination date, except for Single Procedures begun while the Contract was in effect, which are otherwise benefits under the Contract. If the Contract cancels, orthodontic services will end. However, if your coverage terminates, orthodontic services will continue to be covered.

PREDETERMINATIONS

After an examination, your dentist will decide on the treatment that you will need. Delta Dental strongly recommends that if extensive services are to be provided, such as crowns or bridges, or if the cost of treatment will be greater than $300, that you have your dentist obtain a predetermination for your treatment.

Your dentist will submit an attending dentist's statement, requesting a predetermination from Delta Dental for the services you plan. A predetermination does not guarantee payment. It is an estimate of the amount Delta Dental will pay if you are eligible and meet all the requirements of your program at the time the treatment you have planned is completed. Computations are estimates only and are based on what would be payable on the date the Notice of Predetermination is issued if the patient is eligible. Payment will depend on the patient's eligibility and the remaining annual maximum when completed services are submitted to Delta Dental.

Delta Dental will inform your dentist exactly how much of the proposed charges Delta Dental will pay and how much you will pay. You should review this information carefully with your dentist before you schedule the treatment. After the treatment has been completed, your dentist will return the attending dentist's statement to Delta Dental, this time for payment, but you must have been eligible for coverage at the time treatment was started before payment is made. Predetermining extensive treatment is recommended to prevent any possible misunderstandings about your treatment cost and your financial responsibility to your dentist.

If you are not satisfied with the way your treatment was predetermined, be sure to let Delta Dental know before the dental work is begun. In this way, Delta Dental can review your appeal thoroughly.

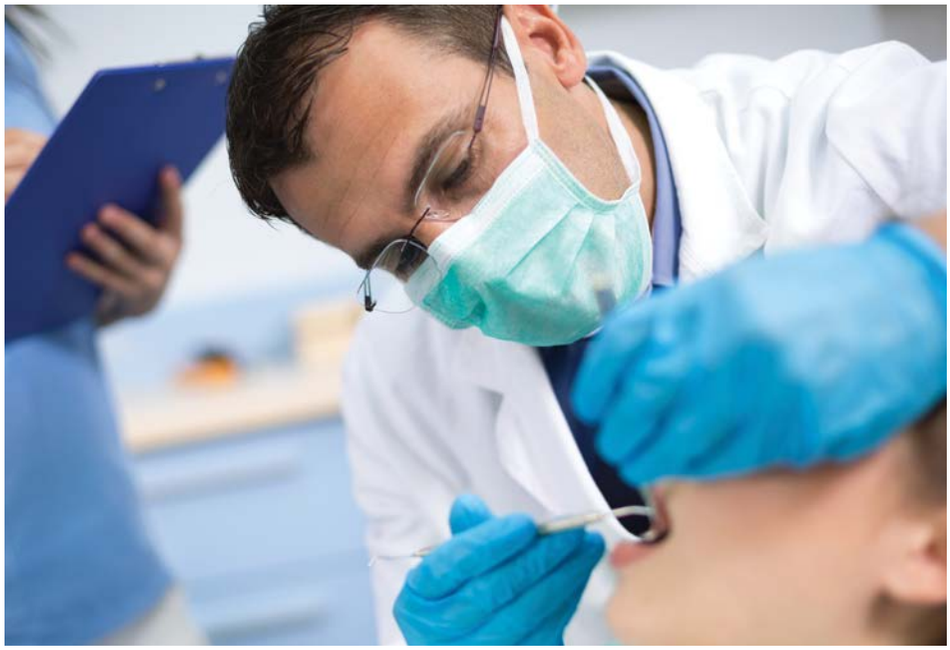
PAYMENT

Delta Dental will pay its dentists (both PPO and Premier) directly. Delta Dental's agreement with Delta Dental dentists makes sure that you will not be responsible to the dentist for any money Delta Dental owes. However, if for any reason, Delta Dental fails to pay a dentist who is not a Delta Dental dentist, you may be liable for that portion of the cost. If you have selected a non-Delta Dental dentist, Delta Dental will pay you. Payments made to you are not assignable (in other words, Delta Dental will not grant a request to pay non-Delta Dental dentists directly).

Payment for any single procedure which is a covered service will only be made upon completion of that procedure. Delta Dental does not make or prorate payments for treatment in progress or incomplete procedures. The date the procedure is completed governs the calculation of any Deductible (and determines when a charge is made against any maximum) under your program.

If there is a difference between what your dentist is charging you and what Delta Dental says your portion should be, or if you are not satisfied with the dental work you have received, contact Delta Dental's Customer Service Department. Delta Dental may be able to help you resolve the situation.

Delta Dental may deny payment of an attending dentist's statement for services submitted more than 12 months after the date the



services were provided. If a Claim is denied due to a Delta Dental dentist's failure to make a timely submission, you shall not be liable to that dentist for the amount which would have been payable by Delta Dental (unless you failed to advise the dentist of your eligibility at the time of treatment). Delta Dental does not pay participating dentists any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

The processes Delta Dental uses to determine or deny payment for services are distributed to all Delta Dental dentists. They describe in detail the dental procedures covered as benefits, the conditions under which coverage is provided, and the limitations and exclusions applicable to the program. Claims are reviewed for eligibility and are paid according to these processing policies. Those Claims which require additional review are evaluated by Delta Dental's dentist consultants. If any Claims are not covered, or if limitations or exclusions apply to services you have received from a Delta Dental dentist, you will be notified by an adjustment notice on the Notice of Payment or Action. You may contact Delta Dental's Customer Service Department for more information regarding Delta Dental's processing policies.

DIAGNOSTIC AND PREVENTIVE BENEFITS

- **Delta Dental PPO**
  Delta Dental pays
  100% of Allowable Amount*
- **Delta Dental Premier**
  Delta Dental pays
  80% of Allowable Amount*
- **Out-of-Network**
  Delta Dental pays
  50% of Allowable Amount*

**After deductible and only up to Annual Maximum Benefit*

Definitions

- **Diagnostic**
  Oral examination, x-rays, diagnostic casts, biopsy/tissue examination, emergency treatment, consultation by a Specialist.
- **Preventive**
  Prophylaxis (cleaning), fluoride treatment, space maintainers.

Limitations

(a) Diagnostic examinations, as defined above, are limited to two per calendar year.

(b) Preventive visits, as defined above, including procedures that include cleanings, are limited to two per calendar year.

(c) Unless special need is shown, full-mouth x-rays are benefits only once in a five-year period.

(d) Bite-wing x-rays are a covered service twice in a calendar year for children up to age 18, and once in a calendar year for adults age 18 and over.

(e) Diagnostic casts are covered only when made in connection with subsequent orthodontic treatment covered under this program.

BASIC BENEFITS

- **Delta Dental PPO**
  Delta Dental pays
  80% of Allowable Amount*
- **Delta Dental Premier**
  Delta Dental pays
  70% of Allowable Amount*
- **Out-of-Network**
  Delta Dental pays
  50% of Allowable Amount*

**After deductible and only up to Annual Maximum Benefit*

Definitions

- **Oral surgery**
  Extractions and certain other surgical procedures, including pre- and post-operative care.
- **Restorative**
  Amalgam, silicate or composite (resin) restorations (fillings) for treatment of cavities (decay).

- **Endodontic**
  Treatment of the tooth pulp.
- **Periodontic**
  Treatment of gums and bones that support the teeth.
- **Sealants**
  Topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay.

Limitations

(a) Periodontal procedures that include cleanings are subject to the same limitations as other cleanings; i.e., cleanings of any kind are a covered service no more than twice per calendar year.

(b) Sealant benefits include the application of sealants only to permanent first and second molars without decay, without restorations and with the occlusal surface intact, for first molars up to age 9, and second molars up to age 14. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.

CROWNS, JACKETS, INLAYS, ONLAYS AND CAST RESTORATION BENEFITS

- **Delta Dental PPO**
  Delta Dental pays
  80% of Allowable Amount*
- **Delta Dental Premier**
  Delta Dental pays
  70% of Allowable Amount*
- **Out-of-Network**
  Delta Dental pays
  50% of Allowable Amount*

**After deductible and only up to Annual Maximum Benefit*

Definition

Crowns, jackets, inlays, onlays and cast restorations are benefits only if they are provided to treat cavities that cannot be restored with amalgam, silicate or composite (resin) fillings.

Limitations

Crowns, jackets, inlays, onlays and cast restorations are benefits on the same tooth only once every five years.

PROSTHODONTIC BENEFITS

- **Delta Dental PPO**
  Delta Dental pays
  80% of Allowable Amount*
  Implants: 50% of the Allowable Amount*
- **Delta Dental Premier**
  Delta Dental pays
  70% of Allowable Amount*
  Implants: 50% of the Allowable Amount*
- **Out-of-Network**
  Delta Dental pays
  50% of Allowable Amount*

**After deductible and only up to Annual Maximum Benefit*

Definition

Construction or repair of fixed bridges, partial dentures and complete dentures are benefits if provided to replace missing, natural teeth. Implant surgical placement and removal and for implant supported prosthetics, including implant repair and re-cementation.

Limitations

1. Prosthodontic appliances and implants are benefits only once every five years, unless Delta Dental determines that there has been such an extensive loss of remaining teeth, or a change in supporting tissues, that the existing appliance cannot be made satisfactory. Delta Dental will replace an implant, a prosthodontic appliance or an implanted supported prosthesis you received under another dental plan if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Delta Dental will pay for the removal of an implant once for each tooth during the Enrollee's lifetime.
2. Delta Dental will pay the applicable percentage of the dentist's fee for a standard cast chrome or acrylic partial or a standard complete denture. A standard partial or complete denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials.

ORTHODONTIC BENEFITS

- **Delta Dental PPO**
  Delta Dental pays
  50% of Allowable Amount*
- **Delta Dental Premier**
  Delta Dental pays
  50% of Allowable Amount*
- **Out-of-Network**
  Delta Dental pays
  50% of Allowable Amount*

**After deductible and only up to Annual Maximum Benefit*

Definition

Orthodontic benefits under this program for procedures using appliances or surgery to straighten or realign teeth, which would not function properly otherwise are available only to eligible Dependent

children to age 19, or to age 23 if a full-time student (student documentation is required).

Limitations

1. If orthodontic treatment has begun before you become eligible for coverage, Delta Dental's payments will begin with the first payment due to the dentist following your eligibility date.
2. Orthodontic benefits are to be paid until the case is completed or the Orthodontic maximum is reached, even if the patient may no longer be eligible.
3. X-rays and extractions that might be necessary for orthodontic treatment are not covered by orthodontic benefits but may be covered under Diagnostic and Preventive or Basic Benefits.

DENTAL ACCIDENT BENEFITS

- **Delta Dental PPO**
  Delta Dental pays
  85% of Allowable Amount*
- **Delta Dental Premier**
  Delta Dental pays
  85% of Allowable Amount*
- **Out-of-Network**
  Delta Dental pays
  85% of Allowable Amount*

**After deductible and only up to Annual Maximum Benefit*

Definition

Any services which would be covered under other benefit categories (subject to the same limitations and exclusions) are covered instead by your dental accident coverage when they are provided for conditions caused directly by external, violent and accidental means. There is a $2,000 annual maximum for dental accidents.

Limitations

Delta Dental will pay dental accident benefits when services are provided within 180 days following the date of accident and shall not include any services for conditions caused by an accident occurring before your eligibility date.

EXCLUSIONS - SERVICES DELTA DENTAL DOES NOT COVER

Delta Dental covers a wide variety of dental care expenses, but there are some services for which it does not provide benefits. It is important for you to know what these services are before you visit your dentist.

Delta Dental does not provide benefits for:

1. Services for injuries covered by Workers' Compensation or Employer's Liability Laws, or services which are paid by any federal, state or local government agency, except Medi-Cal benefits
2. Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth, and teeth that are discolored or lacking enamel
3. Treatment which restores tooth structure that is worn; treatment which rebuilds or maintains chewing surfaces that are damaged because the teeth are out of alignment or occlusion; or treatment which stabilizes the teeth. Examples of such treatment are equilibration and periodontal splinting
4. Any single procedure, or bridge, denture or other prosthodontic service which was started before you were covered by this program
5. Prescribed drugs
6. Experimental procedures
7. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility
8. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures
9. Grafting tissues from outside the mouth to tissue inside the mouth (extra-oral grafts) or the removal of implants
10. Services for any disturbances of the jaw joints (temporomandibular joints, or TMJ) or associated muscles, nerves or tissues
11. Orthodontic services, except those provided to eligible Dependent children
12. Charges for replacement or repair of an orthodontic appliance paid in part or in full by this program

GRIEVANCE PROCEDURE AND CLAIMS APPEAL

- If you have any questions about the services received from a Delta Dental dentist, Delta Dental recommends that you first discuss the matter with the dentist. If you continue to have concerns, you may call or write Delta Dental. Delta Dental will provide notifications if any dental services or Claims are denied, in whole or part, stating the specific

reason or reasons for denial. Any questions of ineligibility should first be handled directly between you and the Plan. If you have a question or complaint regarding the denial of dental services or Claims, the policies, procedures and operations of Delta Dental, or the quality of dental services performed by a Delta Dental dentist, you may contact Delta Dental toll-free at (800) 765-6003, through its website at www.deltadentalins.com, or in writing.

- If you feel your Claim or request has not been processed correctly by Delta Dental, within 180 days following the receipt of your Explanation of Benefits or other initial Adverse Benefit Determination, you may file a first level appeal in writing to:

  Delta Dental
  Attn: Customer Service Department
  P.O. Box 997330
  Sacramento, CA 95899-7330

- If you feel that your first level appeal was not correctly decided by Delta Dental, you have 180 days following receipt of notification of Delta Dental's decision to file a second level appeal with the Plan's Benefits/Appeals Committee in accordance with the procedures set forth on page 44. Please submit in writing your reasons, in clear and concise terms, and include any other pertinent documents or other documentation that will help the Benefits/Appeals Committee of the Plan to understand the situation. The decision of the Benefits/Appeals Committee of the Plan will be final and binding upon all parties, including the Participants and any person claiming under the Participant, subject to the right to bring a civil action under Section 502(a) of ERISA.

