ACTIVE SUMMARY PLAN DESCRIPTION

October 2013

The Plan maintains administrative offices in California and New York. Our West Coast Plan 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 Plan Office, our main Health Plan Office, and remember to include the Participant’s Social Security or identification number.

California (Main) Office
11365 Ventura Blvd.; P.O. Box 1999
Studio City, CA 91614-0999
Main Phone: 855.ASK.4MPI
(855.275.4674)
Main Fax: 818.508.4714

New York Office
145 Hudson St., Suite 6A
New York, NY 10013-2103
Main Phone: 212.634.5252
Main Fax: 212.634.4952

Website: www.mpiphp.org

For information regarding Pension Benefits, please contact the Motion Picture Industry Pension Plan at the California Plan Office number listed above.
Dear Eligible 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 “MPI Health Plan,” or the “Plan”) and to provide you with this guide to the comprehensive Plan available to you and your eligible Dependents.

As an eligible Active Participant, you have an extensive package of benefits that includes comprehensive medical, hospital, prescription drug, vision, dental, and life insurance coverage. In addition, our contracted wellness program offers you preventive screenings and educational programs.

You also have a range of choices. The MPI Health Plan offers our Preferred Provider Organization (PPO), which provides comprehensive medical and hospital coverage throughout the country. Those who reside in California also have a choice of one of two Health Maintenance Organization (HMO) plans offered through Health Net® and Kaiser Permanente®. On the East Coast, Oxford Health Plans® (a Point of Service Plan or POS) is an option. If you select an HMO or the POS plan for your health benefits, the Evidence of Coverage you receive upon enrollment with the Plan or with this Summary Plan Description will become part of your Summary Plan Description. There are also two dental plan options: Delta Dental PPO, available nationwide, and DeltaCare® USA, available to those who reside in California.

Under the Plan’s umbrella of benefits, there are various Provider networks available to you depending upon the options you select. A list of the members of the network(s) you may choose from will be provided upon your request at no cost to you. Information on the Provider network members, e.g., doctors, hospitals, etc., is also available on the respective network websites. (See inside back cover for a complete list of their website addresses.)

This book, our Summary Plan Description (SPD), includes important information to help you understand and appropriately access your benefits. As much as possible, it is written in plain language. However, for legal reasons, we must sometimes use insurance industry and legal terms or phrases. For your reference, we have created a Glossary, located at the back of this book on page 132.

We developed our Summary Plan Description to explain the Motion Picture Industry Health Plan, its restrictions and responsibilities. We make no recommendations regarding the use of any of the options offered, but provide this information for you to select the plans most suited to your needs. For your convenience, we have included comparison charts on pages 32-38 for medical and hospital benefits, and on page 100 for dental plans.

If you have selected the PPO medical and hospital benefits provided by the MPI Health Plan, benefit details are included in this Summary Plan Description. If you have selected an HMO or POS plan, only a summary is included in this book in the section entitled “Health Plan Alternatives.” You may obtain more comprehensive information regarding the benefits available to you by referring to your Evidence of Coverage or by contacting the HMO or POS plan directly.

Throughout the Summary Plan Description, you will find phone numbers, addresses, and websites where you can get further information and answers to your questions regarding any of the benefits offered. Please don’t hesitate to contact us or the Provider networks directly.

Thank you for your participation.

The Board of Directors
Motion Picture Industry Health Plan
MOTION PICTURE INDUSTRY HEALTH PLAN

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Cheiron
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The information in this Summary Plan Description (SPD) is effective for expenses incurred on or after October 1, 2013, and supersedes and replaces all similar information previously issued. A separate SPD is available for the Motion Picture Health Plan for Retired Participants.

The Plan is operated under the provisions of an Agreement and Declaration of Trust, and all benefits provided are subject to the terms of the Trust, this Summary Plan Description and the Group Master Contracts issued by the Union Labor Life Insurance Company covering life insurance, Anthem® Blue Cross, Health Net®, Kaiser Permanente®, Oxford Health Plans®, Delta Dental PPO, DeltaCare® USA, Express Scripts® (prescription drugs), and Vision Service Plan®, which together constitute the Plan documents. The contracts have been issued to the Executive Administrator on behalf of the Directors. The terms of these documents will prevail in the interpretation of questions concerning any subject matter covered in this SPD.

The nature and extent of benefits provided by the Plan and the rules governing eligibility are determined solely and exclusively by the Directors of the Plan. The Directors shall also have full discretion and authority to interpret the Plan and to decide any factual questions related to eligibility for and the extent of benefits provided by the Plan. 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 Directors and cannot enlarge or change such benefits or eligibility rules. In accordance with the terms of the Trust Agreement, the 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 Motion Picture Industry Health Plan for Active Participants is considered a “grandfathered” health plan under the Patient Protection and Affordable Care Act (the “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 limits on benefits).

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the MPI Participant Services Center at 855.ASK.4MPI (855.275.4674). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866.444.3272 or visit 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.

Are you a former Participant of any other health plan that merged into the Motion Picture Industry Health Plan? If so, it is important that you carefully review any appendix included with this Summary Plan Description (SPD) which addresses your particular situation. That appendix may contain special rules that are different from the rules contained in the main SPD. Where there is any conflict between the terms of the appendix and the main SPD, the terms of the appendix will govern you and your Dependents.
Qualifying for Health Benefits
Page 3
Health coverage in the Motion Picture Industry Health Plan (MPIHP) is contingent upon your Employer(s) making the appropriate contributions to the Plan in accordance with the Trust Agreement.

Qualifying and Eligibility Periods
Page 5
Eligibility for six-month Benefit Periods is determined on a rolling monthly basis.

Initial Eligibility
Page 6
If you have never been eligible before or have not been eligible for benefits in any of the five (or more) prior consecutive six-month Eligibility Periods, you may become eligible for benefits:

• In an Eligibility Period subsequent to a Qualifying Period in which you have earned a minimum of 600 hours, or

• After you have earned a combined total of at least 600 hours in two consecutive Qualifying Periods, you may become eligible for benefits in the Eligibility Period subsequent to the second Qualifying Period.

It is critical for newly eligible Participants to promptly respond to all Plan requests for information. Enrollment cannot be completed until all required documentation is received by the Plan. Hours in excess of 600 earned during Qualifying Period(s) for Initial Eligibility are not credited to a Bank of Hours.

Continuing Eligibility
Page 6
Once you have met the requirements for Initial Eligibility, you will be eligible for benefits in each subsequent six-month Eligibility Period, provided that you work, or are on a weekly guarantee for, the minimum number of hours required to maintain your health benefits eligibility. Your eligibility will not be reviewed again until your current benefits expire.

Premium Payments
Page 7
Effective January 1, 2013, quarterly Premiums are required for all Dependents and some Participants. Failure to make payment in a timely manner will terminate your coverage.

Eligible Dependent Family Members
Page 8
Application must be made by the Participant to determine eligibility for ALL Dependent family members. Birth certificates, marriage certificates, spousal coordination of benefit forms and/or other forms of documentation (e.g., divorce/custody documents) are required to make this determination.

Medical and Dental Plan Selection
Page 11
You have a choice of medical/hospital and dental plans. In addition, you will receive vision benefits through Vision Service Plan and Prescription Drug Benefits through Express Scripts.

Open Enrollment
Page 13
The Open Enrollment period occurs throughout the month of July each year for Plan enrollment effective August 1. At that time, you may change your medical/hospital and/or dental coverage. Please Note: Enrollment in the MPIHP/Anthem Blue Cross and/or the Delta Dental PPO Dental Plan is open all year.

Bank of Hours
Page 15
For each Qualifying Period following Initial Eligibility, hours earned in excess of the minimum number required to maintain your health benefits eligibility will be credited to your Bank of Hours, up to a maximum of 450 hours.

Surviving Spouse Coverage
Page 25
If you die while an Active Participant, but you have met the requirements for Retiree Health, you will be considered a Retired Participant for the purpose of extended coverage for your eligible surviving Dependent(s).

Retiree Health Coverage
Page 26
The Motion Picture Industry Health Plan maintains a separate 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 a Participant or Retiree. Eligibility for Retiree Health Benefits is determined separately, based on hours contributed to the Retiree Plan.

Life Insurance
Page 111
Eligible Participants are covered by $10,000 in Life Insurance and $10,000 in Accidental Death and Dismemberment Insurance.

Things to Remember
• Always let the Plan know if you or your Dependent(s) have other insurance coverage.

• The Plan Office needs to be notified in writing whenever you have a change of address, get married, get divorced, have a baby, etc.

• Be sure to have a current set of Health and Pension Plan Beneficiary Cards on file at the Plan Office.

• Pay required Premiums in a timely manner.

Please call us at 855.ASK.4MPI (855.275.4674) for a change of address card or new beneficiary cards. Remember, there are separate beneficiary cards for the Health and Pension Plans. Most of the Plan’s forms are also available on our website: www.mpiphp.org.
Summary Plan Description for Active Participants

Detailed contents of each major section are listed on the title page of that section. A subject index is located at the back of this Summary Plan Description on page 136.

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   7 Dependent Eligibility
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This section of the *Summary Plan Description* provides comprehensive information on the requirements to become and remain an eligible Active Participant of the Motion Picture Industry Health Plan, including information on eligibility extensions and retiree health coverage. It details basic requirements for eligibility for you and for Dependents, same-sex domestic partners and survivors of eligible Participants.

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BASIC REQUIREMENTS FOR PLAN ELIGIBILITY

Becoming and remaining an eligible Participant of the Plan requires that you work a sufficient number of hours in the Motion Picture Production Industry in a job covered by a Collective Bargaining Agreement between one of the participating Unions (see page 125) and any of the participating Employers or under a Non-Affiliate Agreement with a participating Employer. The Collective Bargaining Agreement or Non-Affiliate Agreement must require that contributions be made to the Plan on your behalf. All hours will be credited to the dates on which they were worked, except as noted under the "Grievance Settlement" section on page 4.

Participating Employers
The Plan Office determines, subject to audit, your eligibility for benefits based on reports of hours and contributions received from your Employer(s). To be approved for participation by the Plan’s Board of Directors and therefore eligible to contribute on your behalf, your 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 your 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. Again, your Employer is required to execute certain Plan documents in order to contribute through the payroll company on your behalf.

Non-Affiliated Employees
Some participating Employers also make contributions on behalf of Employees who are not covered by any Collective Bargaining Agreement (i.e., non-affiliated Employees), including certain producers and accountants. These Employers have signed a “Non-Affiliate Agreement” with the Plan. If you are not sure whether your Employer has signed a Non-Affiliate Agreement under which you may be covered or if you need to pay a Premium to obtain coverage, contact the Participant Services Center at 855.ASK.4MPI (855.275.4674).

Partners and Owners
Legally, owners and partners of unincorporated businesses are not considered “Employees” of the Employer. Therefore, although unincorporated businesses are allowed to become a party 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
If you are an officer or controlling Employee shareholder or the spouse of an officer or controlling Employee of a signatory Employer, you may participate in the Plan under the rules governing Employee shareholders. Similarly, if you are a member or officer of a Limited Liability Corporation (LLC) or the spouse of such a member or officer, you 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.) 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 with 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 be directly 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.

Employee Premiums
Some Participants of Employers, other than participating Employers, are required to pay quarterly Premiums in order to receive their own health coverage. Page 7 describes the amount of the Premium under Premium Rate Group 2. Pages 7 and 8 describe how to pay the Premium and the rules about late Premium payments.

Contributions
Contributions on your behalf can be accepted by the Plan only when your Employer has submitted all required documents to the Plan Office and has been approved for participation by the Plan’s Board of Directors. 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’s Participant Services Center at 855.ASK.4MPI (855.275.4674).

Although no deductions are made from your payroll check, the Plan recommends that you maintain your check stubs, deal memos, etc. in case any questions arise as to the number of hours your Employer has reported on your behalf.
If you believe there is a discrepancy between the hours you worked or were guaranteed and the hours in 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 Audit and Collections Department of the Plan at 855.ASK.4MPI (855.275.4674).

**Work Hours**

“Work Hours” are your 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 you are 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
- 67 hours during any six-day workweek
- 75 hours during any seven-day workweek

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 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 a 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.

**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. The credit will extend from that date until the contributions have all been applied, based upon the standard number of hours to have been worked by, or guaranteed to, the individual.
### Qualifying Periods for Monthly Health Eligibility

Eligibility for Active Health 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.

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<tr>
<th>Qualifying Periods</th>
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<td>Work 400 or more hours during this Period (see page 6)</td>
<td>Receive MPI Active health benefits during this Period (see page 6)</td>
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Please visit [www.mpiphp.org](http://www.mpiphp.org) and click on Qualifying Periods to see an extension of dates in the future.
Qualifying Standards
Eligibility for health benefits is contingent upon whether your 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 4. If you work on 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, 855.ASK.4MPI (855.275.4674), of the Plan can tell you the hourly requirements for you to be eligible under the Plan.

Initial Eligibility
The commencement of eligibility for six-month Benefit Periods 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. As an example of initial eligibility, if you began work on March 4, 2013 and reach 600 hours by June 14, 2013, then you would have satisfied the 600 hour requirement for the Qualifying Period of December 23, 2012 through June 22, 2013 and would be eligible for coverage for the Eligibility Period of September 1, 2013 through February 28, 2013.

Please Note: Excess hours earned for initial eligibility are NOT credited to your Bank of Hours.

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.

For example, if you earn 600 hours during the six consecutive Plan Months ending on June 22, 2013, you will be eligible for the six-month Eligibility Period from September 1, 2013 through February 28, 2014.

In order to be eligible for the next Eligibility Period, which would begin March 1, 2014, you would need to earn 400 hours (absent a recognized eligibility extension) during the Qualifying Period from June 23, 2013 through December 21, 2013.

If you don’t qualify for the Eligibility Period commencing March 1, 2014, your eligibility will automatically be reviewed again for the Eligibility Period commencing April 1, 2014 to determine whether you are eligible based on hours earned during the Qualifying Period consisting of the six consecutive Plan Months ending on January 25, 2014. Please see page 15 for details on continuing eligibility.

Eligibility Notification
When you become eligible, we will mail you information and materials about your participation in the Plan. If you are initially eligible, we will contact your Employer(s) and/or Union to obtain your mailing address; however, you may send us your contact information in advance – service@mpiphp.org.

You will be given a choice of hospital/medical and dental plans, which are described in individual sections of this Summary Plan Description.

1. “Benefit Period” means the six calendar months commencing the first day of the third month immediately following the applicable Qualifying Period.
2. “Eligibility Period” means the six month period of time in which Participants are eligible for the benefits of the MPI Health Plan.
3. “Qualifying Period” means the first six of the eight consecutive “Plans Months” immediately preceding the Benefit Period. For example, the applicable Qualifying Period for the Eligibility Period commencing May 1, 2012, was August 21, 2011 through February 18, 2012.
4. “Plan Month” means 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. For example, the Plan Month of July 2013 will end on July 20, 2013 (the Saturday before the last Thursday of July). The immediately following Plan Month will then begin on Sunday, July 21, 2013 and end on Saturday, August 24, 2013.
The following is a summary of the general Dependent eligibility rules. It is important to note, however, that a spouse, or same-sex domestic partner shall not be eligible for MPI Health Plan benefits if such person is required by the Plan to be enrolled (and is not enrolled) in a health plan offered by the spouse or same-sex domestic partner’s Employer. (Please read the Coordination of Benefits section, starting on page 50.)

Please be aware that application must be made and documents submitted by the Participant to determine eligibility for ALL Dependent family members and same-sex domestic partners.

### Premiums

**Premium Rate Group 1** applies to eligible Active Participants who elect to receive MPI Active health coverage for one or more of their Dependents and have $0.305 per hour of their Individual Account Plan contribution re-allocated to the MPI Active Employees Fund.

- For Participants with **1 Dependent**, the Premium is $25 per month, paid quarterly, semi-annually or annually.
- For Participants with **2 or more Dependents**, the Premium is $50 per month, paid quarterly, semi-annually or annually.

**A Participant in this group who does not enroll eligible Dependents will not be required to pay a Premium for his/her own coverage.**

**Premium Rate Group 2** applies to eligible Active Participants who do not have $0.305 per hour of their Individual Account Plan contribution re-allocated to the MPI Active Employees Fund or who do not participate in the MPI Individual Account Plan.

- **Participant-Only Premium**
  - For Participants with **no Dependents**, the Premium is $21 per month, paid quarterly, semi-annually, or annually.
- **Participant Plus Dependent(s) Premium**
  - For Participants with **1 Dependent**, the Premium is $44 per month, paid quarterly, semi-annually or annually.
  - For Participants with **2 or more Dependents**, the Premium is $68 per month, paid quarterly, semi-annually or annually.

Please contact the Participant Services Center at 855.ASK.4MPI (855.275.4674) if you have questions about which group you are in.