SECOND OPINIONS

Delta Dental reserves the right to obtain second opinions through Regional Consultant members of its Quality Review Committee. This Committee conducts clinical examinations, prepares objective reports of dental conditions, and evaluates treatment that is proposed or has been provided.

Delta Dental will authorize such an examination prior to treatment when necessary to make a benefits determination in response to a request for a predetermination of treatment cost by a dentist. Delta Dental will also authorize a second opinion after treatment if an Enrollee has a complaint regarding the quality of care provided.

Delta Dental will notify the Enrollee and the treating dentist when a second opinion is necessary and appropriate, and direct the Enrollee to the Regional Consultant selected by Delta Dental to perform the clinical examination. When Delta Dental authorizes a second opinion through a Regional Consultant, it will pay for all charges. The Enrollee may otherwise obtain second opinions about treatment from any dentist he or she chooses, and Claims for the examination or consultation may be submitted to Delta Dental for payment. Delta Dental will pay such Claims in accordance with the benefits of the program.

BENEFIT COORDINATION

It is to your advantage to let your dentist and Delta Dental know if you have dental coverage in addition to this Delta Dental program. Most dental carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both programs sometimes paying 100% of your dental bill.

Example:

You might have some fillings that cost $100. If the primary carrier usually pays 80% for this service, it would pay $80. The secondary carrier might usually pay 50% for this service. In this case, since payment is not to exceed the entire fee charged, the secondary carrier pays the remaining $20 only. Since this method pays 100% of the bill, you have no out-of-pocket expense.

Be sure to advise your dentist of all programs under which you have dental coverage and have him or her complete the dual coverage portion of the attending dentist's statement so that you receive all benefits to which you are entitled.

For further information, contact the Delta Dental Customer Services Department at (888) 335-8227.

This *SPD* constitutes only a summary of the dental plan. The dental plan contract must be consulted to determine the exact terms and conditions of coverage.

DeltaCare USA

DeltaCare USA
Dental Health Plan
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703
(800) 422-4234
www.deltadentalins.com

Group Number:
01551-0001

DELTACARE USA IS A PREPAID PLAN THAT IS AVAILABLE ONLY IN CALIFORNIA

If you select DeltaCare USA, the dentist you have chosen from the list provided, and subsequently listed on your Selection form, is the only dentist you may see. If you need to change dentists, you must contact DeltaCare USA directly and make any changes through them. DeltaCare USA has dentists available throughout California. To enroll, you must complete the DeltaCare USA portion of your Benefit Selection form and return it to the Plan Office. Upon enrollment, DeltaCare USA will provide you with an identification card, and a complete list of all benefits and coverage (with applicable exclusions and limitations) will be provided to you. You may also request an advance copy by calling Delta Dental.

SERVICES AVAILABLE AT NO COST

Partial List Only

- Visits and diagnostic
- Radiographs (x-ray)
- Restorative dentistry (fillings and crowns)
- Crowns and pontics*
- Prosthetics (dentures and partials)
- Oral surgery (extractions, impacted teeth, local anesthetics)
- Periodontics (treatment of gums)
- Endodontics (root canal therapy)

**Plus actual lab costs of precious metals*

ORTHODONTICS**

- **Dependent Children Up to Age 19**
  (Dependent Children Ages 19-23, if full-time student)
  $1,100 Maximum
- **Adults**
  $1,500 Maximum

*** Excluding $250 start-up fees*

SUMMARY OF LIMITATIONS

1. Prophylaxis limited to two in a 12-month period.
2. Full upper and/or lower dentures are not to exceed one each in any five-year period. Replacement will be provided by DeltaCare USA for an existing denture or bridge only if it is unsatisfactory and cannot be made satisfactory.
3. Partial dentures are not to be replaced within any five-year period unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
4. Denture relines limited to one during any 12 consecutive months.
5. Five periodontal treatments during any 12 consecutive months.
6. Bite-wing x-rays limited to not more than one series of four films in any six-month period.
7. Full mouth x-rays limited to one set every 24 consecutive months.
8. Fixed bridges will be authorized only when a partial denture cannot satisfactorily restore the case. However, removable partial dentures which involve only one side of the upper or lower dental arch are generally not considered to satisfactorily restore a case. If fixed bridges are used when a partial denture could satisfactorily restore the case, it is considered optional treatment. The patient would be responsible for the difference in cost between a partial denture and the fixed bridge.

SUMMARY OF EXCLUSIONS

1. Cosmetic dental care.
2. General anesthesia and the services of a special anesthesiologist.
3. Dental conditions arising out of, and due to, the member's employment or for which Workers' Compensation is payable.
4. Services, which are provided to the member by state government or agency thereof or are provided without cost to the member by any municipality, county or other subdivision.
5. Hospital charges of any kind.
6. Major surgery of fractures and dislocations.
7. Loss or theft of dentures or bridgework.
8. Implants

COMPLAINT PROCEDURE

- DeltaCare USA shall provide notification if any dental services or Claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or Claims, the policies, procedures or operations of DeltaCare USA, or the quality of dental services performed by a contract dentist, you may call DeltaCare USA's Customer Service Department at (800) 422-4234, or the complaint may be addressed in writing to:

  DeltaCare USA
  Attn: Quality Management Department
  P.O. Box 6050
  Artesia, CA 90702

- Written communication must include:

1. the name of the patient,
2. the name, address, telephone number, and identification number of the Primary Enrollee,
3. the name of the Applicant, and
4. the dentist's name and facility location.

For complaints involving an Adverse Benefit Determination (e.g., a denial, modification or termination of a requested benefit or Claim) you must file a request for review (a complaint) with DeltaCare USA within 180 days after receipt of the adverse determination. DeltaCare

USA's review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, DeltaCare USA will provide you with copies of any pertinent documents that are relevant to the benefit determination, e.g., a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment it relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the contract, DeltaCare USA shall consult with a dentist who has appropriate training and experience. If any consulting dentist is involved in the review, the identity of such consulting dentist will be available upon request.

Within five calendar days of the receipt of any complaint, including Adverse Benefit Determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may also require that you be referred to a regional dental consultant for clinical evaluation of the dental services provided. DeltaCare USA will forward to you a determination, in writing, within 30 days of receipt of a complaint.

If the complaint involves severe pain and/or imminent and serious threat to a patient's dental health, DeltaCare USA will provide the Enrollee written notification regarding the disposition or

pending status of the complaint within three days.

If you have completed DeltaCare USA's grievance process, or you have been involved in DeltaCare USA's grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care. You may file a complaint with the California Department of Managed Health Care immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to your dental health. The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against DeltaCare USA, you should first telephone DeltaCare USA at (800) 422-4234 and use DeltaCare USA's grievance process before contacting the California Department of Managed Health Care. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your DeltaCare USA, or a grievance that has remained unresolved for more than 30 days, you may call the California Department of Managed Health Care for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The California Department of Managed Health Care also has a toll-free telephone number – (888) HMO-2219 and a TDD line – (877) 688-9891 for the hearing and speech impaired. The California Department of Managed Health Care's website, www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

An IMR is generally not applicable to a dental plan unless that dental plan covers services related to the practice of medicine or offered pursuant to a contract with a health plan providing medical, surgical or hospital services.

Since the Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the Claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA.

- The address of the U.S. Department of Labor is:

  U.S. Department of Labor, Employee Benefits Security Administration
  200 Constitution Avenue NW
  Washington, DC 20210

healthy MPI

Engage ▸ Educate ▸ Empower

Take A Positive Step Today

Classes are available to participants of the Motion Picture Industry Health Plan (the "Plan").

To view available classes and to register for a class, please visit The Wellness Program page at www.mpiphp.org.

MOTION PICTURE INDUSTRY HEALTH PLAN

ADDITIONAL HEALTH BENEFITS

Notes

Life Insurance

The Union Labor Life Insurance Company
8403 Colesville Road
Silver Spring, MD 20910

Group Policy:
G-1558 & C-3739

LIFE INSURANCE FOR PARTICIPANTS

The Plan insures you as an eligible Participant in the amount of $10,000 of life insurance through The Union Labor Life Insurance Company ("Union Labor Life") payable in full to your beneficiary in the event of your death from any cause (on or off the job) while you are an eligible Participant. For Accelerated Benefits for Terminal Illness, see page 138.

DESIGNATING A BENEFICIARY

Your beneficiary is the party or parties named by you to receive the benefits payable upon your death. You may name one or more beneficiaries to receive the death benefit.

You may change your beneficiary at any time, without the consent of the previously named beneficiary. Such change must be made on the Plan

beneficiary form and must be dated and signed by the Participant. Your beneficiary change will take effect upon receipt by the Plan's Eligibility Department.

Upon notification of the Participant's death, any death benefit due under the Life Insurance and Accidental Death and Dismemberment Benefits will be made to your named beneficiary as follows:

1. If you have named more than one beneficiary, each surviving beneficiary will share equally, unless otherwise indicated by you when the Beneficiaries were named.
2. If there is no named beneficiary, or if no named beneficiary is surviving at the time of your death, payment will be made to the first surviving class in the following order of preference:

(a) Your surviving Spouse;

(b) Your children in equal shares;

(c) Your parents in equal shares;

(d) Your brothers and sisters in equal shares; or

(e) Your executors or administrators of your estate.

In order to determine which class of individuals is entitled to the death benefit, Union Labor Life may rely on an affidavit made by any individual listed above. If payment is made based on an affidavit, Union Labor Life and the Plan will be discharged of liability for the amount so paid, unless written notice of Claim by another individual listed above is received before payment is made.

3. If the beneficiary is a minor or someone not able to give a valid release for payment, Union Labor Life will pay the benefit to his or her legal guardian. If there is no legal guardian, Union Labor Life may pay the individual or institution that has, in its opinion, custody and principal support of such beneficiary. Union Labor Life and the Plan will be fully discharged of its liability for any amount of benefit so paid in good faith.

TOTAL AND PERMANENT DISABILITY WAIVER OF PREMIUM

A Participant under the age of 60:

1. Who becomes Totally Disabled while insured under his policy; and
2. For whom premium payments continue to be made or whose coverage is terminated for failure to meet the Eligibility requirements stated in this policy because of Total Disability.

A Participant may apply to continue his or her life insurance under this Waiver of Premium provision.

The initial continuation of insurance under this provision will be for 12 months from the date Premium payments on behalf of the Participant cease, but in no event longer than 24 months from the date Total Disability began.

Waiver of premium will continue until the earlier of:

1. The date the Participant's Total Disability ends; or
2. The end of the 12-month period.

If the Total Disability extends to the Participant's attainment of age 65, then continuation of insurance under this provision will continue and all further premiums will be waived.

Additionally, if a Participant's Total Disability begins after attainment of age 60, and such Participant becomes Totally Disabled while insured under this policy, he or she may apply to continue his or her life insurance under this Waiver of Premium provision until the date his or her Total Disability ends, up to age 65.

"Totally Disabled" and "Total Disability" mean:

1. that during the first 24 months of Total Disability, the Participant is unable to perform with reasonable continuity the substantial and material duties of his or her business, occupation, or employment due to injury or illness; or
2. after the first 24 months of Total Disability, the Participant, due to injury or illness, is unable to engage with reasonable continuity in any other business, occupation, or employment in which he or she could reasonably be expected to perform satisfactorily in light of his or her age, education, training, experience, station in life, or physical and mental capacity.

The Participant must submit satisfactory written proof (the "Initial Proof") of Total Disability within 12 months from the date the premium payments on behalf of such Participant cease; but in no event more than 24 months from the date Total Disability began. "Initial Proof" means completion and submission of the application required for requesting Waiver of Premium benefits. The date a Participant's Total Disability began is shown in the application. The Initial Proof must show that the Total Disability began while the Participant was insured under this policy.

Notice of Application for Waiver Determination

Union Labor Life will give written notice to the applicant within ten days of receipt of an application for waiver. The notice will state whether or not the application is approved and give the reasons for any disapproval. If the application for waiver is disapproved, the Participant may continue eligibility under this policy for life insurance only if the Plan continues the Participant on a premium-paying basis.

A Participant who is denied continuation of his or her group life insurance through Waiver of Premium and:

1. Is not continued by the Plan on a premium-paying basis: or
2. Did not exercise his or her right to convert to an individual policy of life insurance may be entitled to the same conversion rights that applied to the Participant on the date his or her life insurance would have terminated in the absence of this Waiver of Premium provision.

A Participant who holds an individual conversion policy and who has been denied continuation of his or her group life insurance through Waiver of Premium may continue his or her coverage under the individual conversion policy.

Death of Participant Before or While Waiver of Premium Is in Effect

If a Participant applies for waiver under this provision and dies before this Waiver of Premium is in effect, the beneficiary must submit written proof that Total Disability continued without interruption from the date the Participant became Totally Disabled to the date of death. Except that if at the time of death, life insurance on the Participant has been continued on a premium paying basis, the Amount of Insurance in force under this policy will be paid to the beneficiary, subject to all the terms and conditions of this policy.

If a Participant dies while this Waiver of Premium is in effect, the beneficiary must submit written proof that Total Disability continued without interruption from the last anniversary of the Union Labor Life's receipt of proof of Total Disability to the date of death.

Benefit Amount

The amount of life insurance continued under this Waiver of Premium will be the Amount of Insurance in force for the Participant on the date premium payments for the Participant ceased or he or she became Totally Disabled. The amount of life insurance continued under this Waiver of Premium is subject to any reduction or termination in the Amount of Insurance, as shown on the Schedule of Benefits.

Any Participant who:

1. Is approved for waiver under this provision; and
2. Holds an individual policy of life insurance through exercise of the Conversion Privilege under this policy is not entitled to receive benefits under both this policy and the individual conversion policy for the same amounts of insurance. At the time of the Participant's death, payment will be made under this policy only if the individual conversion policy is surrendered to Union Labor Life without Claim other than for return of the premiums paid, less dividends.

Continuance of Waiver of Premium

A Participant who has applied for and received approval of Waiver of Premium for the life insurance benefit under this policy may continue the Waiver of Premium for additional 12-month periods,

provided the Participant:

1. Remains Totally Disabled; and
2. Submits written proof of continued Total Disability no less than 90 days after the termination of the period for which the Union Labor Life is liable. Failure to furnish proof as required will not invalidate or reduce the benefit if it was not reasonably possible to give proof within the time required provided proof is furnished as soon as reasonably possible and except in the absence of legal capacity, not later than one year from the time proof is otherwise required. Such proof must be sent to Union Labor Life at the Participant's own initiative; Union Labor Life shall not be required to request such proof.