### Payment Options

MPI offers flexible payment options for Active Health 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 pre-pay annually. *(Please note that making an annual payment does not guarantee eligibility.)*

**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, 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.

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

### Proration of Premiums

Participants who are in the middle of an Eligibility Period on January 1, 2013, when the Premiums become effective, will be required to pay a prorated portion of the Premium. The amount of the proration will be based on the number of months the Participant and/or his/her eligible Dependent(s) would be covered in 2013 during that Eligibility Period.

For example, if the Eligibility Period ends on March 31, 2013, the Participant will be required to pay three months of Premiums for January, February and March in order to maintain his/her coverage (if in Group 2) and that of his/her eligible Dependent(s).

### Premiums for Dual MPI Coverage

Married or qualified same-sex domestic partner Participants who individually qualify for coverage through MPI must each pay the applicable Dependent Premium in order to receive dual coverage (with MPI being both primary and secondary coverage) for themselves and their eligible Dependent children.
Grace Period/Termination of Coverage
Prior to January 1, 2014, payments must be received no later than 15 days after the Payment Due Date. If payment has not been received within 30 days after the Payment Due Date, coverage for the individual(s) listed on the Notice will be terminated retroactively to the Payment Due Date. Participants who do not pay the appropriate Premium will be responsible for repayment of any overpayments (see page 48) made by MPI for expenses incurred on or after the Payment Due Date.

Beginning January 1, 2014, payments must be received by the Payment Due Date. If payment is not received timely, 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, coverage will be terminated retroactively to the Payment Due Date.

An individual whose coverage is terminated due to non-payment of Premiums may not be re-enrolled until the beginning of his/her next Eligibility Period, unless there is a Qualifying Life Event as defined by the IRS or the Participant is eligible for a Reinstatement of Coverage Exemption. (See below.)

Reinstatement of Coverage Exemption
Following termination of coverage due to non-payment of Premiums, MPI will allow a Participant to reinstate his/her eligibility, or that of his/her Dependent(s), prior to the beginning of his/her next Eligibility Period a maximum of one time every three years. The Participant will be required to 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.

For example, if a Participant’s or his/her Dependent’s coverage is terminated on January 1, 2014 for non-payment and subsequently approved for reinstatement on March 15, 2014, 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
If a new Dependent is added after an Eligibility Period has begun due to a Qualifying Life Event, the Participant will be required to pay the Premium for the full month in which the request is made plus Premiums for the remainder of the Eligibility Period. Coverage will begin on the date the payment is received.

For example, if a Participant is eligible January through June and adds a Dependent and makes the Premium payment on March 15th, the Participant would owe the Premium for the months of March through June and coverage would be effective March 15th.

If a Participant removes a Dependent during an Eligibility Period, he or she will receive credit 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 a Qualifying Life Event or the Participant is eligible for a Reinstatement of Coverage Exemption. (See above.)

Retroactive Coverage Due to Late Reported Hours
Participants awarded retroactive coverage due to an Employer compliance audit or late reported hours for any Eligibility Periods that include January 2013 or later will be required to pay the Participant and/or Dependent(s) Premiums retroactively to receive the coverage in the associated Eligibility Period.

Credit/Refunds
If a Participant pre-pays 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 pre-paid Premiums refunded to them must request a refund in writing.

COBRA Continuation Coverage
COBRA Continuation Coverage 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 is not a Qualifying Life Event and, therefore, is not eligible for COBRA coverage.

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

It is extremely important that you are aware of how coverage for your spouse or same-sex domestic partner is affected by primary and secondary insurance requirements. (See pages 50 and 51 for additional information regarding Spouse Coordination of Benefits for Participants in the MPIHP Anthem Blue Cross Health Plan Option.)

Your eligible Dependents are:
• Your lawful spouse
• Your qualified same-sex domestic partner (provided the requirements listed in this section are met)
• 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) are eligible for medical and prescription drug coverage until they reach the age of 26. If they are eligible for coverage through their own Employer, then they are not eligible for MPI coverage until January 1, 2014.
• Your unmarried children are eligible for dental and vision coverage until they reach the age of 19 (or 23 if a full-time student).
• Any child required to be recognized under a Qualified Medical Child Support Order (QMCSO).
Divorce Notification Requirements
You must notify the 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 COBRA, as described on page 18. If you fail to notify the Eligibility Department of a change in your marital status, and we pay a Claim for your former spouse for services rendered after the divorce date, you and your former spouse will be held personally liable for reimbursement to the Plan for benefits and 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.

Same-Sex Domestic Partner Coverage
Health Plan benefits are available to the same-sex domestic partners of Active and Retired Participants. If you are interested in obtaining same-sex domestic partner coverage, please contact the Plan Office so that we may send you an information and enrollment packet.

Definition of Same-Sex Domestic Partner
Prior to January 1, 2014, the rules governing coverage of same-sex domestic partners are similar to those applied to spouses of Participants, although there are several important distinctions, as outlined in this section. A domestic partnership, for purposes of coverage by the Plan, is defined as:

• A committed same-sex relationship similar to a marriage,
• Has been in existence for at least six months,
• Includes financial interdependence, and
• Both partners intend that the relationship be permanent
If you live in a jurisdiction that allows the registration of domestic partners, including California, you must be registered as domestic partners in that jurisdiction. For additional information, please contact the Participant Services Center at 855.ASK.MPI (855.275.4674).

On or after January 1, 2014, MPI will provide eligibility to the same-sex spouses of participants who have been legally married in the District of Columbia or a state or foreign jurisdiction in which same-sex marriage is recognized as legal, regardless of where the participant resides.

MPI will continue to provide health benefits for qualified unmarried same-sex domestic partners who are currently covered by the Plan and who reside in the District of Columbia or a state that recognizes same-sex marriage, until December 31, 2014. Effective January 1, 2015, coverage will not be provided unless the same-sex couple has legally married.

Coverage of same-sex domestic partners will continue to be provided on the same basis as in the past in jurisdictions that do not recognize same-sex marriages. If a same-sex couple residing in such a state moves to a state or other jurisdiction that does recognize same-sex marriages or if the state or other jurisdiction in which a same-sex couple lives changes its law so that same-sex marriages are recognized, the couple will have ninety (90) days to get married. At the end of that ninety (90) day period, coverage will cease for the non-participant partner unless the couple has married.

Both before and after January 1, 2014, your same-sex domestic partner will not be eligible if either you or your partner has a spouse or other domestic partner, or if you are related by blood closer than the law would permit for marriage.

Coverage Provided
In general, coverage for a same-sex domestic partner is the same as coverage provided for the spouse of a Participant. Coverage is available for your domestic partner’s children, if any, if they are also Dependents of the Participant. Your eligible Dependents are:

• 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) are eligible for medical and prescription drug coverage until they reach the age of 26. If they are eligible for coverage through their own Employer, then they are not eligible for MPI coverage until January 1, 2014.

• Your unmarried 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 dental and vision coverage until they reach the age of 19 (or 23 if a full-time student).

• Any child required to be recognized under a QMCSO.

As with coverage for spouses and Participants, if your same-sex domestic partner is covered by another health plan, please carefully read the Coordination of Benefits section on page 50 of this SPD.

Establishing Coverage
To establish coverage, both same-sex domestic partners must sign the Plan’s Affidavit of Domestic Partnership before a notary public and under penalty of perjury. In addition, you must provide to the Plan a completed Coordination of Benefits questionnaire and at least three* of the following items:

1. Domestic Partnership Agreement
2. Joint mortgage or lease
3. Designation of domestic partners as each other’s life insurance or retirement plan beneficiaries
4. Designation of domestic partners as each other’s primary beneficiary in will
5. Joint ownership of a motor vehicle, primary checking account or primary credit account
6. Other documentation, satisfactory to the Plan, confirming mutual financial support
California Resident Requirements
The Plan requires eligible California Participants wishing to obtain health coverage for their same-sex domestic partners to register their partnership with the Secretary of State in addition to completing the Plan’s Affidavit. Like the Plan’s Affidavit of Domestic Partnership, the State’s declaration must be signed by both partners before a notary public, under penalty of perjury. You may obtain Declaration forms from the county clerk or the office of the Secretary of State. The form is also available online at: www.sos.ca.gov/dpregistry/forms.htm#forms.

The Declaration form must be filed with the State of California (Secretary of State, P.O. Box 942877, Sacramento, CA 94277-0001; 916.653.3984). The Secretary of State will register the Declaration and return a copy of the registered form to the domestic partners. The Participant must submit a copy of the registered form to the Eligibility Department of the California Plan Office in order for it to be recognized.