Right to Require Examination

Union Labor Life, at its own expense, may require a Participant whose life insurance has been continued by this Waiver of Premium to be examined by a physician of its choice, at any reasonable time during the Participant's first two years of Total Disability. After two years, Union Labor Life will not require such examination more than once a year.

Conversion Privilege

A Participant whose life insurance was continued by this Waiver of Premium may be entitled to the same conversion rights that applied to the Participant on the date his or her life insurance would have terminated in the absence of this Waiver of Premium provision.

ACCELERATED BENEFITS FOR TERMINAL ILLNESS

If, as an active eligible participant, it is determined that you suffer from a terminal condition (i.e., your life expectancy is 24 months or less) or for other specified conditions, $5,000 of your life insurance benefits may be paid in a lump sum to you, or a designated party, prior to your death. Contact the Plan's Participant Services Center at (855) 275-4674.

If a person dies after a request is made for the Accelerated Benefit, but before such benefit is paid, the Accelerated Benefit is not payable. The amount of insurance under the life insurance benefit of this policy will be paid to the beneficiary as if no request for an Accelerated Benefit had been made.

In order to be considered for an Accelerated Benefit payment, a request for an Accelerated Benefit payment must be submitted in writing to the Plan's Eligibility Department by you or your legal representative.

At your own expense, you must supply proof satisfactory to the Plan (e.g., clinical, radiological, laboratory evidence, etc.) of the diagnosis and limited life expectancy. The diagnosis must be made by a licensed, qualified physician.

Note:

The physician cannot be a member of your family, and the diagnosis must have been made after you became eligible. If the Plan does not agree with the diagnosis, it may require an additional medical examination. If the Chief Medical Officer disagrees with your physician, the physicians will jointly select a third physician to perform an examination. The decision of the third physician will be final and binding upon all parties. In addition, you must supply the Plan's Eligibility Department with a written consent of your irrevocable beneficiary.

Only one Accelerated Benefit payment will be paid. Once the Accelerated Benefit has been paid, your Life Insurance amount will be reduced by the amount of the Accelerated Benefit payment. This Accelerated Benefit option will be terminated upon the date of death or if you retire or are otherwise not covered for Life Insurance. The Accelerated Benefit may not be converted to an individual policy.

Accelerated Benefits Will Not Be Paid Under the Following Circumstances

1. For greater than 50% of your life insurance benefit or for less than $5,000;
2. For any reason other than diagnosis of terminal illness or one of the other specified conditions;
3. For Accidental Death or Dismemberment benefits;
4. When all, or a portion, of your Life Insurance benefits are to be paid as part of a divorce settlement;
5. If you have been eligible for Life Insurance benefits for less than two years;
6. If, on March 23, 1994, a) you were Disabled or b) your Life Insurance had been extended under a Total and Permanent Disability as described above;
7. If you are required by law to use this benefit to meet the Claim of creditors, whether in bankruptcy or otherwise;
8. If you are required by a governmental agency to use this benefit to apply for, obtain or keep a government benefit or entitlement; or

9. If the terminal medical condition is caused by intentional self-inflicted injury or attempted suicide. Neither the Plan nor Union Labor Life is responsible for any tax or any other effects of an Accelerated Benefit payment. Receipt of an Accelerated Benefit payment may be taxable income to you or your beneficiary. You and your beneficiary may wish to consult with a personal tax advisor.

The Accelerated Benefit will terminate on the date the policy is terminated. Additional provisions under Union Labor Life policy may apply. Please contact the Plan's Eligibility Department for further information.

CONVERSION PRIVILEGE FEATURE

If your eligibility terminates, your group life insurance (up to the amount you could convert) will be continued for a period of 31 days.

During this 31-day period, you have the right to convert all or a portion of the amount of insurance which has terminated into an individual life policy without having to pass a physical examination.

Note:

An Accelerated Benefit may not be converted to an individual policy, and the amount of life insurance available for conversion will be reduced by the amount of the Accelerated Benefit payment.)

Death Within the Conversion Period

If a Participant dies during the 31-day conversion period, the maximum amount of life insurance which he or she was entitled to convert will be paid as a benefit under this group policy; the benefit will be paid to the last beneficiary named by the Participant, whether or not conversion was applied for, and premium paid.

If a conversion policy was applied for, such conversion policy will be null and void even if this policy had been issued; and no death Claim will be payable under the conversion policy. Union Labor Life will return any premium paid for the conversion policy.

ACCIDENTAL DEATH AND DISMEMBERMENT FOR PARTICIPANTS

As an eligible, Active Participant, you are insured for $10,000 against death and dismemberment in an accident on or off your job.

If you are killed in an accident or die within 90 days as a result of the accident, your beneficiary will be paid $10,000, in addition to the $10,000 to be paid under your Life Insurance.

If you accidentally suffer the loss of both hands, both feet, or the sight of both eyes within 90 days of the accident, you will be paid $10,000.

If you accidentally suffer the loss of one hand, one foot, or the sight of one eye within 90 days of the accident, you will receive $5,000.

No benefit will be paid for any loss that is caused or substantially contributed to by any of the following:

1. any attempt at suicide or intentionally self-inflicted injury, while sane or insane;
2. war or any act of war;
3. active participation in a riot, insurrection, or terror activity;
4. committing or attempting to commit a felony;
5. the Participant's voluntary intake of any drug unless prescribed by a physician and taken in accordance with the physician's instructions or any poison, gas, or fumes unless they are the direct result of an occupational accident;
6. being intoxicated as defined by the jurisdiction where the loss occurred;
7. being engaged in an illegal occupation; or
8. engaging in aviation other than as a fare-paying passenger.

FUNERAL EXPENSES

If an individual appears to the Plan and/or to Union Labor Life to be equitably entitled to compensation because he or she has incurred expenses on behalf of the deceased Participant's burial, the Plan and/or Union Labor Life may pay to such individual the expenses incurred up to $1,000. Such payment, however, shall not exceed the amount due under this policy. Union Labor Life and the Plan shall be fully discharged of liability for any amount of benefit so paid in good faith.

- To obtain a copy of the Certificate of Insurance, please call or write the Plan Office:

Motion Picture Industry Health Plan
Attn: Eligibility Department
P.O. Box 1999
Studio City, CA 91614-0999
(855) 275-4674

Prescription Drug Benefit

EXPRESS SCRIPTS®

Express Scripts
P.O. Box 30493
Tampa, FL 33630-3493
(800) 987-5247
www.ESRX.com

Express Scripts has established a customized, national network of participating pharmacies to serve eligible Participants and their dependents. To locate a participating retail pharmacy convenient to you, call Express Scripts at (800) 987-5247 or login to the Express Scripts website at www.ESRX.com. Registration to the site is free. Have your identification number and a recent prescription number handy. "Locate a Pharmacy" is on the Manage Prescriptions pull-down menu. You can search by ZIP code or by city and state. Also, consider downloading the Express Scripts mobile app for free.

ELIGIBILITY

If you or your Dependent(s) are eligible for benefits under the rules and regulations of the Plan, you may also be eligible for the prescription drug benefits described in this *SPD*.

GENERAL COVERAGE

Covered medications are reasonable and necessary for the diagnoses, and require a Provider's prescription by law.

Initially, you may receive up to a 30-day supply of your long-term medication (according to the amount prescribed by your Provider) at a participating retail pharmacy, with the cost, less Co-Payment, paid by the Plan.

REFILLS

After the initial fill, the Plan will pay for one refill of a long-term medication at a participating retail pharmacy for up to a maximum 30-day supply in accordance with the number of refills and quantity indicated by your Provider, less Co-Payment. New prescriptions will be required in instances where federal and/or state laws forbid refills.

Filling Short-Term Medications

You may obtain all your short-term drugs, such as antibiotics, at a participating retail pharmacy. You will pay the lesser of your participating retail pharmacy Co-Payment or the cost of these medications.

Filling Long-Term or Maintenance Medications

The first two times that you fill a prescription for a long-term drug at a participating retail pharmacy, you will pay your retail Co-Payment and receive up to a 30-day supply of medication.

Except as provided in the following paragraph, for continued retail purchases beyond the allotted two, you will be required to pay 100% of the cost of medication.

Participants may fill long-term or maintenance medications, up to a 90-day supply, through Express Scripts mail-order prescription or at a Walgreens, Duane Reade or Happy Harry's retail store through their Smart90 Program. Standard Express Scripts mail order Co-Payments will apply.

If you or your Provider submit a prescription for less than a 90-day supply, you will receive the lesser amount at the 90-day Co-Payment cost.

RETAIL COSTS AND CO-PAYMENTS

The Co-Payment amount is paid by you to the pharmacy at the time your prescription is filled.

MAIL ORDER COSTS AND CO-PAYMENTS

Express Scripts provides the option of a mail-order prescription service for you and your eligible Dependents for the dispensing of

▸ **Schedule of Co-Payments:**

ANY RETAIL PHARMACY (Up to a 30-day supply)	WALGREENS, DUANE READE OR HAPPY HARRY'S PHARMACY (Up to a 90-day supply)	MAIL-ORDER (90-day supply)
Generic Drugs		
$10	$25	$25
Preferred Brand Drugs		
$25	$65	$65
All Other Brand Drugs		
$40	$100	$100

maintenance medications.

If a generic drug is available but you or your Provider choose the brand name, you must pay the difference in cost between the generic and the brand-name drug, plus your generic Co-Payment.

HOW TO USE THE EXPRESS SCRIPTS HOME DELIVERY SERVICE

There are some medications that are not appropriate for dispensing by mail because they are for acute conditions, are potent pain medications and/or have special dispensing requirements. Be sure to confirm with your Provider before you order by mail.

Medications classified as Schedule II (CII) by the Drug Enforcement Administration (DEA), including most opioid analgesics and amphetamines, cannot be obtained via mail-order pharmacy. Schedule II medications can be filled at participating retail pharmacies for up to a 30-day supply, or a Walgreens, Happy Harry's or Duane Reed pharmacies for up to a 90-day supply.

Easy Steps to Order by Mail

1. **Your prescription:**
   Ask your Provider to write your prescription(s) for up to a 90-day supply, plus refills for up to one year, if appropriate.

- Be sure you have a 14-day supply of your medication on hand to allow for processing and delivery the first time. If needed to hold you over, ask your Provider for a prescription for a 30-day supply that you can fill at a participating Express Scripts network pharmacy.

2. **Getting started:**
   The first mail-order fill of a new prescription can be handled in one of two ways.

- **Order by mail:**
  You can mail the new prescription(s), a completed Express Scripts Pharmacy by Mail form and the appropriate Co-Payment to Express Scripts.
  - Visit www.mpiphp.org to print the form.
  - You may submit a check or money order, or complete the credit card authorization on the order form.
  - Call Express Scripts at (800) 987-5247 to obtain Co-Payment amounts.
- **Order by fax:**
  Ask your Provider to call (888) 327-9791 for instructions on how to fax a prescription.
- Only a Provider may fax a prescription.
  - You will be billed by Express Scripts for your Co-Payment.

3. **Refilling your prescription:**
   Look for the refill date on your prescription bottle or the refill slip from your previous order and be sure to order 14 days before your medication will run out. You may refill in any of three ways.

- **Online:**
  Log on to www.ESRX.com to view available prescription refills.
  - Simply check the box next to the item(s) you want to order and follow the on-screen instructions to check out.
  - You may pay by credit card online.
- **By telephone:**
  Call (800) 987-5247 to use the automated refill system.
- **By mail:**
  Use the refill order included with your previous shipment. Mail it with your Co-Payment to

Express Scripts in the return envelope provided.

SPECIALTY MEDICATIONS AND ACCREDO HEALTH GROUP

Specialty medications, which are typically medications that require special handling and are administered either by you or a healthcare professional, are a covered benefit only when obtained through the Express Scripts Specialty Care Pharmacy, Accredo Health Group ("Accredo"). This means that if you obtain your specialty medications somewhere other than from Accredo, you may be fully responsible for the cost. This does not apply to specialty medications supplied by a hospital.

Your medications will be shipped to you at no extra charge. If you prefer, you can have your medication shipped to your Provider's office (where allowable by law), if your Provider administers your medication. Plus, you will receive, at no additional charge, the necessary supplies (such as needles and syringes) to administer your medication.

To order specialty medications or for additional information, call toll-free to (800) 501-7260 between 8:00 a.m. and 8:00 p.m., Eastern Time, Monday through Friday. If you prefer, have your Provider call (800) 987-4904.

PATIENT SAFETY AND SUPPORT PROGRAMS

For the Plan, Express Scripts has various patient safety and support programs in place such as concurrent and retrospective drug utilization reviews, Rational Med, Personalized Medicine, and more. Some medications may require a clinical review to determine coverage of the medication and may have other restrictions such as quantity limits.

CHOOSING A BRAND-NAME DRUG WHEN A GENERIC FORMULATION IS AVAILABLE

If a U.S. Food and Drug Administration ("FDA") approved generic medication is available, but a Participant or his or her Provider choose the brand-name medication, a Participant must pay the difference in cost between the generic and the brand-name medication, plus his or her generic Co-Payment. If any of the following rare circumstances exist, brand-name medications may be approved without the requirement that the Participant pay the difference in cost:

1. The Provider documents an allergy (e.g., hypersensitivity reaction, gluten or dairy intolerance) to an inactive ingredient in the available generic equivalent products, and there has been an adequate trial of two or more therapeutically equivalent generic alternatives (unless there is only one available). Additionally, the Participant or his or her Provider must submit a report about the allergy to the FDA through the Safety and Information and Adverse Event Reporting Program on MedWatch and provide a copy of that report to the Plan. The allergic reaction must not be a side effect of the active ingredient of the drug per the manufacturer's package insert.
2. The Participant is taking a drug on Express Scripts' narrow therapeutic index list, and the Provider documents decreased effectiveness of the generic medication.
3. There is a drug shortage of all generic alternatives to such an extent that a generic alternative drug cannot be reasonably obtained.
4. Anti-seizure medications that meet all of the requirements below:

(a) In the rare event that a brand-name drug controls seizures better than its generic equivalent, brand-name anti-seizure medications may be covered at the generic reimbursement rate without payment of the difference in cost between the brand-name drug and the generic, even though an FDA approved generic formulation is available.

(b) Documentation required to consider this benefit includes a preauthorization request, consultation and/or progress notes and a letter of medical necessity from the treating Provider or neurologist.

(c) Documentation must establish that the generic formulation was used for a reasonable period of time and that seizures remained uncontrollable. Periodic review of the effectiveness of the brand formulation will also be required.

(d) The aforementioned documentation must be sent to the Plan's Medical Review Department; the decision of the Plan's Chief Medical Officer will be final and binding.

OUT OF THE COUNTRY

Express Scripts' mail order service is

limited to delivery to U.S. addresses. If you are planning a trip out of the country, ensuring that you have the medications that you will need while you are away from home requires advance planning. Through Express Scripts by mail, you can obtain 90-day prescriptions which may cover the duration of your trip.

If you are traveling out of the country for a longer period of time, Express Scripts' mail order service or Walgreens, Duane Reade or Happy Harry's pharmacies may be able to fill your prescription(s) for up to six months, provided you are otherwise eligible for medication during that six-month benefit period. In order to do so, you need to complete the following steps:

1. Contact the Plan to communicate your need for medication(s) for your trip out of the country. The Plan will need to know both the duration of your trip and the expected date of return. The approval process will include checking your eligibility for health benefits and checking when you last received refills of your medications. If your eligibility will lapse during your trip, the extended prescription(s) will be limited to the duration of time that the Plan will be providing coverage for you. The Plan will not authorize any more medication than you would have received had you remained in the United States.
2. Provide documentation to the Plan to substantiate your travels and support your request for more than a 90 days' supply of medication. This documentation must be submitted to the Plan at least five days prior to the initial travel date. Acceptable forms of documentation include:
   - (a) Work documentation, such as a contract; or
   - (b) Vacation documentation, such as an airplane ticket.
3. If appropriate, Plan staff will administer a vacation override benefit directly to Express Scripts notifying them that you have been approved to receive up to a six months' supply of a specific medication.
4. You will need to provide Express Scripts or the participating retail pharmacy with a valid prescription from your Provider for the length of time the prescription will be needed.

Note:

Your eligibility for Plan benefits must cover the duration of the extended prescription(s).

Also, lost and stolen medications cannot be replaced, and Schedule II (narcotics) and Schedule III (stimulants, and certain hormones) medications are excluded from the benefit.

If you are going out of the country for longer than six months, you must obtain a valid prescription from your Provider for the amount of additional medication(s) needed and pay for the prescription(s) yourself at a participating retail pharmacy.

REIMBURSEMENT PROCESS

If you pay for a prescription and would like to be reimbursed, please proceed as follows:

1. Retain the receipts for the medication(s) you purchased indicating the name of the medication along with the quantity received and the dollar amount paid.
2. Upon return, but no later than 12 months from the date of fill, forward the following information to:

   Express Scripts
   Attention: Commercial Claims
   P.O. Box 14711
   Lexington, KY 40515-4711

   - (a) The prescription receipt(s); and
   - (b) A completed Express Scripts Prescription Direct Drug Claim form, which can be obtained by calling (800) 987-5247 or downloaded from the Express Scripts website at www.ESRX.com.

Express Scripts may reimburse you up to the Allowable Amount less Co-Payments that apply, as long as you were eligible with the Plan during the time period the medications were used and there are no duplicate prescriptions or duplicate quantities of medications processed for those dates of service.

Note:

Reimbursement will be paid at the rate of 85% of Express Scripts' contracted rate (i.e., the Allowable Amount) with the pharmacy filling the prescription, less the Co-Payment. Reimbursement is based on generic or lower cost brand-name products, if either is available.

PRESCRIPTION DRUG COORDINATION OF BENEFITS

If a Dependent has other prescription drug benefits available to him or her, the other non-Plan coverage will be considered the primary plan for coordination purposes. This does not apply to

individuals who have dual-coverage, where each has Express Scripts coverage through the Plan.

For those who have additional coverage, the other (primary) insurance plan's instructions for purchasing medications must be followed. After that purchase, you must submit the receipt, along with a completed Express Scripts Prescription Drug Reimbursement form, to Express Scripts at the address on the form.

If the primary prescription plan benefits paid more than Express Scripts would have paid toward that prescription (if Express Scripts had been the primary plan), no additional payment will be made by Express Scripts. There will be no reimbursement to the Participant or eligible dependent. If the primary plan paid less than Express Scripts plan would allow, you may receive a check for the difference, minus your Co-Payment.

In addition, Express Scripts will coordinate drug Claims with Medicare Part B, where applicable. Although the major benefit under Medicare Part B is payment for Providers' services, there are some limited medications/treatments that are covered and will be coordinated through the Plan's prescription drug plan.

OVER-UTILIZATION

If determined by the Medical Review Department that there is an over-utilization of any medication(s), there will be no further payment made for those medications unless it is subsequently determined that continued use is considered sound medical practice.

In addition, if prescription drugs are obtained through an affiliated pharmacy for an ineligible person, you, the Participant, will be held personally liable and must reimburse the Plan for any benefits extended.

If you submit a prescription for medication that is not covered by the Plan, the prescription will be returned to you. Please see "Other Covered/Not Covered Items" below.

OTHER COVERED/ NOT COVERED ITEMS

Covered

- The following items, which may not require a prescription by law, are covered when they are prescribed in writing for:
- Diabetes
  - Insulin;
  - Blood glucose testing strips/ supplies (except blood glucose monitors, GlucoWatch products, and insulin pumps);
  - Regular or disposable insulin syringes/needles; and
  - Disposable lancets.
- Flu vaccination
- Other immunization covered by the Plan
- Retin-A[1] equivalent generics (for the diagnoses of acne vulgaris or Darier's disease only)
- Compound-drugs containing at least one legend ingredient (prior authorization is required)
- Any other drug which, under applicable state law, may only be dispensed upon the written prescription of a Provider or other lawful prescriber.
  - Erectile dysfunction drugs are covered benefits for male Participants and their eligible male Dependents. Up to six pills or doses per consecutive 30-day period through an Express Scripts participating pharmacy are covered when accompanied by an appropriate prescription from a licensed Provider who prescribed the drug for the treatment of impotence. Up to 18 pills or doses per consecutive 90-day period through the Express Scripts mail order service or Walgreens, Duane Reade or Happy Harry's pharmacies are covered.
  - Birth control pills and devices

Not Covered

- Medications that may be purchased without a prescription even though your Provider writes a prescription for it.
- Medication dispensed in the Provider's office.
- Vitamins, minerals or food supplements (except injectable B12 for pernicious anemia, significantly higher doses of Vitamin D and folic acid for some deficiency conditions, activated Vitamin D/calcitriol for renal failure and some

[1] Satisfactory written documentation in the form of clinical office notes or narrative confirming the diagnosis must be sent to the Plan's Medical Review Department before or after the purchase of the prescription if coverage is to be provided.

endocrine disorders, Vitamin K to treat clotting disorders, some prescription prenatal vitamins and fluoride containing medications, and intravenous iron to treat severe iron deficiency anemia will be covered when prescribed by a Provider and medically necessary).

- Amphetamines[2] and anorectics (drugs used for weight control purposes).
- Drugs used for the treatment of infertility.
- Drugs prescribed, other than bupropion and Chantix (varenicline), whose only use is for smoking cessation.
- Drugs used for cosmetic purposes.
- Minoxidil compounds (Rogaine) used for hair loss.
- Progesterone compounds and suppositories prescribed for premenstrual syndrome.
- Retin-A for any circumstance other than the diagnosis of acne vulgaris or Darier's disease
- Appliances, prosthetics, devices, bandages, heat lamps, braces, splints, cosmetics, dietary supplements, health and beauty aids.
- Proton pump inhibitors.
- Non-sedating antihistamines.
- Any medications, treatments or services which are not reasonable and necessary for the specific diagnosis under the given clinical circumstances.
- Any services, items or medications which are not approved by the FDA for the specific diagnosis.
- Experimental and investigational services, treatments, medications or devices.
- Any drugs prescribed for illness or injury covered by any Workers' Compensation or occupational disease law, any drugs prescribed for an illness or injury determined to be the liability of a third party, any drugs that exceed the requirements of sound medical practice or that are prescribed relative to conditions and/or services that are excluded from your Plan coverage, will not be covered.
- Replacement of lost or stolen prescription medication will not be covered.

FURTHER INFORMATION/DISPUTES

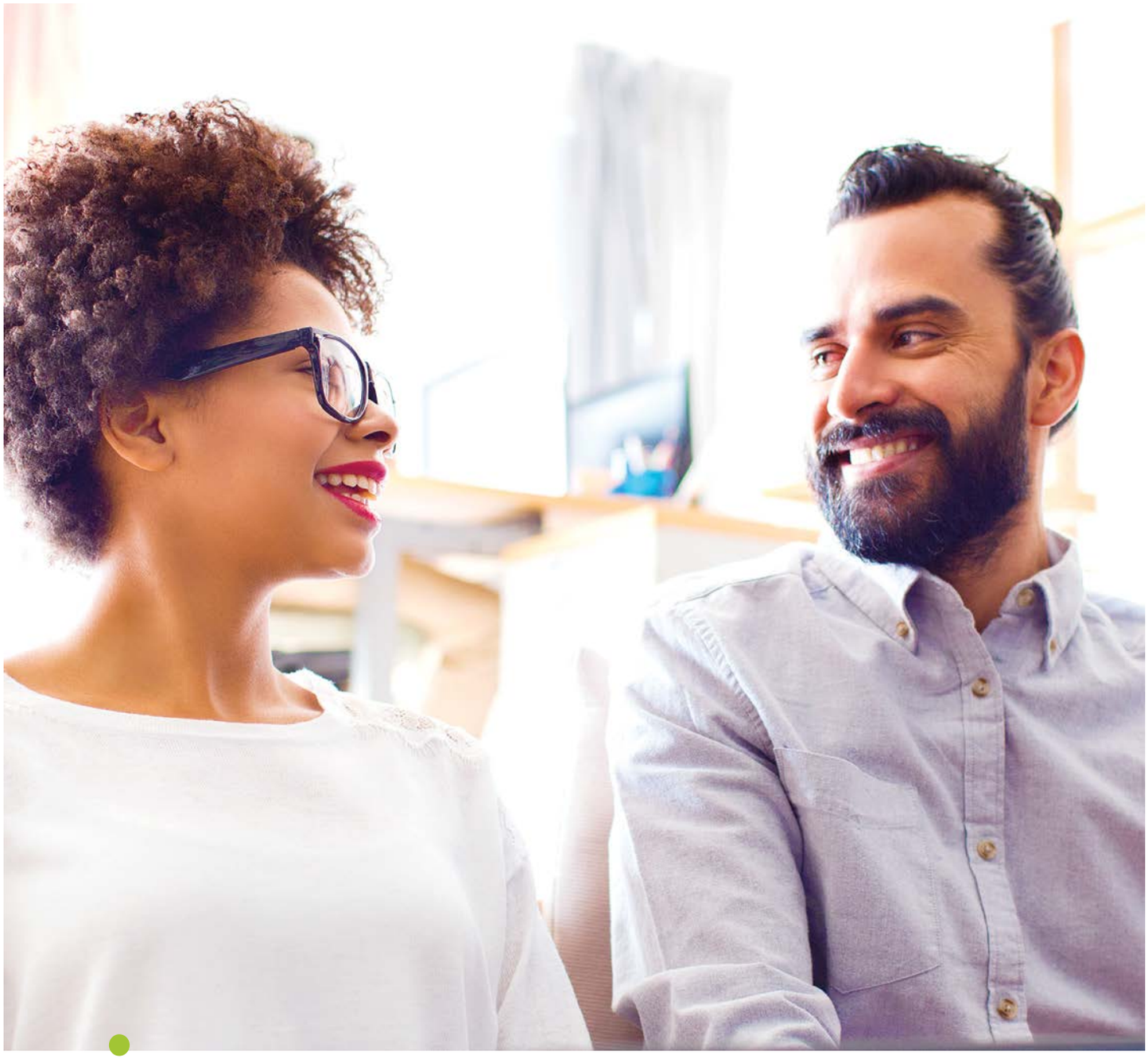
- If you have any questions or concerns regarding your prescription drug benefit, call Express Scripts toll-free at (800) 987-5247.
- If you feel that your Claim or request has not been processed correctly by Express Scripts, within 180 days following the receipt of your Explanation of Benefits or other initial Adverse Benefit Determination, you may file a first level appeal in writing to:

  Express Scripts
  Attn: Clinical Appeals Department
  P.O. Box 66588
  St. Louis, MO 63166-6588

- If you feel that your first level appeal was not correctly decided by Express Scripts, you have 180 days following receipt of notification of Express Scripts' decision to file a second level appeal with the Plan's Benefits/Appeals Committee in accordance with the procedures set forth on page 44. Please submit in writing your reasons, in clear and concise terms, and include any other pertinent documents or other documentation that will help the Plan's Benefits/Appeals Committee to understand the situation. The decision of the Benefits/Appeals Committee will be final and binding upon all parties, including the Participants and any person claiming under the Participant, subject to the right to bring a civil action under Section 502(a) of ERISA.

[2] If an amphetamine has been prescribed for attention deficit hyperactivity disorder or narcolepsy, an exception can be made to the non-covered status. Satisfactory written documentation by the prescribing physician of the clinical findings and diagnosis must be sent to the Plan's Medical Review Department either before or after the purchase of the prescription if coverage is to be provided.

Vision Services



Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195
www.vsp.com

Vision Service Plan (VSP) has an extensive nationwide network of Providers who agree to provide the finest ophthalmic care and eyewear to patients covered by VSP. VSP is designed to encourage you and your Dependent(s) to maintain your vision through regular eye examinations and to help with vision care expenses for required glasses or contact lenses.

This plan is designed to cover your visual needs rather than cosmetic eyewear. The following is only a summary of the vision plan using a VSP Choice Network Provider. For further benefit information, please contact VSP directly.