Relevant Tax Laws and Costs
You or your domestic partner may have to pay the tax costs as a result of the Plan providing these benefits. If your domestic partner is your Dependent for tax purposes, the value of coverage will not be included in your taxable income. Generally, a Dependent is a member of your household who receives more than half of his or her support from you. If you Claim your domestic partner as a tax Dependent, the Plan will give you an affidavit in which you must state as such.

If your partner is not your tax Dependent, the relevant tax laws provide that you will owe federal taxes (including withholding taxes, such as Social Security) on the value of the coverage that the Plan provides to your domestic partner. You may also owe state taxes depending upon the laws of the state in which you reside. The reason for this is that the value of the coverage is considered wages for tax purposes. Accordingly, you must prepay taxes on the value of the coverage on a quarterly basis, including the Employer portion of any withholding taxes.

The Plan will provide a schedule by which you can determine the appropriate amount of tax based upon the type of health coverage provided. The Plan will send the Participant a Form 1099 in January for the prior year showing how much tax was paid for the benefits.

COBRA Costs
If you lose health coverage due to a reduction in hours, you may continue to self-pay the Premiums for yourself, your domestic partner, and your eligible Dependent children for a period of time under the Plan’s COBRA rules. COBRA coverage is not available to your domestic partner upon your death or the termination of the relationship. Your same-sex domestic partner will not have the option to individually self-pay under COBRA.

Termination of Same-Sex Domestic Partnership
You must notify the Plan in writing within ten days of the termination of your domestic partnership. Your partner will not be eligible for COBRA coverage after the termination of the partnership. Coverage for the domestic partner terminates at the end of the month in which the domestic partnership ends. If you fail to notify the Plan of the termination of your partnership, you and your domestic partner will be held liable to the Plan for benefits paid after the termination date.

Falsification of Status
If false or misleading information regarding the status of your domestic partner relationship is provided to the Plan, or if you fail to notify the Plan of the dissolution of your domestic partnership in a timely manner, both you and your domestic partner will be held jointly and individually responsible for reimbursement to the Plan of benefits and expenses, including attorneys’ fees and costs incurred by the Plan as a result of your statements, actions or failure to notify the Plan. In addition, filing a false affidavit with the Plan may be a criminal offense.

* California Residents: The California registration with the Secretary of State counts as one of these items.
**Medical and Dental Plan Selection**

In addition to prescription drug (Express Scripts) and vision (Vision Service Plan) plans, you have a choice of medical/hospital and dental plans. You will find comparisons between the various plans and descriptions of each in this *Summary Plan Description*. The Directors make no recommendation of the plans, but make them available so that you may select the plan most suited to your needs. *Note: If you or your Dependent(s) are covered by any other group health plan, please carefully read the Coordination of Benefits section of this SPD.*

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**Your Plan Options**

You may select only one medical/hospital plan and one dental plan.

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<thead>
<tr>
<th>Medical/Hospital Plans</th>
<th>Dental Plans</th>
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<tbody>
<tr>
<td>Motion Picture Industry Health Plan/Anthem Blue Cross*</td>
<td>Delta Dental PPO Dental Plan*</td>
</tr>
<tr>
<td>Health Net**</td>
<td>DeltaCare USA Dental Health Plan**</td>
</tr>
<tr>
<td>Kaiser Permanente**</td>
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<tr>
<td>Oxford Health Plans***</td>
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</tbody>
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**Medical Plan Selection for the Newly Eligible**

When you first become eligible for benefits and return the Beneficiary/Enrollment card to the Plan Office, you will be enrolled and covered by the Motion Picture Industry Health Plan/Anthem Blue Cross Plan.

If you decide to select Health Net, Kaiser Permanente, or the Oxford Health Plans, your coverage with that plan will be effective the first of the month following the receipt of your completed enrollment form. Until your HMO or POS coverage is effective, you will be covered by the Motion Picture Industry Health Plan/Anthem Blue Cross.

If you are already covered in Health Net, Kaiser Permanente, or the Oxford Health Plans through some other group or individual plan, you can be enrolled in that plan from the first month of your eligibility. 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 & dismemberment insurance, dental, vision care, and prescription drug benefits will not be affected by your choice of medical/hospital plan.

With the exception of chiropractic care, hearing aids, 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 selected by the Participant. The Wellness Program is available only in Southern California. However, printed educational/information materials are available to all Participants.

**Dental Plan Selection for the Newly Eligible**

When you first become eligible for benefits and return the Beneficiary/Enrollment card to the Plan Office, you will be enrolled and covered by the Delta Dental PPO Dental Plan. If you choose to select the pre-paid 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 pre-paid dental coverage is effective, you will be covered by the Delta Dental PPO Dental Plan.

Your selected plan will remain the same unless you select a different plan during Open Enrollment, held in July of each year.

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*MPI coverage offered residents living throughout the country.*  
**MPI coverage offered to residents living in California only.*  
***MPI coverage offered to residents living in New York, New Jersey and Connecticut only.*
Initial Eligibility Packet
Approximately two weeks prior to your eligibility effective date, the Plan will send you a packet containing a Summary Plan Description (SPD), a selection form to enroll in your choice of medical/hospital and dental plans, and a Beneficiary/Enrollment card to enroll your Dependents and designate the beneficiary(ies) of your life insurance.

No benefit cards can be provided and no Claims can be paid until you return all of your required enrollment documents.

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.

Continuing Eligibility
If you continue to be eligible for a subsequent six-month Eligibility Period, you will receive a new Premium Notice approximately 30 to 60 days prior to the Eligibility Period. If you do not meet the eligibility requirement for continuing eligibility, you will not receive a Premium Notice. If you believe there is any discrepancy between your hours worked and the hours reported on your statement of hours, as reported on the Plan’s web site, you must first attempt to resolve the discrepancy with your Employer(s) before the Plan can take action.

In the event it has been revised, a Summary Plan Description (SPD) may also be sent to you.

Benefit Cards - Motion Picture Industry Health Plan/Anthem Blue Cross/Dental/Prescription
If you select the Motion Picture Industry Health Plan (MPIHP)/Anthem Blue Cross Health Plan, then Anthem Blue Cross will send you two benefit identification cards.

If you need additional cards, you must submit a written request to the Eligibility Department. This request must be signed by the Participant and identified by the Participant’s Social Security or identification number before additional cards will be issued.

Benefit Cards - Alternate Health Plans
If you select a plan other than MPIHP/Anthem Blue Cross, your medical/hospital benefit cards will be issued directly from that plan: Health Net, Kaiser Permanente or Oxford Health Plans, whichever you choose. Your prescription drug benefit cards will be sent to you from the MPI Health Plan Office.

Benefit Cards - Dental
Dental enrollment information is provided on the identification cards issued by the Plan Office. If you select the pre-paid dental plan, an additional dental benefit card will be issued directly from DeltaCare USA.

Loss of Benefit Cards
Please report the loss of your card(s) to the Participant Services Center at 855.ASK.4MPI (855.ASK.4MPI (855.275.4674).

To report the loss of an HMO/POS benefit card, call your chosen plan:

- Health Net: 800.522.0088
- Kaiser Permanente: 800.464.4000
- Oxford Health Plans: 800.444.6222
Beneficiary/Enrollment Card
Upon qualification for Initial Eligibility, you will be sent a beneficiary/enrollment card that is used to enroll your Dependents and designate the beneficiary(ies) of your life insurance. You must complete and return this enrollment card. Benefit cards will not be issued, and no Claims can be paid until you return your beneficiary/enrollment card.

Open Enrollment
The Open Enrollment period occurs throughout the month of July each year for Plan enrollment effective August 1. At that time, you may change your medical/hospital and/or dental coverage. Please Note: Enrollment for the MPIHP/Anthem Blue Cross and/or 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 health coverage and you later lose that other coverage, you may be able to enroll yourself or your Dependents in this Plan.

Your loss of other health insurance coverage qualifies for 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
• You or your Dependent(s) lost your other coverage either because you exhausted your rights to COBRA continuation coverage, or you no longer were eligible under that plan, or the Employer stops contributing towards your or your Dependents’ 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 Dependents if you provide notice 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 this Plan, coverage will be retroactively effective to the date of the birth, adoption, or marriage, whichever is applicable, unless the Participant is ineligible on those dates.

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

Either you or your Dependent is covered under a Medicaid plan or a state child health plan, and coverage of yourself or your Dependent is terminated under that plan as a result of loss of eligibility for coverage, and you request coverage under this Plan within 60 days after the date of that termination.