COVERED BENEFITS

A $20 Co-Payment per individual applies for the following covered benefits:

- A standard eye exam is covered once every Calendar Year beginning in January.
- Spectacle lenses (single vision, lined bifocal and lined trifocal) are covered once every Calendar Year beginning in January. Photochromic/tints are covered for all, and polycarbonate lenses are covered for Dependent children. There is an average of a 20% to 25% discount on non-covered lens options.
- Frames are covered once every other Calendar Year beginning in January. Your frame allowance is $145. If you select a frame with a cost that exceeds the allowance, the overage will be discounted by 20%.
- Participants and their eligible Dependents may obtain additional pairs of glasses or sunglasses at a 20% discount, including lens options, if purchased within 12 months of their last well vision exam.

Every Calendar Year, your benefit allows you to receive either contact lenses and a fitting and evaluation at an allowance of $105, or single vision, lined bifocal, and trifocal spectacle lenses for your existing frames. Your contact lens fitting and evaluation is also discounted at 15%.

You are eligible for frames every other year regardless of whether or not you chose to receive contact lenses or spectacle lenses the prior year. You have an allowance of $145 on a wide selection of frames. For your frame, you will also receive an additional 20% discount on any amounts exceeding those allowances.

Note:

- Any costs exceeding the allowance are the responsibility of the patient. Special rebates are available on select brands of contacts. Visit www.vsp.com for details.
- The Plan offers a 15% discount on an In-Network Provider's contact lens exam. This benefit is available in conjunction with the contact lens allowance or can be used to purchase contacts in addition to glasses. This discount is available for 12 months following the patient's last covered eye exam from the VSP In-Network Provider who provided the exam.

Medically necessary contact lenses are covered in full when prescribed by a VSP Provider for certain conditions of anisometropia, aphakia, high ametropia, nystagmus or other medical conditions that inhibit the use of glasses.

APPOINTMENTS

Call the VSP In-Network Provider of your choice for an appointment, identifying yourself as a VSP patient. The In-Network Provider will then contact VSP for authorization and detailed information about your eligibility and Plan coverage. No up-front paperwork or preauthorization is required. If you need help locating a VSP Choice Network Provider, visit www.vsp.com or call VSP at (800) 877-7195. If you are not eligible for benefits at the time you call for an appointment, the Provider's office will communicate that information to you when it has been determined.

- The VSP identification is the Social Security Number of the Participant.

OPTIONS

The following options are available to Participants and their eligible Dependents at an additional Out-of-pocket cost:

- Blended lenses
- Oversized lenses
- A frame that costs more than allowable

- Contact lenses (except as noted above)
- Certain limitations on low vision care
- Cosmetic lenses
- Progressive multifocal lenses
- Optional cosmetic processes
- Coated or laminated lenses
- UV protected lenses

NOT COVERED

There is no benefit for professional services or eyewear connected with:

- Orthoptics or vision training and any associated supplemental testing
- Two pairs of glasses in lieu of bifocals
- Any eye exam or corrective eyewear required by an Employer as a condition of employment
- Corrective vision treatment of an experimental nature
- Plano lenses (nonprescription)
- Medical or surgical treatment of the eyes
- Replacement of lenses and frames furnished under this program, which are lost or broken except at the normal intervals when services are otherwise available

USE OF A NON-VSP PROVIDER

You may obtain covered services from any other licensed optometrist, ophthalmologist or optician of your choice. You must pay the Provider in full and submit an itemized receipt to VSP. Typically you will receive a lesser benefit when using a non-VSP Provider. VSP will reimburse you up to the amounts allowed under your Plan's Out-of-Network reimbursement schedule. Co-Payment and benefit frequencies still apply. Contact VSP for further information about the Out-of-Network reimbursement schedule.

The reimbursement schedule does not guarantee full payment, nor can VSP guarantee patient satisfaction when services are received from a non-VSP Provider. All Claims must be filed within six months from the date services were completed. Reimbursement benefits are made directly to the Participant and are not assignable to the Provider.

CLAIMS PROCESSING

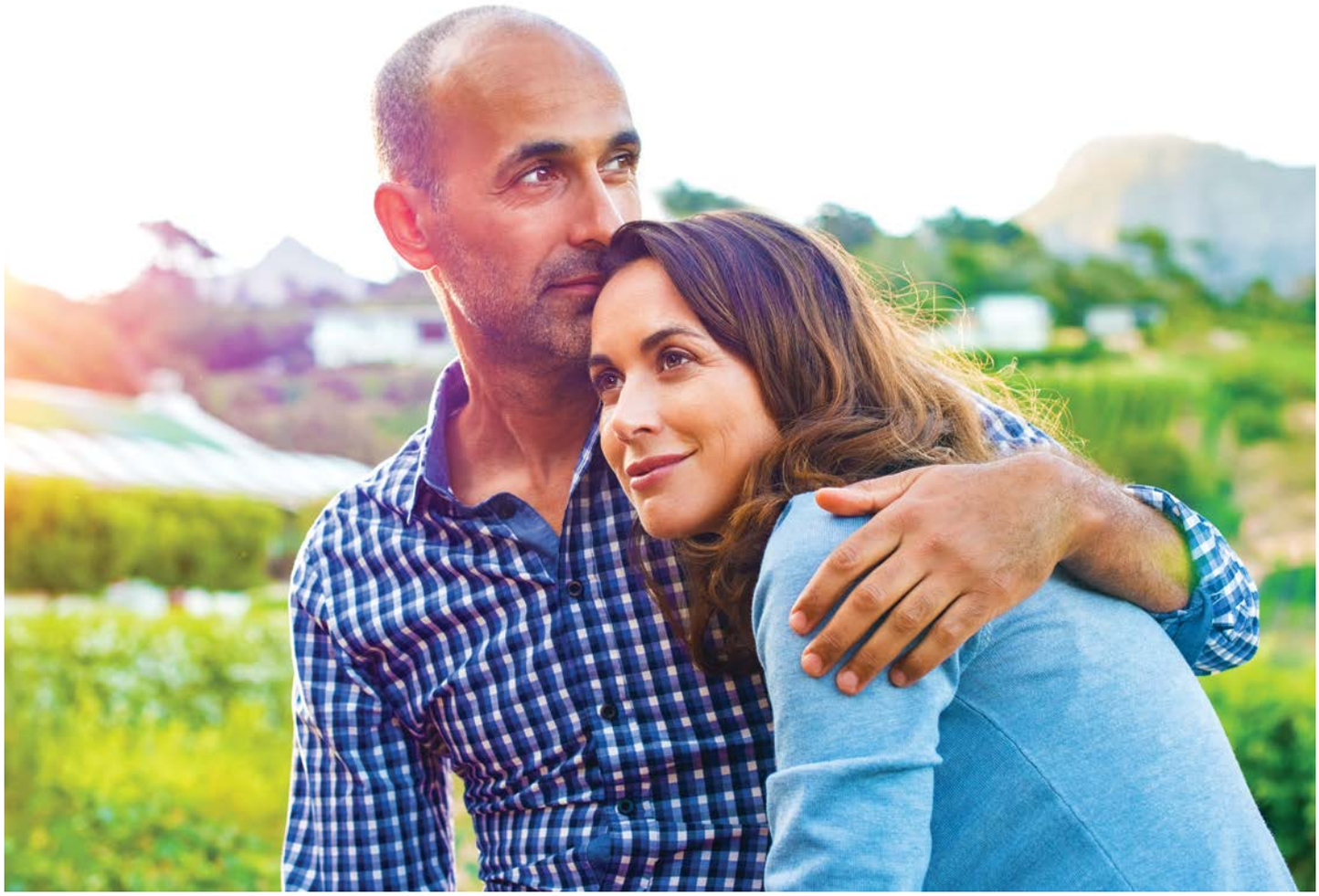
- If you have any questions or concerns regarding your vision services benefit, call VSP toll-free at (800) 877-7195.
- If you feel your Claim or request has not been processed correctly by VSP, within 180 days following the receipt of your Explanation of Benefits or other initial Adverse Benefit Determination, you may file a first level appeal in writing to:

  VSP
  3333 Quality Drive
  Rancho Cordova, CA 95670

APPEALS

If you feel that your first level appeal was not correctly decided by VSP, you have 180 days following receipt of notification of VSP's decision to file a second level appeal with the Plan's Benefits/Appeals Committee in accordance with the procedures set forth on page 44. Please submit in writing your reasons, in clear and concise terms, and include any other pertinent documents or other documentation that will help the Committee to understand the situation. The decision of the Plan's Benefits/Appeals Committee will be final and binding upon all parties, including the Participants and any person claiming under the Participant, subject to the right to bring a civil action under Section 502(a) of ERISA.

The Wellness Program



healthy MPI

Engage ▸ Educate ▸ Empower

For more information on Wellness Programs, please visit www.mpiphp.org/home/wellness, or contact the Wellness Program at either wellness@mpiphp.org or by calling (800) 654-WELL.

The Board of Directors of the Plan adopted The Wellness Program for all Plan Participants (including HMO enrollees) and their eligible Dependents. The Wellness Program is administered by the Plan. The Wellness Program encourages and supports a broad concept of overall health, including support for physical, emotional, financial and lifestyle wellness.

OUR WELLNESS PHILOSOPHY

The Plan's Wellness Program incorporates six pillars of wellness: Mindfulness and Purpose, Nourishment, Movement and Exercise, Sound Sleep, Financial Wellness, and Prevention and Safety. Each of these areas need to be well-managed to achieve overall Participant wellness and well-being and the Plan's Wellness Program is designed to support such efforts.

The Plan's Wellness Program offerings include: onsite wellness classes, webinars, podcasts, smoking-cessation programs, diabetes prevention programs, healthy weight programs and workshops, gym discounts and much more.

MOTION PICTURE
INDUSTRY HEALTH PLAN

ABOUT THE PLAN

Notes

The Plan Defined

This *SPD* describes the Plan's comprehensive medical and hospital benefits of the MPIHP/Anthem Blue Cross Health Plan, Health Maintenance Organization (HMO) and Oxford options, dental plans, life insurance, prescription drug plan, vision plan, wellness program and member assistance. This section of the book provides valuable reference information on the structure and operation of the Plan.

The Plan is established by Collective Bargaining Agreements between many of the Unions and Employers in the motion picture production industry. It is primarily supported by Employer contributions as provided by these agreements. The Plan is governed by a Board of Directors appointed in equal number by the participating Unions and Employers. Contributions, until necessary to pay insurance Premiums or benefits, are invested with the advice of professional investment advisers.

PARTICIPATING UNIONS

- International Union of Security-Police-Fire Professionals of America, Local 1
- Unite Here!, Local 11
- International Brotherhood of Electrical Workers, Local 40
- Affiliated Property Craftspersons, Local 44
- Motion Picture Studio Mechanics (NY/NJ), Local 52
- Plumbers & Pipefitters, Local 78
- Motion Picture Studio Grips/Crafts Service, Local 80
- International Union of Security-Police-Fire Professionals of America, Local 100
- Motion Picture Script Supervisors, Production Office Coordinators and Accountants, Local 161
- Office & Professional Employees International Union, Local 174
- International Brotherhood of Teamsters, Studio Transportation Drivers, Local 399
- International Cinematographers Guild and Publicists, Local 600
- Production Sound Technicians, TV Engineers, Video Assist Technicians & Studio Projectionists, Local 695
- Motion Picture Editors Guild, Local 700
- Motion Picture Costumers, Local 705
- Make-Up Artists & Hair Stylists, Local 706
- Studio Utility Employees (Laborers), Local 724
- Studio Electrical Lighting Technicians, Local 728
- Motion Picture Set Painters & Sign Writers, Local 729
- Operative Plasterers and Cement Masons International Association, Local 755
- Art Directors Guild, Local 800
- Theatrical Teamsters, Local 817
- Animation Guild, Local 839
- Script Supervisors/Continuity, Coordinators, Accountants & Allied Production Specialists Guild, Local 871
- Motion Picture Studio Teachers & Welfare Workers, Local 884
- Costume Designers Guild, Local 892
- Teamsters, Local 911
- Studio Security & Fire Association
- SEIU United Service Workers West

- Communication Workers of America, Parking Production Assistants

PARTICIPATING EMPLOYERS

Participating Employers are defined as Employers engaged in the production of motion pictures or engaged primarily in the business of furnishing materials or services for motion picture productions, and which have entered into a Collective Bargaining Agreement(s) with one or more participating Unions requiring contributions to the Plan. Participating Employers also includes named Employers, and in some cases, Employers of Nonaffiliates.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

This book constitutes the *Summary Plan Description for the Motion Picture Industry Health Plan for Active Participants* ("*SPD*"). Set forth below is certain disclosure information required by Employee Retirement Income Security Act of 1974 (ERISA) Section 102(b). This *SPD*, together with the Agreement and Declaration of Trust and the agreements between the Plan, Anthem Blue Cross, Health Net, Kaiser Permanente, Oxford Health Plans, Optum Behavioral Health, Delta Dental PPO Plan, DeltaCare USA, the Union Labor Life Insurance Company, Express Scripts and Vision Service Plan, constitute the Plan documents.

The name and type of administration of the Plan

The Motion Picture Industry Health Plan for Active Participants is a collectively bargained, Joint Trusteed Labor-Management Trust.

FULLY-INSURED BENEFITS

The carriers listed below provide fully-insured benefits under the Plan.

DeltaCare USA
12898 Towne Center Drive
Cerritos, CA 90703-8579
Administers and provides HMO dental benefits.

Health Net
21600 Oxnard Street
Woodland Hills, CA 91367
Health Maintenance Organization, which administers and provides medical and hospital benefits.

Kaiser Permanente
393 E. Walnut Street
Pasadena, CA 91188
Health Maintenance Organization, which administers and provides medical and hospital benefits.

The Union Labor Life Insurance Company
8403 Colesville Road
Silver Spring, MD 20910
Administers Life Insurance, Accidental Death and Dismemberment benefits

SELF-INSURED BENEFITS

The Plan is fully self-insured for the benefits obtained through the carriers listed below which administer at least a portion of the benefits for the Plan, but do not insure or otherwise guarantee any of the benefits of the Plan.