Also, if you or your Dependents are 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 Dependents in the Plan if they are not already enrolled.

Required Dependent Documentation
In addition to completion of the Beneficiary/Enrollment card, application must be made to the Eligibility Department to determine eligibility for coverage of all Dependent family members. Copies of birth certificates, marriage certificates, spousal Coordination of Benefits forms (see page 50 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 Health and Pension Plans are notified of any changes made by the completion of new Beneficiary/Enrollment cards and the submission of required documentation. If your Dependents or beneficiary(ies) change, contact the Eligibility Department immediately, and you will be sent new cards. Revised Beneficiary/Enrollment cards 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 Eligibility Department by using the Change of Address form that can be obtained from the Participant Services Center or the MPIHP website. However, please be aware that if you provide change of address information in any other way, including by marking on a Claim form that your address has changed, 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.

The Social Security or 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 do not return this form, you will be automatically enrolled in the MPIHP/Anthem Blue Cross Health Plan and the Delta Dental PPO Dental 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, 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 in the next section, you will be sent a Notice of Ineligibility along with information relevant to extending your coverage.
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 explained in the next section;
2. The Plan is terminated; or
3. You fail to pay any required Premium.

Coverage for your Dependents will end on the earliest of the following:

1. The date you lose 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. You fail to pay any required Premium for Dependent coverage.

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 on the 15th of each month 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.

Certificate of Creditable Coverage

You and/or your covered Dependents are entitled by law to have, and will be provided with, a certificate of creditable coverage. Certificates of Creditable Coverage indicate the period of time you and/or your Dependent(s) were covered under the Plan (including, if applicable, COBRA coverage), as well as certain additional information required by law.

This certificate may be necessary if you and/or your Dependent(s) become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered Dependent(s) a health insurance policy within 63 days after your coverage under this Plan ends. The certificate is necessary because it may reduce any Exclusion for pre-existing conditions that may apply to you and/or your covered Dependent(s) under a new group health plan or health insurance policy.

This certificate will be provided to you shortly after this Plan knows, or has reason to know, that coverage (including COBRA coverage) for you and/or your covered Dependent(s) has ended. This certificate will also be provided once the Plan Office receives a request for this certificate, provided that the Plan Office receives the request within two years after the later of the date that your coverage under this Plan ended or the date your COBRA coverage ended.

The certificate will be sent to you (or to any of your covered Dependent(s) by first class mail shortly after your or their coverage under this Plan ends. If you (or any of your covered Dependent(s) elect COBRA coverage, another certificate will be sent to you or your Dependent(s) if COBRA coverage is provided only to them, by first class mail shortly after the COBRA coverage ends for any reason.

Please address all requests for Certificates of Creditable Coverage To:
Participant Services Center
Attn: Eligibility
Motion Picture Industry Health Plan
P.O. Box 1999
Studio City, CA 91614-0999
855.ASK.4MPI (855.275.4674)
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 reach the amount needed to establish eligibility for the new Benefit Period will be automatically withdrawn beginning January 1, 2013. Any remaining hours will stay in your bank for subsequent eligibility. In each subsequent Qualifying Period, if the combination of hours worked and bank hours equals or exceeds the required amount, you will remain eligible.

However, if hours worked and bank hours do not equal the required amount, all remaining bank 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 on page 6.

You will receive notice of the automatic use of your bank hours with your Premium notice. It will be shown on your Statement of Hours report. If you do not have to pay Premiums, but your Bank of Hours is being used so that you can remain eligible, then you will receive a notification and the Statement of Hours report. 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.

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

If you fail to work at least 400 hours in a Qualifying Period beginning on or after August 21, 2011, due to a family or medical leave covered by FMLA, your leave time, up to 12 workweeks 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 leave shall also count toward this 1,250-hour requirement. (See page 22 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. For 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 Eligibility Department of the fact that you lost hours 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.

Emergency Leave
Emergency leave is only available if you were working at a work site where 50 or more Employees worked within a 75-mile radius at the time you requested your leave. To be eligible for emergency leave, you must meet the following conditions:

1. You were working for a participating Employer covered under Chapter 315 of the California Labor Code (CFRA) and any other state law.
2. 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.
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. 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.
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.

If you meet all of the above conditions, you will be credited with the hours which you would have worked prior to the job elimination.
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.

Note: 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
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. Below is a brief chart describing the different extension types.

Short-Term Disability – Six Months
If you lost eligibility because you were unable to work due to an illness or injury requiring a doctor’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.

<table>
<thead>
<tr>
<th>Type</th>
<th>Short-Term</th>
<th>Long-Term</th>
<th>Permanent (10/10/Disability)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>• Unable to work because of illness or injury requiring doctor’s care</td>
<td>• Unable to work at your normal occupation or perform similar job functions</td>
<td>• Totally and permanently disabled</td>
</tr>
<tr>
<td>Length of Extension</td>
<td>• Six months</td>
<td>• Maximum 18 months, but reduced by a Short-Term Disability extension and/or COBRA</td>
<td>• Lifetime</td>
</tr>
<tr>
<td>Effective Date of Disability</td>
<td>• Disability must occur within 90 days of your last reported hours</td>
<td>• Disability must exist at the time eligibility terminated</td>
<td>• Must be disabled at the time of retirement</td>
</tr>
</tbody>
</table>
| Qualifications        | • Must collect State Disability (SDI) benefits or provide other proof if there is no SDI in your state  
                       | • 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 | • Proof of disability required  
                       | • Certification from Medical Director  
                       | • Not available to HMO Participants but Participants can change to the MPIHP/Anthem Blue Cross Plan | • Ten Qualified Years/10,000 hours, regardless of age  
                       | • Retire under Pension Disability requirements  
                       | • Social Security Award, or if over age, certification by Medical Director |
| Benefits              | • Full Benefits                    | • Comprehensive medical and prescription only  
                       | • No hospital, vision, dental or life insurance | • All Retiree Health benefits |
| Dependent Coverage    | • Dependents are covered           | • Dependents are not covered                   | • Dependents are covered     |
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 complete and return the form along with 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. If the state in which you live does not have state disability, the Plan will require other such proof of disability as it deems reasonable.

Notice Regarding Short-Term Disability Extensions
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—credited hours—they are two separate extensions and each has its own set of rules. Excess disability hours are not credited to the Bank of Hours.

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

Long-Term Disability - 18 Months
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 comprehensive medical and prescription benefits under the MPIHP/Anthem Blue Cross Plan. Hospital, vision, dental and life insurance benefits are not included in this extension.

Your Dependents are not covered under this extension. However, they can continue their medical/hospital, 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 Medical Review Department before this extension may be granted.

A Long-Term Disability extension applies during continuous disability for a maximum of 18 months. If you have received COBRA and/or 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 MPIHP/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.

Note: Your maximum COBRA coverage period will be reduced by the term of your Long-Term Disability extension. If you are entitled to only 18 months of COBRA coverage and you receive an 18-month Long-Term Disability extension, COBRA coverage will not apply when the Long-Term Disability extension has terminated. However, if you are entitled to 29 months of COBRA coverage and you received an 18 month Long-Term Disability extension, an additional 11 months of COBRA coverage may be available after the Long-Term Disability extension has terminated. See the discussion of “COBRA Continuation Coverage in Cases of Disability” on page 19 for more information.

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.

Permanent Disability Extension - Retirement
If you retire under the Disability Pension requirements of the Motion Picture Industry Pension Plan, you will be entitled to Retiree Health Benefits effective on the date of your retiree certification, regardless of age if you meet the requirements as described below.

You may retire under this provision if you have a minimum of ten Qualified Years and 10,000 Hours for which contributions have been paid to the Retiree Health Plan, are totally and permanently disabled at the time of your retirement AND

1. You are eligible to retire and have retired under the Disability Pension provisions of the Motion Picture Industry Pension Plan; or
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 Health Plan benefits effective on the date of your certification as being totally and permanently disabled by the Plans’ Medical Review Department; or
3. You meet all of the requirements for such a Disability Pension but are not a Participant in the Motion Picture Industry Pension Plan.
What is COBRA Coverage?
COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying 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, COBRA 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 coverage.

Who is Entitled to Elect COBRA?
For Participants
COBRA continuation coverage 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 continuation coverage 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 Coverage
The Plan office is responsible for administering COBRA coverage. In order to have the option to elect COBRA coverage 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. That notice should be sent to:

Participant Services Center
Attn: Eligibility
Motion Picture Industry Health Plan
P.O. Box 1999 Studio City, CA 91614-0999
855.ASK.4MPI (855.275.4674)
FAX: 818.766.1229

The Plan office will then send you information about COBRA coverage. (Note: Employers do not notify the Plan of these events.)