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

Partially administers the payment of medical and hospital Claims for the PPO Participants in California, partially administers, with the BlueCard program, the medical and hospital Claims outside the State of California, and provides access to its network of hospitals and medical Providers.

Oxford Health Plans
Oxford Health Plans (N.Y.), Inc.
1133 Avenue of the Americas
New York, NY 10036
Administers and provides access to its network of hospitals and medical Providers under its Point of Service network. Available only to Participants living in New York, New Jersey or Connecticut.

Delta Dental PPO Plan
P.O. Box 7736
San Francisco, CA 94120
Administers and provides access to its network of dentists.

Express Scripts
P.O. Box 30493
Tampa, FL 33630-3493
Administers the prescription drug retail and mail-order programs.

Optum Behavioral Health
A United Health Group Company
P.O. Box 55307
Sherman Oaks, CA 91413-0307
Administers and provides access to its network of behavioral health Providers and provides the member assistance program.

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670
Administers and *provides access to the vision network.*

NAME AND ADDRESS OF PERSON DESIGNATED AS AGENT FOR THE SERVICE OF LEGAL PROCESS

David Asplund
Chief Executive Officer
Motion Picture Industry Health Plan
11365 Ventura Boulevard
Studio City, CA 91604-3148
Service of legal process may also be made upon a Plan Trustee (Director).

NAME AND ADDRESS OF THE PLAN ADMINISTRATOR

Board of Directors
Motion Picture Industry Health Plan
11365 Ventura Boulevard
Studio City, CA 91604-3148

NAMES AND ADDRESSES OF DIRECTORS

See page 166.

SPONSORS

A complete list of the Employers and Employee organizations sponsoring the Plan may be obtained by Participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by Participants and beneficiaries at the principal offices of the Plan and at other specific locations such as Union halls. Participants and beneficiaries may also receive, upon request, information from the Plan Administrator as to whether a particular Employer or Employee organization is a plan sponsor, and the sponsor's address.

SOURCE OF FINANCING OF THE PLAN

Contributions made to the Plan by Employers signatory to certain Collective Bargaining Agreements in the motion picture industry requiring the payment of such contributions and premium payments by Participants.

ENDING DATE OF PLAN YEAR

Plan Year:
The Plan Year is a calendar year for accounting purposes.

INTERNAL REVENUE SERVICE IDENTIFICATION NUMBER

95-6042583

PLAN NUMBER

501

REMEDIES AVAILABLE UNDER THE PLAN

Remedies are available for redress of Claims which are denied in whole or in part, including provisions required by Section 503 of the Employee Retirement Income Security Act of 1974.

AVAILABILITY OF DOCUMENTS AND OTHER IMPORTANT INFORMATION

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

- Examine, without charge, at the Plan Office, and at all 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 Administrator 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 all Plan 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 the updated *SPD*. 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 the Summary Annual Report.
- Continue Group Health Plan Coverage

– Continue health care coverage for the Participant, his or her spouse or his or her Dependent(s) if there is a loss of coverage under the Plan as a result of a qualifying event. A Participant or their Dependent(s) may have to pay for such coverage. Review this *SPD* and the documents governing the Plan on the rules governing COBRA rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating certain rights, ERISA imposes duties upon the people who are responsible for operating the Employee benefit plan. The people who govern your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and solely in the interest of you and other Plan Participants and beneficiaries. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive it 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 Plan Administrator.

If you have exhausted the Plan's Claims and appeals process and 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 qualified status of a medical child support order, you may file suit in a 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 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 that 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 NW; Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

YOUR RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

QUICK TIP

WANT TO LEARN MORE ABOUT ADDING DEPENDENTS TO YOUR PLAN?

See page 24

Notice Of Non-Discrimination

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The Plan provides free aids and services to people with disabilities to communicate effectively with them. These aids and services include:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats and other formats)

The Plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Plan Office.

If you believe the Plan has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Lori Brogin, the Plan's Chief Compliance Officer, at (855) 275-4674 or at P.O. Box 1999, Studio City, California 91614.

- You can file a grievance in person or by mail. If you need help filing a grievance, Lori Brogin is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

- or by mail or phone at:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  (800) 368-1019 or
  (800) 537-7697 (TDD)

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

Notice Of Non-Discrimination

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-855-275-4674.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。
請致電 1-855-275-4674.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-855-275-4674.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-855-275-4674 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-275-4674.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-275-4674.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Rele 1-855-275-4674.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-275-4674.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.
Zadzwoń pod numer 1-855-275-4674.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para 1-855-275-4674.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero 1-855-275-4674.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-275-4674.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-855-275-4674 まで、お電話にてご連絡ください。

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-275-4674.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-275-4674។

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.
Hu rau 1-855-275-4674.

Glossary of Terms

ACTIVE PARTICIPANT

An active Employee or COBRA Participant who has met the eligibility requirements for participation in the Plan and is eligible to receive Plan benefits.

ADVERSE BENEFIT DETERMINATION

An Adverse Benefit Determination is a denial, reduction or termination of, or a failure to provide or make payment for, a benefit, including any such denial based on your eligibility to participate in the Plan. This term applies to health care benefit determinations and certain disability determinations including those resulting from the application of any Utilization Review as well as failure to cover an item or service because it is determined to be experimental or investigational or not medically necessary or appropriate.

ALLOWABLE AMOUNT

The maximum amount the Plan allows for a Covered Service.

AMBULATORY SURGICAL CENTER

An ambulatory center is a free-standing outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

ANCILLARY SERVICES

Health care services provided by health professionals who are typically not physicians.

ASSISTANT SURGEON

An Assistant Surgeon (M.D., D.O., D.P.M.) is a physician who helps a surgeon during a highly technical surgery.

BALANCE BILLING

Balance Billing occurs when a Provider bills a patient for any unpaid balance of the Provider's charges after both the Plan and the patient have paid their portions, i.e., Allowed Amount has been paid.

BANK OF HOURS

Refers to those hours that are worked beyond those necessary for current Eligibility that are held for future Eligibility.

BENEFIT PERIOD

The six calendar months commencing the first day of the third month immediately following the applicable Qualifying Period.

CASE MANAGEMENT

A process by which a nurse coordinator works with the patient, the family and the attending physician to develop an individualized and appropriate treatment plan.

CASE MANAGEMENT COORDINATOR

An experienced health care professional (nurse, social worker, Provider or pharmacist) who works with patients, Providers and insurers to coordinate all necessary aspects of health care. Case Management Coordinators evaluate necessity, appropriateness and efficiency of services and drugs provided to individual patients.

CLAIM

A notice to one of the Plan's claim administrators/insurance companies that a person received care thought to be covered by the Plan. A Claim is also a request for payment.

CLAIMANT

A Participant or Dependent that submits a Claim.

COBRA

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and refers to coverage available after loss of eligibility under the terms of that law.

COINSURANCE

A term that describes a shared payment between an insurer or the Plan and an insured individual. It is usually described in percentages.

Example:

The plan or insurance company agrees to pay 90% of the Allowed Amount and the individual picks up 10%.

COLLECTIVE BARGAINING AGREEMENT

An agreement between a Union and a contributing Employer which covers work performed by an active Employee working within the Union's jurisdiction for such Employer and otherwise obligates such contributing Employer to contribute to the Plan with respect to such work.

CONTRACTING PROVIDER

A Provider of service who has an agreement with a carrier that is contracted with the Plan to provide his or her service at specific rates, usually lower than if there were no contract in place.

COORDINATION OF BENEFITS

When a Participant or eligible Dependent has other insurance, Coordination of Benefits is the process used to determine the appropriate primary payer and secondary payer of the benefit(s).

CO-PAYMENT

A payment by the insured individual, usually a flat dollar amount, such as $15 per office visit. Co-Payments are typically made at the time of the service.

COSMETIC SURGERY

Cosmetic Surgery means those procedures that are performed primarily to make an improvement in a person's appearance. Cosmetic Surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. It is different from reconstructive surgery. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function but may also be done to approximate a normal appearance.

COVERED SERVICES

The Plan provides benefits for specific medical services that have been approved by its Board of Directors. In order for a specific medical service to be covered, it must be a service for which the Plan has established a benefit. The service must be medically necessary and reasonable.

CUSTODIAL CARE

Custodial Care means care which is designed to help a person in the activities of daily living. Continuous attention by trained medical or paramedical personnel is not necessary. Such care may involve:

1. Preparation of special diets.
2. Supervision over medication that can be self-administered.
3. Assisting the person in getting in or out of bed, walking, bathing, dressing, eating, or using the toilet.

DEDUCTIBLE

The amount an individual must pay for health care expenses before insurance (or a self-insured plan) covers any health care costs. Typically, it is an annual amount.

DENIAL OF CLAIM

Refusal by an insurance company or self-insured Plan to honor a request by an individual (or his or her Provider) to pay for health care services obtained from a health care professional.

DEPENDENT

A Participant's:

1. Lawful spouse;
2. Children (including your biological children, legally adopted children, children

placed with you for adoption, stepchildren, foster children, and/or any child for whom you, the Participant, are the legal guardian) are eligible for medical and prescription drug coverage until they reach the age of 26.

3. Unmarried children are eligible for dental and vision coverage until they reach the age of 19 (or 23 if a full-time student).

4. Any child required to be recognized under a Qualified Medical Child Support Order.

DISABILITY RETIREMENT PENSION BENEFIT

One type of retirement benefit under the Motion Picture Industry Pension Plan. A Disability Retirement Pension Benefit is available to a Participant of any age who is disabled, as defined under the Motion Picture Industry Pension Plan's guidelines, and has met the required Qualified Hours and Qualified Years of the Pension Plan.

DURABLE MEDICAL EQUIPMENT

This is medical equipment which is:

- Ordered by your Provider;
- Primarily used for medical purposes;
- Able to withstand repeated use;
- Generally not of use in the absence of sickness or injury; and
- Appropriate for use in the home.

ELIGIBILITY

This describes Participants and their Dependents who have met conditions to receive benefits through the Plan.

ELIGIBILITY PERIOD

The six-month period of time in which Participants are eligible for the benefits of the Plan.

EMPLOYEE

There are three general requirements to be considered an "Employee" for purposes of participation in the Plan:

1. You must either:

   a. work for an Employer and be covered by a Collective Bargaining Agreement which requires Employer contributions to the Plan; or

   b. if you are a non-affiliated Employee, you must be part of a group designated as eligible to participate by your Employer, with a sufficient written agreement as approved by the Plan's Board of Directors;

2. You must be in the labor pool in the Los Angeles area; and

3. You must be hired by an Employer in the Los Angeles area to perform:

   a. services in the Los Angeles area in the industry;

   b. temporary services outside the Los Angeles area in connection with motion picture or commercial productions.

In addition, the term "Employee" includes the following individuals outside of the Los Angeles area:

- A cameraperson employed by an Employer under a Collective Bargaining Agreement with IATSE or its Local 600 working in the United States or Puerto Rico or performing temporary services outside the United States and Puerto Rico.
- A freelance unit publicist who is hired in New York, New Jersey, Connecticut, Baltimore, Maryland, District of Columbia, Cook County, Illinois, Georgia, Louisiana, New Mexico, Massachusetts, Rhode Island or Pennsylvania to work in the United States, its territories, or Canada under a Collective Bargaining Agreement between an Employer and IATSE or its Local 600.
- An editorial or post-production sound Employee employed by an Employer under a Collective Bargaining Agreement with IATSE or its Local 700 working in the United States or Puerto Rico or performing temporary services outside the United States and Puerto Rico.
- An Employee of the Motion Picture Industry Pension Plan, Individual Account Plan, Health Plan, the Motion Picture Association of America or Local 600 or Local 700 working in the United States or IATSE Local 52 working in New York or New Jersey or Local 161 working in New York, New Jersey or Connecticut.
- A studio mechanic: (i) employed by an Employer under a Collective Bargaining Agreement with IATSE Local 52 working in New York or New Jersey or performing temporary services outside of those areas, but within the States of Connecticut, Delaware or Pennsylvania, excluding the City of Pittsburgh; or (ii) in the labor pool in New York and New Jersey, hired by an Employer in New York or New Jersey to perform services in the industry, employed prior to May 14, 2006, under an IATSE, Local 52 Feature and Television Collective Bargaining Agreement which required contributions to the Plan, and hired by an Employer, on or after May 14, 2006, under an IATSE Collective Bargaining Agreement to perform

services outside of the geographic jurisdiction of IATSE, Local 52, as set forth in the May 16, 2006 Motion Picture Studio Mechanics, Local 52, IATSE Feature and Television Production Contract with Major Producers.

- A script supervisor, production office coordinator, assistant production office coordinator, production accountant, payroll accountant or assistant production accountant: (i) employed by an Employer under a Collective Bargaining Agreement with IATSE Local 161 working in New York, New Jersey or Connecticut or performing temporary services in Delaware, Maine, Massachusetts, New Hampshire, Pennsylvania, Rhode Island, Vermont, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, or West Virginia; or (ii) employed, prior to March 3, 2007, under an IATSE Local 161 Feature and Television Collective Bargaining Agreement which required contributions to the Plan, hired by an Employer on or after March 3, 2007 to perform services outside of the geographic jurisdiction of the 2003 Motion Picture Script Supervisors and Production Office Coordinators, Local 161, IATSE and M.P.T.A.A.C. Motion Picture Theatrical and TV Series Production Contract, or its successor agreements, and employed under a Collective Bargaining Agreement permitting redirection of contributions to the Plan on behalf of the Employee.
- An art director employed by an Employer under a Collective Bargaining Agreement with IATSE or its Local 800 working in the United States, United States territories, Puerto Rico or Canada, but excluding employment on New York based productions or productions made in the vicinity of New York, when such productions are made with on-production crews obtained exclusively from New York.
- A non-affiliated production accountant employed by an Employer under a Production Accountants Group Designation working in New York or New Jersey or hired in New York or New Jersey to work anywhere in the United States, its territories or Canada.
- A freelance casting director or freelance associate casting director who is working under a Collective Bargaining Agreement with Teamsters Local 399 or Teamsters Local 817 hired to perform services in New York City and/or in Los Angeles County, or hired by an Employer in New York City or in Los Angeles County to perform work outside of such areas in connection with the production of either live action theatrical motion pictures, live action prime time television motion pictures, or a motion picture of a different type which the Employer, at its sole discretion, has determined will be covered by one of such Collective Bargaining Agreements.
- A freelance operator employed as a technical production crew member:

1. through the Employer's southern California office or crewing service, to perform service in connection with the live broadcast or recording of events held in Los Angeles, Ventura, Orange or San Diego counties or the greater Palm Springs area, or
2. through the Employer's southern California office or crewing service, to temporarily perform services in connection with the live broadcast or recording of events held outside such counties and area if a Collective Bargaining Agreement with IATSE requires contributions to the Plan on behalf of such Employee, the Employee is not hired from San Diego Local 795, IATSE, and the Employee is not a Participant in the IATSE National Health and Welfare, Annuity or Pension Funds, by virtue of customarily being employed under an IATSE Collective Bargaining Agreement covering geographic regions other than those described above.

- A location scout/manager under a Collective Bargaining Agreement between the Employer and Teamsters Local 817 hired by the Employer:

1. to perform services in the states of New York, New Jersey, Connecticut or Rhode Island or
2. hired by the Employer in New York, New Jersey, Connecticut or Rhode Island to perform work outside of such areas in connection with the production of commercials or promos.

- An assistant location manager, location scout, location coordinator or location assistant under a Collective Bargaining Agreement between the Employer and Teamsters Local 817 hired by the Employer to perform services in the states of New York, New Jersey or Connecticut in connection with the production of feature motion pictures or television.

EMPLOYER

Any organization which produces motion pictures or commercials in the Los Angeles area or whose business is primarily the furnishing of goods or services for motion picture or commercial production in the Los Angeles area and which has executed a Collective Bargaining Agreement with any Union. That Agreement must require contributions to the Plan by the identified Employer, as approved by the Board of Directors. The term "Employer" also means the Motion Picture Industry Pension, Individual Account, and Health Plans and various Local Unions participating in the plans and "named Employers" such as the AMPTP, Contract Services Administration Trust Fund, Motion Picture Association of America, The Entertainment Industry Foundation, Directors Guild of America Contract Administration, Directors Guild Producer Training Plan and First Entertainment Federal Credit Union. The term "Employer" also includes any member of the AMPTP or any other Employer that produces motion pictures or commercials outside of the Los Angeles area, that becomes a party to this Plan and has signed a Collective Bargaining Agreement with IATSE or IATSE Local 600, 700, 52, 161 or 800 or Teamsters Locals 399 and 817 that requires contributions by such Employer to the plans, but only with respect to Employees who satisfy the definition of "Employee" set forth above. A "loan-out" company that is controlled by the only Employee performing work covered by an applicable Collective Bargaining Agreement is not an "Employer" for purposes of the Plan.

EXCLUSIONS OR NON-COVERED SERVICES AND ITEMS

Medical services that are not covered by an individual's insurance policy or self-insured plan.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

Arrangement consisting of a group of Providers who have a contract with an insurer, Employer, third party administrator or other sponsoring group. Typically, Out-of-Network coverage is not provided.

EXPLANATION OF BENEFITS

A summary of services provided and the amounts paid.

GUILD

Any one of the participating Unions or Guilds listed on page 153.

HEALTH MAINTENANCE ORGANIZATIONS (HMO)

Health Maintenance Organizations typically represent a "prepaid" or "capitated" insurance plan in which individuals or their Employers pay a fixed monthly fee for services, instead of a separate charge for each visit or service. The monthly fees remain the same regardless of types or levels of services provided. Services are provided by Providers who are employed by, or under contract with, the HMO. HMOs vary in design. Depending on the type of the HMO, services may be provided in a central facility or in a Provider's own office.

HOME HOSPICE

A program designed to provide a caring environment to supply the physical, emotional, social, spiritual and practical needs of the terminally ill. The program stresses palliative care rather than curative care; it stresses quality of remaining life rather than quantity. It is conducted primarily in the home of the person with a limited life expectancy when that person has made the decision to spend the last months of life as comfortable as possible at home. The program offers professional medical care, sophisticated symptom relief, nursing or home aid care where appropriate, and respite care for family members, if needed.

IN-NETWORK

This phrase refers to Providers or health care facilities that are part of a health plan's network of Providers with which it has negotiated a contracted rate for services.

INITIAL ELIGIBILITY

The beginning of the period when a Participant is first able to receive benefits through the Plan.

INPATIENT CARE

The type of treatment you receive when you are an overnight patient at a hospital or treatment center.

MANAGED CARE

A system that integrates financing, delivery and measurement of appropriate medical care through:

1. contracts with selected Providers, hospitals and pharmacy benefit networks to furnish a comprehensive set of health care services to enrolled members, usually for a predetermined monthly Premium;
2. utilization and quality controls that Contracting Providers agree to accept;
3. financial incentives for patients to use Providers and facilities associated with the Plan; and
4. in some cases, an assumption of some financial risk by Providers. The goal is to provide value through a system that provides people access to quality, cost-effective health care.

MAXIMUM ALLOWABLE AMOUNT

The maximum amount of money that an insurance company (or self-insured plan) will consider in determining the covered benefits/ amount the Plan will pay.

MEDICAID

A program of health insurance provided by the state and federal government for the poor, elderly and disabled.

MEDICARE

Health insurance provided by the federal government for the elderly and disabled.

OPEN ENROLLMENT

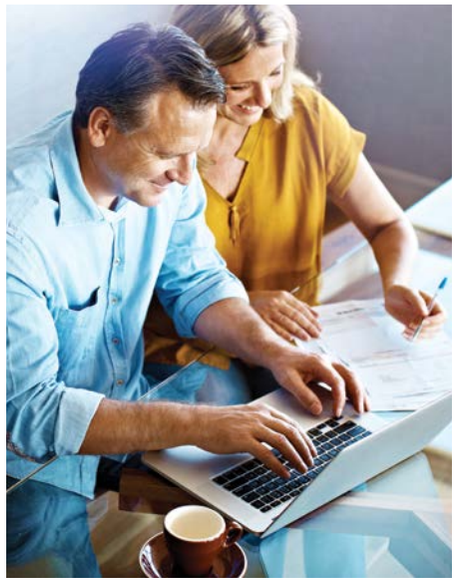
A specified period of time in which Employees may change their plan to a different plan (Anthem Blue Cross, Kaiser Permanente, Health Net or Oxford Health Plans) offered by the Plan and have the new plan effective at a later date.

OUT-OF-NETWORK PROVIDER

This phrase refers to Providers who are not in one of the Plan's networks. Your expenses are usually much greater using these Providers.

OUT-OF-POCKET MAXIMUM

The most money you can expect to pay for covered services. MPIHP/Anthem Blue Cross and Oxford do not count Co-Payments toward satisfying the Out-of-Pocket Maximum. They only count Coinsurance payments and Deductibles. Health Net and Kaiser Permanente count both Coinsurance payments and Co-Payments when determining if their Out-of-Pocket Maximum has been satisfied. Once the Out-of-Pocket Maximum has been met, the Plan will pay 100% of the Allowable Amount, less any



applicable Co-Payments for MPIHP/ Anthem and Oxford.

OUTPATIENT CARE

The type of treatment in a Provider's office or clinic.

OVERPAYMENTS

"Overpayment" is the term used to refer to a Plan payment which is overpaid due to other health carrier payments, third-party liability, incorrect billings, miscalculations, etc.

PARTICIPANT

See Active Participant

PARTICIPANT IDENTIFICATION NUMBER

Refers to your identification number found on your benefit card.

PARTICIPATING PROVIDER OR PARTICIPATING HEALTHCARE PROVIDER

A Provider who is contracted to deliver medical services to individuals covered by the Plan. The Provider may be a hospital, pharmacy or other facility or a Provider who has contractually accepted the terms and conditions as set forth by the Plan.

PLAN

The Plan is the Motion Picture Industry Health Plan for Active Participants described in this *SPD*.

PLAN MONTH

The period of time beginning on the Sunday before the last Thursday of each month and ending on the Saturday before the last Thursday of the following month.

Example:

The Plan Month of July 2018 will end on July 21, 2018 (the Saturday before the last Thursday of July). The immediately following Plan Month will then begin on Sunday, July 22, 2018 and end on Saturday, August 25, 2018.

PLAN OFFICE

The Plan Office is the general administrator of the Plan.

POINT OF SERVICE (POS) PLAN

A Point of Service Plan allows Participants a choice of accessing services either In-Network or Out-of-Network. The In-Network alternative works much like a Health Maintenance Organization and requires that Participants seek care through a Primary Care Provider who is part of the POS network. That Primary Care Provider will make Referrals to Specialists if she/he deems it necessary. Using the Out-of-Network plan alternative provides Participants self-referred access to any Provider, but at a greater Out-of-Pocket cost.

PREAUTHORIZATION

Written approval from an insurer or your plan that a procedure or item is a covered benefit under the Plan of benefits.

PREFERRED PROVIDER ORGANIZATION (PPO)

A program in which contracts are established with Providers of medical care such as The Industry Health Network of the UCLA-Motion Picture & Television Fund. Usually the benefit contract provides significantly better benefits (lower Co-Payments and/or Coinsurance) for services received from Preferred Providers, thus encouraging covered persons to use these Providers. Covered persons generally are allowed benefits for non-Participating Providers services, usually with significantly greater Co-Payments and/or Coinsurance.

PREMIUM

The amount paid for Plan coverage or any insurance policy. In the "Basic Requirement for Plan Eligibility" section, the Premium is the amount owed for a Participant and/or his or her Dependent(s) to pay in order to receive coverage from the Plan.

PRIMARY CARE PROVIDER (PCP)

A health care professional (usually a medical physician) who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a "quarterback" for an individual's medical care, referring the individual to more specialized Providers for Specialist care.

PROVIDER

Provider is a term used for health professionals who provide health care services such as physicians, hospitals, nurse practitioners, chiropractors, physical therapists, and others offering specialized health care services.

QUALIFYING LIFE EVENT

A personal change in status which may allow a Participant to change his or her benefit elections.

QUALIFYING PERIOD

The first six of the eight consecutive Plan Months immediately preceding the Benefit Period.

Example:

The applicable Qualifying Period for the Eligibility Period commencing January 1, 2018 was April 23, 2017 through October 21, 2017.

QUALIFIED YEAR

A Qualified Year is any year in which you worked at least 400 hours, for which contributions were made to the Retiree Health Plan. Please be aware that your Retiree Health Plan Qualified Years may be more than Pension Plan Qualified Years if you incurred a "break in service" under the Motion Picture Industry Pension Plan.

REFERRAL

Approval or consent by a Primary Care Provider for patient to receive services from an Ancillary Provider or as Specialists.

RETIREE HEALTH BENEFITS

Benefits provided by the Motion Picture Industry Health Plan for Retired Participants (also referred to as "Retiree Plan," "Retiree Health," and "Retiree Health Plan").

SECOND SURGICAL/ MEDICAL OPINION

An opinion obtained from an additional health care professional prior to the performance of a medical service or a surgical procedure. It may refer to a formalized process, voluntary or mandatory, which is used to help educate a patient regarding treatment alternatives and/or to determine medical necessity.

SPECIALIST

A Provider who practices medicine in a specialty area. Cardiologists, orthopedists and gynecologists are all examples of Specialists. Under most health plans, family practice physicians, pediatricians and internal medicine physicians are not Specialists.

SURGICAL ALLOWANCE

For this Plan, the Surgical Allowance for the Out-of-Network Ambulatory Surgical Centers' facility charge is the Usual, Customary and Reasonable Rate of the attending surgeon.

SURGICAL CENTER

A Surgical Center, sometimes called an Ambulatory Surgical Center, is a free-standing outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

UNION

Any one of the participating Unions or Guilds listed on page 153.

USUAL, CUSTOMARY, AND REASONABLE (UCR) RATE

A Provider charge is considered "Usual, Customary and Reasonable" if the amount is similar to what most Providers in the area charge for this same service.

UTILIZATION REVIEW

Programs designed to reduce unnecessary medical services, both inpatient and outpatient. Utilization Reviews may be prospective, retrospective, concurrent, or in relation to discharge planning.