In providing this notice, you must use the form entitled “Notice of Qualifying Life Event (Form & Notice Procedures),” and you must follow the Notice Procedures for Notice of Qualifying Life Event that appears at the end of the form. 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 during the 60-day period after the later of the date the event occurs 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. (A copy of the Notice of Qualifying Life Event (Form & Notice Procedures) can be obtained from the Plan office.)

Electing COBRA Continuation Coverage
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. However, a qualified beneficiary’s COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

Coverage Provided Through COBRA
If you choose COBRA coverage, 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 Employees and their families, the same change will be made in your COBRA continuation coverage.

Core and Non-Core Benefits
Your right to continued health care coverage includes the “Non-Core Benefits.” This package includes medical, hospitalization, prescription drug, vision, and dental coverage. However, for a lesser Premium payment, you may elect to continue “Core Benefits,” which include medical, hospitalization and prescription drug coverage only. Neither of these rates includes life insurance. To continue your life insurance coverage, see Conversion Privilege Feature on page 113 of the Active Health Summary Plan Description.

Cost of COBRA Continuation Coverage
The amount you, your covered spouse, and/or your covered child(ren) must pay for COBRA coverage 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 coverage charge is different in cases of extended coverage due to disability. See the section entitled COBRA Continuation Coverage in Cases of Disability, below.

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 coverage. The cost of COBRA coverage 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 amounts 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 continuation coverage 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. Please note that eligibility status cannot be verified and Claims 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 coverage, 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 Continuation Coverage
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.

18 Months (Participant and Eligible Spouse and Dependents)
COBRA continuation coverage 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 continuation coverage 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 coverage and the disability lasts until the end of the 18-month period of continuation coverage. You or your Dependent 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. (See “COBRA Continuation Coverage in Cases of Disability,” below.)

36 Months (Eligible Spouse and Dependents Only)
COBRA continuation coverage for your Dependents 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
• You become entitled to Medicare
• Your child ceases to be eligible for Plan coverage. For example, he or she reaches the maximum age limit.

If you lose coverage due to employment termination or reduction in hours within 18 months after becoming covered by Medicare, your spouse and eligible Dependents may continue coverage for up to 36 months from the date of your Medicare entitlement.

COBRA Continuation Coverage in Cases of Disability
If you, your spouse, or any of your covered Dependent children are entitled to COBRA coverage 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 disability begins or continues during the first 60 days of COBRA coverage and continues at least until the end of the 18-month period of continuation coverage.
2. The disabled covered person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration.
b. Before the initial 18-month COBRA coverage period ends. If the Plan is not notified during the 60-day notice period and within 18 months after the covered Employee’s termination of employment or reduction of hours, there will be no disability extension of COBRA coverage. This extended period of COBRA coverage will end at the earlier of:

- The last day of the month during which Social Security 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 Coverage in Cases of Disability
If the 18-month period of COBRA continuation coverage 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 coverage.

CAL-COBRA
Participants living in California and enrolled in Kaiser 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 Employee During COBRA Coverage Period
A child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that the covered Employee 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 or Open Enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate Recipients Under Qualified Medical Child Support Orders
A child of the covered Employee who is receiving benefits under the Plan pursuant to a QMCSO received by the Plan during the covered Employee’s period of eligibility with the Plan is entitled to the same rights to elect COBRA as an eligible Dependent child of the covered Employee.

New Dependent(s) Acquired Under COBRA
If you acquire a new Dependent through marriage, birth, or placement for adoption while you are enrolled in COBRA coverage, you may add that Dependent to your coverage for the balance of your COBRA coverage period. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for five months of COBRA coverage. 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 coverage, 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 coverage. A child born to or placed for adoption with the Employee while covered under COBRA will be a qualified beneficiary.

Group Health Plan Coverage Loss
If, while you are enrolled in COBRA coverage, your spouse or Dependent loses coverage under another group health plan, you may enroll the spouse or Dependent for coverage for the balance of the period of COBRA coverage. The spouse or Dependent must have been eligible for COBRA coverage but not enrolled. When COBRA enrollment was offered and declined, the spouse or Dependent must have been covered under another group health plan or must have had other health insurance coverage.

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

The loss of coverage must be due to one of the following:
- Exhaustion of COBRA continuation coverage 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 become entitled to Medicare, or if a covered child ceases to be a Dependent child under the Plan during an 18-month period of COBRA coverage (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 coverage, up to a maximum of 36 months.

For example, assume you lose your job (the first COBRA qualifying event), and you enroll yourself and your covered eligible Dependents for COBRA coverage. 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 coverage for an additional 33 months, for a total of 36 months of COBRA coverage.

Please note that 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.
Attention MEDICARE Enrollees — Be aware that Participants enrolled in MEDICARE who elect COBRA coverage and receive MEDICARE benefits at a time that they are not actively employed will have their COBRA coverage as secondary insurance only.

In providing this notice, you must use the form entitled “Notice of Second Qualifying Event (Form & Notice Procedures),” and you must follow the Notice Procedures for Notice of Second Qualifying Event that appears at the end of the form. Again, 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 coverage due to a second qualifying event. (The Notice of Second Qualifying Event (Form & Notice Procedures) is attached to and is part of this initial notice; a copy of the Notice of Second Qualifying Event (Form & Notice Procedures) can also be obtained from the Plan Office.)

In no case are you, the Participant, entitled to COBRA coverage 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 coverage 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 Employee under the Plan when a covered Employee becomes entitled to Medicare.

Termination of COBRA Continuation Coverage

Self-Payment
Once COBRA continuation coverage 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, and that plan does not contain any legally applicable Exclusion or limitation with respect to a pre-existing condition that the covered person may have.
• 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
• The COBRA period (18, 29, or 36 months) ends

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 continuation coverage, you should contact the Plan Office. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (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:

Participant Services Center
Attn: Eligibility
Motion Picture Industry Health Plan
P.O. Box 1999
Studio City, CA 91614-0999
855.ASK.4MPI (855.275.4674)
FAX: 818.766.1229

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 Alternatives
If you exhaust the option for continuation coverage or do not wish to extend benefits under COBRA continuation coverage, 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.

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 insurance companies do 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 CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).

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:

- Ninety (90) days from the date of discharge if the period of service was more than one hundred eighty (180) days,
- Fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more but less than one hundred eighty (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 thirty-one (31) days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended for up to two (2) 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 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 Summary Plan Description.

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 continuation coverage 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 (such as the Persian Gulf Crisis), the 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.
**Student Eligibility for Dental and Vision**

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/her 23rd birthday. 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 quarterly 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 finish school in the spring session will be covered through August, provided the Participant is still eligible for benefits. 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 page 50.

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 at six (6)-month intervals, not to exceed one year. Learning disabilities, behavioral problems, ADHD, substance abuse, etc., are not qualified reasons for extension of coverage.

**Required Student Documentation for Dental and Vision**

At the beginning of each new session, certification of school enrollment or a schedule of classes showing the number of units or hours must be submitted to the Plan. A transcript of grades, showing the units or hours completed, must be submitted to the Plan at the end of each session. If the student withdraws from school, the Participant is responsible for supplying the Plan with the withdrawal date at the close of the session.

To maintain uninterrupted eligibility for a student until age 23, it is the Participant’s responsibility to have the student supply the 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.

**Handicapped 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 physical or mental handicap (for example cerebral palsy, mental retardation, autism, bipolar disorder) and because of that handicap are incapable of self-sustaining employment and independent care and maintenance. The status and condition of the Dependent MUST be certified at least annually by the attending physician. The provisions regarding Coordination of Benefits, including Medicare and Medicaid and, if married, spousal Coordination of Benefits, will apply to your Dependent. Please carefully read the Coordination of Benefits section of your SPD.

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.

The statement from the attending physician must include the diagnosis, the date of the commencement of the incapacity and the expected date of recovery. Proof of the continued existence of such incapacity must be furnished to the Plan Office annually.

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.

**Eligibility for Medical, Hospital, and Pharmacy Coverage**

After initial eligibility has been established, it is critical for the Participant to notify the Plan of any other coverage that may be available to his/her spouse, domestic partner, or covered children up to age 26. See page 50 for details.
**Divorced Spouse(s) and Dependent Children**

If your covered spouse and/or any Dependent children lose coverage due to one of the following events, the spouse or Dependent children may purchase COBRA continuation coverage for up to 36 months:

1. Death of the Participant;
2. Divorce (Note: To qualify for COBRA coverage, the Plan Office must be notified within 60 days of the date that the final decree of divorce or dissolution is filed with the court, or the date that coverage would have terminated because of the divorce, whichever is later); or
3. A Dependent child is no longer considered a Dependent as defined by the Plan.