Board of Directors

Patric Abaravich
Local 728
1001 West
Magnolia Boulevard
Burbank, CA 91506

Aric Ackerman
1619 Artesia Boulevard,
Unit E
Manhattan Beach,
CA 90266

Alex Aguilar
Local 724
6700 Melrose Avenue
Hollywood, CA 90038

Helayne Antler
Sony Pictures
Entertainment
10202 West Washington
Boulevard, Suite SPP-5408
Culver City, CA 90232

Mark Badagliacca
Paramount Pictures Corp.
5555 Melrose Avenue,
Redstone 136
Los Angeles, CA 90038

Jay Barnett
CBS Studios, Inc.
4024 Radford Avenue
Studio City, CA 91604

Scott Bernard
Local 695
5439 Cahuenga Boulevard
North Hollywood,
CA 91601

Krysten Brennan
Walt Disney Pictures
500 S. Buena Vista Street
Burbank, CA 91521

Ann Calfas
Twentieth Century Fox
2121 Avenue of the Stars,
22nd Floor, Suite 2230
Los Angeles, CA 90067

Michael Campolo
Warner Bros.
Television Productions
4000 Warner Boulevard,
Building 137, Room 1013A
Burbank, CA 91505

Stephanie Caprielian
ABC Studios
500 S. Buena Vista
Boulevard, M/C 4204
Burbank, CA 91521

Tommy Cole
Local 706
828 North Hollywood Way
Burbank, CA 91505

Thomas Davis
Local 80
2520 West Olive Avenue,
Suite 200
Burbank, CA 91505

Steve Dayan
Local 399
4747 Vineland Avenue
North Hollywood,
CA 91602

Eryn Doherty
NBC Universal
100 Universal City Plaza
1280-3
Universal City, CA 91608

Colleen Donahue
Local 161
630 Ninth Avenue,
Suite 1103
New York, NY 10036

Kenny Farnell
Local 399
4747 Vineland Avenue
North Hollywood,
CA 91602

Marc Flynn
IBEW Local 40
5643 Vineland Avenue
North Hollywood,
CA 91601

John Ford
Local 52
19-02 Steinway Street
Astoria, NY 11105

Nicole Gustafson
Paramount Pictures
Corporation
5555 Melrose Avenue,
Zukor, Suite 1101
Los Angeles, CA 90038

Hank Lachmund
Warner Bros.
Television Productions
4000 Warner Boulevard,
Building 137, Room 1009
Burbank, CA 91505

Matthew Loeb
IATSE
207 West 25th Street,
4th Floor
New York, NY 10001

Carol Lombardini
AMPTP
15301 Ventura Boulevard,
Building E
Sherman Oaks, CA 91403

Michael Messina
Warner Bros.
Studios Facilities
4000 Warner Boulevard,
Building 17, Room 206
Burbank, CA 91522

Michael Miller
IATSE
10045 Riverside Drive
Toluca Lake, CA 91602

Diane Mirowski
AMPTP
15301 Ventura Boulevard,
Building E
Sherman Oaks, CA 91403

Rebecca Rhine
Local 600
7755 Sunset Boulevard
Hollywood, CA 90046

Michael Rosenfeld
The Walt Disney Company
500 South Buena Vista
ROD Building, Suite 310
Burbank, CA 91521

Joseph Scudiero
Entertainment Partners
2950 North
Hollywood Way
Burbank, CA 91505

Joshua Staheli
Local 399
4747 Vineland Avenue
North Hollywood,
CA 91602

Rachel M. Stanley
Local 892
3919 West Magnolia Blvd.
Burbank, CA 91505

Index

These Appendices are intended to outline any differences between the Plan and your benefits. These Appendices, plus the information contained in the *SPD*, constitute your *Summary Plan Description.*

MOTION PICTURE INDUSTRY HEALTH PLAN

HEALTH BENEFITS APPENDIX

Notes

Local 52

ACTIVE FORMER EAST COAST LOCAL 52 WELFARE FUND PARTICIPANTS

DEAR ACTIVE PARTICIPANT:

This Appendix is for those eligible Local 52 Welfare Fund Participants who became Participants of the Motion Picture Industry Health Plan ("Plan") on January 1, 2004 ("Merger Date"), the effective date of the merger between the two plans. This Appendix explains your health benefits where they differ from the Plan of benefits because of the merger transition, and is part of your *SPD*. You should also retain your Local 52 Welfare Fund Summary Plan Description, as some of those rules are relevant.

If you have any questions about your benefits, you may call either Plan Office.

Sincerely,

BOARD OF DIRECTORS
Motion Picture Industry Health Plan

The nature and extent of benefits provided by the Plan and the rules governing eligibility are determined solely and exclusively by the Board of Directors of the Plan, consistent with applicable law. The Board of Directors shall also have full discretion and authority to interpret the plan of benefits and to decide any factual question related to eligibility for and the extent of benefits provided by the Plan, consistent with applicable law.

Employees of the Plan have no authority to alter benefits or eligibility rules. Any interpretations or opinions given by Employees of the Plan are not binding upon the Board of Directors and cannot increase or change such benefits or eligibility rules. In accordance with the terms of the Trust Agreement, the Board of Directors reserve the right to change the nature and extent of benefits provided by the Plan and to amend the rules governing eligibility at any time, consistent with applicable law.

MERGER TRANSITION RULES

Benefit Maximums

The benefit you received prior to the Merger Date shall be applied, if practical, as determined by the Plan against any benefit maximum established by the Plan whether such maximum is determined on an Eligibility Period, lifetime basis or any other period of time.

Eligibility for Retiree Health Under the Plan Rules

If you retire on or after January 1, 2004, you will qualify for Retiree Health Benefits if you meet the requirements for Qualifying Years and hours. Generally, for periods prior to the Merger Date, your days and years under the Local 52 Pension Plan will count toward eligibility for Retiree Health coverage. Your Local 52 pension days will be converted to hours by multiplying the number of days by 12. The formula for calculating Qualification Years is summarized in the document "Important Information for Participants in the Local 52, IATSE Pension Fund and Reserve (Annuity) Fund," sent to you at the time of the merger. However, for hours worked from January 1, 1997 to December 31, 2003 under a Local 52 Collective Bargaining Agreement that did not provide for pension contributions to the Local 52 Pension Fund, Local 52 Welfare Fund hours for which contributions were paid shall count toward Retiree Health eligibility through the Plan.

Local 161

ACTIVE FORMER EAST COAST LOCAL 161 WELFARE FUND PARTICIPANTS

DEAR ACTIVE PARTICIPANT:

The Appendix is for those eligible Local 161 Welfare Fund Participants who became Participants of the Motion Picture Industry Health Plan (MPIHP) on January 1, 2005 ("Merger Date"), the effective date of the merger between the two plans. This group consists of Active Participants of the Local 161 Welfare Fund who resided in New York, New Jersey or Connecticut as of December 31, 2004, based on the last records on file with the Local 161 Welfare Fund.

This Appendix explains eligibility and health benefits issues where they differ from those contained in the general *SPD*, and is part of your *SPD*. You should also retain your Local 161 Welfare Fund Summary Plan Description, as some of those rules are relevant.

If you have any questions about your benefits, you may call either Plan Office.

Sincerely,

BOARD OF DIRECTORS
Motion Picture Industry Health Plan

The nature and extent of benefits provided by the Plan and the rules governing eligibility are determined solely and exclusively by the Board of Directors of the Plan, consistent with applicable law. The Board of Directors shall also have full discretion and authority to interpret the Plan of benefits and to decide any factual question related to eligibility for and the extent of benefits provided by the Plan, consistent with applicable law.

Employees of the Plan have no authority to alter benefits or eligibility rules. Any interpretations or opinions given by Employees of the Plan are not binding upon the Board of Directors and cannot enlarge or change such benefits or eligibility rules. In accordance with the terms of the Trust Agreement, the Board of Directors reserve the right to change the nature and extent of benefits provided by the Plan and to amend the rules governing eligibility at any time, consistent with applicable law.

MERGER TRANSITION RULES

Carryover Bank of Hours

Your bank of hours with the Local 161 Welfare Fund was based on credited days worked through December 31, 2003, minus any such credited days used for acquiring coverage with the Local 161Welfare Fund for the period from April 1, 2004 through March 31, 2005. You were allowed to carry over to the Plan up to (but no more than) 300 hours of that 161 bank ("Carryover Bank.") A "credited day" was equivalent to 12 hours. If less than 300 hours were in the Carryover Bank, the lesser amount was carried over. The Carryover Bank may be used for acquiring coverage for the Plan Eligibility Periods commencing on or after January 1, 2005. However, the use of such hours is subject to all general Plan rules with respect to banked hours. You could begin banking hours under the Plan commencing in the Qualifying Period running from April 25, 2004 through October 23, 2004, under the general Plan rules.

Retiring on or After January 1, 2005

If you retire on or after January 1, 2005, you will qualify for Retiree Health Benefits if you meet the Retiree Health Plan requirements for Qualifying Years and hours. These general requirements are described in your *SPD*. Generally, for periods prior to the Merger Date, your days and years under the 161 Pension Fund will count toward eligibility for the Plan.

Local 600 (644) / 666

ACTIVE FORMER EAST COAST LOCAL 600 (644)/666 WELFARE FUND PARTICIPANTS

DEAR ACTIVE PARTICIPANT:

The former Local 666 IATSE Pension and Welfare Funds, and the former Local 600 Pension and Welfare Funds (formerly Local 644), merged with the Motion Picture Industry Pension & Health Plans, effective January 1, 1999 ("Merger Date").

This Appendix is intended to outline any differences between the Plan and your benefits. This Appendix, plus the information contained in the *SPD*, constitute your summary plan description.

If you have any questions about your benefits, you may call the Plan Office.

Sincerely,

BOARD OF DIRECTORS
Motion Picture Industry Health Plan

The nature and extent of benefits provided by the Plan and the rules governing eligibility are determined solely and exclusively by the Board of Directors of the Plan, consistent with applicable law. The Board of Directors shall also have full discretion and authority to interpret the Plan of benefits and to decide any factual question related to eligibility for and the extent of benefits provided by the Plan, consistent with applicable law.

Employees of the Plan have no authority to alter benefits or eligibility rules. Any interpretations or opinions given by Employees of the Plan are not binding upon the Board of Directors and cannot increase or change such benefits or eligibility rules. In accordance with the terms of the Trust Agreement, the Board of Directors reserve the right to change the nature and extent of benefits provided by the Plan and to amend the rules governing eligibility at any time, consistent with applicable law.

MERGER TRANSITION RULES

Benefit Maximums

The benefit you received prior to the Merger Date shall not be applied against any benefit maximum established by the Plan, whether such maximum is determined on an Eligibility Period, lifetime basis or any other period of time.

Eligibility for Retiree Health Under the Plan Rules

If you meet the Plan rules for Retiree Health Benefits, you will receive the benefits provided in your *Summary Plan Description for the Motion Picture Industry Health Plan for Retired Participants*. The Plan's general rules for Retiree Health eligibility are provided in your *SPD*.

The calculation of Qualifying Years and hours completed toward satisfying the eligibility rules for retiree benefits under the Plan shall be determined under the merger rules provided in the "Pension Plan Merger and Defined Contribution Plan Agreements," for all periods ending prior to the Merger Date. In general, your hours and years with the Local Fund will count toward eligibility for the Plan's retiree coverage. These rules are summarized in the documents "Important Information for Participants in The International Photographers Local 600 Pension Fund" and "Important Information for Participants in the International Cameramen's Local 666 Pension Fund," previously furnished to you, as applicable.

Local 700

ACTIVE FORMER EAST COAST LOCAL 700 WELFARE FUND PARTICIPANTS

DEAR ACTIVE PARTICIPANT:

Effective as of the close of business June 30, 2002 ("Merger Date"), the Local 700 Editors (NY) Film Producers Welfare Fund ("Local 700 Welfare Fund") merged into the Motion Picture Industry Health Plan ("Plan"). Effective July 1, 2002, Participants of the Local 700 Welfare Fund who were eligible (as explained below) received the benefits provided by the Plan to all Participants and were subject to the rules of the Plan, except as set forth below. Please familiarize yourself with the enclosed *SPD* as well as the remaining transition rules on the following page. You should also retain your last Local 700 Welfare Fund Summary Plan Description, as some of those rules may be relevant.

If you have any questions about your benefits, you may call the Plan Office.

Sincerely,

BOARD OF DIRECTORS
Motion Picture Industry Health Plan

The nature and extent of benefits provided by the Plan and the rules governing eligibility are determined solely and exclusively by the Board of Directors of the Plan, consistent with applicable law. The Board of Directors shall also have full discretion and authority to interpret the Plan of benefits and to decide any factual question related to eligibility for and the extent of benefits provided by the Plan, consistent with applicable law.

Employees of the Plan have no authority to alter benefits or eligibility rules. Any interpretations or opinions given by Employees of the Plan are not binding upon the Board of Directors and cannot increase or change such benefits or eligibility rules. In accordance with the terms of the Trust Agreement, the Board of Directors reserve the right to change the nature and extent of benefits provided by the Plan and to amend the rules governing eligibility at any time, consistent with applicable law.

MERGER TRANSITION RULES

Banking of Hours

Local 700 Participants may have banked dollar credits, from before the Merger Date, that were converted from dollars to hours at the rate of one hour for each $5 in the bank. Ordinarily, the Plan does not permit banking of hours beyond 450. Nevertheless, any 700 Fund Bank converted credits over 450 hours were banked with the Plan and kept until used. After July 1, 2002, additional hours cannot be banked until the Local 700 Participant's bank balance drops below the Plan's 450 hour limit.

Special 1979 Bank

Certain Local 700 Participants were previously given a special one-time grant in 1979 that could only be used in the event that:

ⓐ they did not have sufficient hours to continue their eligibility or

ⓑ they had no existing normal bank. All such Special Bank dollars were converted to hours at the rate of $5 equaling one hour as set forth in Paragraph 1, above.

Benefit Maximums

The benefits you received prior to the Merger Date shall be applied, if practical, as determined by the Plan against any benefit maximum established by Plan whether such maximum is determined on an Eligibility Period, lifetime basis or any other period of time.

Eligibility for Retiree Health Under the Plan Rules

The Plan's general rules for Retiree Health eligibility are provided in your *SPD*. However, for periods prior to the Merger Date, there are special rules for calculating Qualifying Years and hours for Retiree Health Benefit. Generally, for periods prior to July 1, 2002, your hours and years under the Local 700 Pension Fund will count toward eligibility for Retiree Health coverage. The specific calculation rules are contained in the "Pension Plan Merger Agreement" (and summarized in the "Important Information for Participants in the Local 700 Editors (NY) – Film Producers Pension Fund" previously furnished to you).

Retiree Health Subsidy

Local 700 Participants who were at least age 50 and had at least five Pension Credits under the Local 700 Pension Plan as of July 1, 2002, and who do not qualify for Retiree Health Benefits under the Plan rules when they retire, may qualify and receive the Retiree Health Benefits if they meet the pre-merger Local 700 Welfare Plan eligibility rules and pay the same subsidy percentage required under the Local 700 Welfare Plan rules. If you are eligible for this subsidy, you will pay 50% of the self-pay rate if you had 10 or more pension credits as of the Merger Date; and 75% of the self-pay rate if you had less than 10 pension credits as of the Merger Date. If such Participant also qualifies for Retiree Health Benefits under the Plan, the retiree benefit payable shall be determined solely under the Plan rules.

Notes

MPI
MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS™

MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS™

PARTICIPANT SERVICES CENTER

Email
service@mpiphp.org

Call Toll-Free
(855) ASK-4MPI or
(855) 275-4674
Hours: 6 am to 7 pm
(Pacific Time)

Fax
(818) 766-1229 – California
(212) 634-4952 – New York

Website
www.mpiphp.org

Mailing Address
MPIPHP
P.O. Box 1999
Studio City, CA 91614-0999

Office Locations
11365 Ventura Boulevard
Studio City, California 91604
(818) 769-0007
Hours: 8 am to 5 pm
(Pacific Time)

145 Hudson Street, Suite 6-A
New York, New York 10013
(212) 634-5252
(888) 758-5200 – Toll Free
Hours: 9 am to 5 pm
(Eastern Time)