*Note:* To qualify for COBRA coverage, the Plan Office must be notified within 60 days of the date on which the Dependent child no longer falls within the Plan definitions for an eligible Dependent, or the date coverage would have terminated as a result of that change of status, whichever is later.

An eligible Dependent spouse who is not yet divorced cannot be removed from your coverage.

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**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) providing continued health care coverage for your 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.

A description of the procedures governing a QMCSO is available without charge from the Plan Office.

**Required Premium Payments**

Premium payments must be made on a timely basis for Dependent coverage to continue.
Surviving Dependents

Death of an Active Participant Qualified for Retiree Health Benefits
If you should die while an Active Participant, but you have already met the requirements for Retiree Health Benefits, you will be considered a Retired Participant for the purpose of extending coverage for your eligible surviving Dependent(s).

Surviving Spouse or Same-Sex Domestic Partner Eligibility
Subject to the Coordination of Benefits rules, discussed on page 50, coverage is provided for your eligible surviving spouse or eligible same-sex domestic partner if you have not yet retired but have qualified for Retiree Health Benefits. If you have been married or your same-sex partner has been covered under the Plan for at least two years and you are at least age 62 at the time of your death, your surviving spouse or same-sex partner will continue to be eligible for his/her lifetime, or until “remarriage.” “Remarriage” includes marriage or certification under any state law as a Domestic Partner.

If you have not yet retired but have qualified for Retiree Health Benefits, you have been married or your same-sex partner has been covered under the Plan for at least two years and you die prior to reaching age 62, your eligible surviving spouse or eligible same-sex partner 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 or same-sex domestic partner 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 page 50, if you have qualified for Retiree Health Benefits, any eligible children you have at the time of your death will continue to have coverage until such time as they cease to qualify by reason of age or loss of full-time student status.

Duration of Dependent Retiree Benefits
Continuation coverage will be provided to surviving Dependents under these provisions only if there are sufficient funds available in the Retiree Health Plan to continue to provide these benefits. The Retiree Health Plan is a separate trust, and there is no guarantee of continued funding of that trust.

Death of an Active Participant Not Qualified for Retiree Health Benefits
The Plan will extend coverage for your eligible Dependents for a period of six months without cost, beginning the 1st of the month following the date of your death. In addition, if you had already earned eligibility for the subsequent Benefit Period, then your eligible Dependents will be covered through the end of the Benefit Period for which Benefits had been earned. At the end of this extended survivor coverage, your eligible Dependents may purchase continuation coverage through COBRA.

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 or same-sex domestic partner for a period of six months without cost. At the end of this extended coverage, your spouse may purchase continuation coverage through COBRA.

Death of an Ineligible Participant Not Qualified for Retiree Health Benefits
If you should die while ineligible for benefits and have not met the requirements for Retiree Health, but your death occurs during a Qualifying Period in which you already worked the minimum number of hours required to qualify for benefits in the subsequent Eligibility Period, your eligible Dependents will be covered during that subsequent Eligibility Period.

At the end of this extended survivor coverage, your eligible Dependents may purchase continuation coverage through COBRA.
Certification of Retirement
To establish eligibility for Retiree Health Benefits, you must contact the Motion Picture Industry Pension Plan at 855.ASK.4MPI (855.275.4674). If you qualify for Retiree Health Benefits, the Pension Plan will verify the number of hours and Qualified Years you have accrued, and the age at which you will be eligible. The Pension Plan will send a certification to the Eligibility Department of the MPI Health Plan, which will send you an enrollment packet.

Basic Requirements
Your eligibility for Retiree Health Benefits, with the exception of a total and permanent disability retirement, is not dependent upon your qualifying for retirement under the provisions of the Motion Picture Industry Pension Plan. The rules governing the Retiree Health Plan and the rules governing the Motion Picture Industry Pension Plan are similar but separate. You will qualify for Retiree Health Benefits 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 Industry has been certified by the Motion Picture Industry Pension Plan.

Please Note:
1. “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 Pension Plan.
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 Retiree Health Benefits. Upon your request, the 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 Health Benefits eligibility. In that event, the Benefits/Appeals Committee will credit you with one or more additional Qualified Years. See page 66 for instructions for filing an appeal.

Effective Date of Benefits
The effective date of your Retiree Health 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 Health Benefits until the effective dates listed below.

If you are a Participant in the Motion Picture Industry Active Health Plan and retire under the following terms, you will be enrolled in the Retiree Health Plan effective on the date of your certification as a retiree. However, if you have qualified for benefits in the Active Health Plan, your $10,000 life insurance benefit will remain in effect as long as you would have been eligible in the Active Health Plan.

1. With 15 Qualified Years and 20,000 Credited Hours, the earliest that Retiree Health Benefits will commence is on the 1st 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 Year 2000.
2. With 20 Qualified Years and 20,000 Hours, your Retiree Health Benefits will commence the 1st of the month following your 62nd birthday.
3. With 30 Qualified Years and 55,000 Hours, your Retiree Health Benefits will commence the 1st of the month following your 61st birthday.
4. With 30 Qualified Years and 60,000 Hours, your Retiree Health Benefits will commence the 1st of the month following your 60th birthday.

Are you a former Participant of any other health plan that merged into the Motion Picture Industry Health Plan? If so, it is important that you carefully review any appendix included with this Summary Plan Description (SPD) which addresses your particular situation. That appendix may contain special rules that are different from the rules contained in the main SPD. Where there is any conflict between the terms of the appendix and the main SPD, the terms of the appendix will govern you and your Dependents.
Total and Permanent Disability - 10 Qualified Years and 10,000 Hours
You will be entitled to Retiree Health Benefits effective on the date of your retiree certification, regardless of age, if you meet the following requirements.

You may retire under this provision if you have a minimum of ten Qualified Years and 10,000 hours for which contributions have been paid to the Retiree Health Plan, you are totally and permanently disabled at the time of your retirement, 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 Health 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 Pension but are not a Participant in the Motion Picture Industry Pension Plan.

Duration of Eligibility
Eligibility for Retiree Health may be discontinued if there are not sufficient funds available in the Trust to continue to provide these benefits or if the Retiree Health Plan is amended to reduce benefits. The Retiree Health Plan is a separate trust, and there is no guarantee of continued funding of that trust. In addition, your eligible Dependents may be entitled to continue coverage upon your death. (See the “Surviving Dependents” section of this book on page 25 for additional information.)

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

• Medicare may become primary. (See page 52 for details.)

• Through OptumHealth Behavioral Solutions, mental health and chemical dependency benefits change.

• Prescription Drug benefits Co-Pays change.

• 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 113.)

• Your Dependents are covered only until age 19 unless they satisfy the requirements for being a student (see page 23), in which case coverage may continue until attainment of age 23.

Note: The 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.

Work After Retirement
If you re-qualify for eligibility in the Active Health Plan on the basis of hours worked after the date of your retirement certification, you will be transferred to the Active Health 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 Health Plan.

Any questions you may have regarding information included in the Summary Plan Description concerning eligibility should be directed to:
Participant Services Center
Attn: Eligibility
Motion Picture Industry Health Plan
Studio City, CA 91614-0999
855.ASK.4MPI (855.275.4674)
As an Active 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 benefit options. The Plan Options Summary and Medical Plan Benefit Comparison Chart provided in the following pages offer you factual information to help you identify the right benefit match for your individual circumstances.

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As an Active 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 you factual 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.

Our 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 Directors also reserve the right to alter and amend the level and nature of benefits provided.

If you are in doubt about coverage of a certain service or are seeking review of a Claim that has already been processed by the Plan, we suggest you write to the Plan Office for clarification, requesting a written response rather than obtaining information over the telephone.

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 Directors and cannot enlarge or change such benefits or eligibility rules. (See “Claims Appeals Procedures,” page 66.)

Eligible Participants

- If you or your Dependents are entitled to Medicare, the payment of your Claims is explained under the section entitled “Medicare Coordination” on page 52.
- If you or a family member has other Employer group health insurance available to you, please see the section “Coordination of Benefits”, page 52.
- The sections entitled “Workers’ Compensation” on page 54 and “MPI Health Plan Benefits and Limitations” on page 55 should be of interest to all eligible persons.
- The life insurance, vision care, and prescription drug benefits remain the same whether you select the MPIHP/Anthem Blue Cross, Health Net, Kaiser Permanente or Oxford Health Plans.

Services Provided in California

Regardless of where you live, you may choose the Motion Picture Industry Health Plan/Anthem Blue Cross coverage, the benefits of which are described in detail in this Summary Plan Description. If you live in California, you may, instead, choose to be covered through Health Net or Kaiser. Health benefits provided through those plans are summarized in their respective sections of this Summary Plan Description.

Due to time needed for the enrollment process, during the first month of your initial selection of Health Net or Kaiser, you will be covered in the MPIHP/Anthem Blue Cross Plan. You will then move to Health Net or Kaiser at the beginning of the second month. However, if during that first month of your initial selection, you are already covered in your chosen HMO through some other group or individual plan, you will be enrolled in the chosen HMO from the first month of eligibility.

Services Provided Outside California

Participants residing outside California will be enrolled in the BlueCard® Program. However, Oxford, a Point of Service Plan, is also available as an alternate choice for residents of the Oxford service area of New York, New Jersey and Connecticut.

For those Participants residing in the Oxford service area, during the first month of your initial selection of Oxford, you will be covered in the BlueCard® Program. If, during that first month of your initial selection, you are already covered in Oxford through some other group or individual plan, you will be enrolled in Oxford from the first month of eligibility.
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<th>Oxford Health Plans New York, New Jersey and Connecticut Only</th>
</tr>
</thead>
</table>
| **Out-of-Network Coverage** | • Yes, as shown below  
  • Balance Billing could occur | Only in an emergency | Only in an emergency | • Yes, as shown below  
  • Balance Billing could occur |
| **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  
  • Includes Coinsurance; does not include Co-pays  
  • Out-of-Network: Unlimited | • $1,500 per person up to $4,500 per family  
  • Includes Coinsurance and Co-pays | • $1,500 per person up to $3,000 per family  
  • Includes Coinsurance and Co-pays | • In Network: Not Applicable  
  • Out-of-Network: $8,000 per person up to $16,000 per family  
  • Includes Coinsurance and Deductible; does not include Co-pays |
| **Hospital Services** | • Room and Board  
  • Intensive Care  
  • Ancillary Services  
  • Semi-Private Room | • In-Network: 10% Coinsurance plus $100 per admission  
  • Out-of-Network: 50% Coinsurance plus $100 per admission | • No Charge | • In Network: No charge  
  • Out-of-Network: Deductible plus 30% Coinsurance |
<table>
<thead>
<tr>
<th>Health Care Benefits</th>
<th>MPIHP/Anthem Blue Cross</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Extended Care</strong></td>
<td>• In-Network: 10% Coinsurance</td>
<td>No charge (up to 100 days per calendar year)</td>
<td>No charge (up to 100 days per calendar year)</td>
<td>• In Network: No charge</td>
</tr>
<tr>
<td></td>
<td>• Out-of-network: 50% Coinsurance</td>
<td></td>
<td></td>
<td>• Out-Of-Network: Deductible plus 30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>• Plan coverage ends after - 90 days for Participants - 60 days for Dependents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Services Within or Outside Service Area</strong></td>
<td>• 10% Coinsurance plus $100 Co-pay (waived if admitted to a hospital)</td>
<td>• $35 Co-Pay (waived if admitted to a hospital)</td>
<td>• $35 Co-Pay (waived if admitted to a hospital)</td>
<td>• $25 Co-Pay (waived if admitted to a hospital)</td>
</tr>
<tr>
<td></td>
<td>• All covered services when medically necessary are available anywhere in the world from any licensed physician, surgeon or general hospital,</td>
<td>• All covered services when medically necessary are available anywhere in the world from any licensed physician, surgeon or general hospital,</td>
<td>• All covered services when medically necessary are available anywhere in the world from any licensed physician, surgeon or general hospital,</td>
<td>• All covered services when medically necessary are available anywhere in the world from any licensed physician, surgeon or general hospital</td>
</tr>
<tr>
<td></td>
<td>• Out-of-Network hospital facility Allowable Amounts (not professional Allowable Amounts) capped at $1,000 per emergency</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Professional Benefits</strong></td>
<td>• MPTF/TIHN: $5 Co-Pay</td>
<td>• $15 Co-Pay for office visits; No charge for inpatient visits</td>
<td>• $15 Co-Pay for office visits; No charge for inpatient visits</td>
<td>• In-Network: $15 Co-Pay for office visits; no charge for inpatient visits</td>
</tr>
<tr>
<td></td>
<td>• In Network in MPTF area: 10% Coinsurance plus $30 Co-Pay</td>
<td></td>
<td></td>
<td>• Out-Of-Network: Deductible plus 30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>• In Network out of MPTF area: 10% Coinsurance plus $15 Co-Pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Out-of-Network in MPTF area: 50% coinsurance plus $30 co-pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Out-of-Network out of MPTF area: 50% Coinsurance plus $15 Co-Pay</td>
<td></td>
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</tbody>
</table>

- Room and Board in a Skilled Nursing Facility
- Other Services and Supplies

- 10% Coinsurance plus $100 Co-pay (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,
- Out-of-Network hospital facility Allowable Amounts (not professional Allowable Amounts) capped at $1,000 per emergency

- All covered services when medically necessary are available anywhere in the world from any licensed physician, surgeon or general hospital

- Co-Pays apply per visit to office visits and inpatient visits unless otherwise noted

- $25 Co-Pay
  - No charge for inpatient visits

- MPTF/TIHN: $5 Co-Pay
  - $15 Co-Pay for office visits; No charge for inpatient visits
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<tr>
<th>Health Care Benefits</th>
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<td><strong>Professional Benefits</strong> (continued)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgent Care Visits:</td>
<td>• Same as Physician Visits</td>
<td>• $35 Co-Pay</td>
<td>• $15 Co-Pay</td>
<td>• $15 Co-Pay</td>
</tr>
<tr>
<td>• Anesthesia (Note that anesthesiologist can be Out-of-Network even when the hospital and surgeon are In-Network)</td>
<td>• In Network: 10% Coinsurance • Out-of-Network: 50% Coinsurance</td>
<td>• In Network: No charge • Out-of-Network: Not covered</td>
<td>• In Network: No charge • Out-of-Network: Not Covered</td>
<td>• In Network: No charge • Out-of-Network: 30% Coinsurance</td>
</tr>
<tr>
<td>• Ambulance Services (including air ambulance)</td>
<td>• Emergency: 10% Coinsurance • Non-emergency and medically necessary • In Network: 10% Coinsurance • Out-of-Network: 50% Coinsurance</td>
<td>• Emergency: No charge • Non-emergency: Prior approval is required</td>
<td>• Emergency: No charge • Non-emergency: Prior approval is required</td>
<td>• Emergency: No charge • Non-emergency: Prior approval is required • Non-emergency Air Transportation is not covered</td>
</tr>
<tr>
<td>• Laboratory Tests and Diagnostic Imaging</td>
<td>• In Network: 10% Coinsurance • Out-of-Network: 50% Coinsurance</td>
<td>• No charge</td>
<td>• No charge</td>
<td>• In-Network: No charge • Out-of-Network: Deductible plus 30% Coinsurance</td>
</tr>
<tr>
<td>• Injectable Drugs (Outpatient)</td>
<td>• Allergy Shots and Injectable Drugs not covered by Express Scripts • In-Network: 10% Coinsurance • Out-of-Network: 50% Coinsurance • Covered through Express Scripts. See Express Scripts section</td>
<td>• No Charge for injections, allergy injection services or testing (Injections for infertility are paid at 50%) • Also covered through Express Scripts. See Express Scripts section</td>
<td>• Most injectable drugs, including allergy tests, provided at no charge if administered in the medical office; see Evidence of Coverage • Also covered through Express Scripts. See Express Scripts section</td>
<td>• Subject to Physician Visit Co-Pay • Also covered through Express Scripts. See Express Scripts section</td>
</tr>
<tr>
<td>Health Care Benefits</td>
<td>MPIHP/Anthem Blue Cross</td>
<td>Health Net California Only</td>
<td>Kaiser Permanente California Only</td>
<td>Oxford Health Plans New York, New Jersey and Connecticut Only</td>
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<tr>
<td>Professional Benefits (continued)</td>
<td>• Eye Examinations $20 Co-Pay for routine eye examinations and corrective lenses are covered through VSP (see Vision Service Plan section) Non-routine same as Physician Visit</td>
<td>• $15 Co-Pay per visit Routine exams are also covered through VSP at a $20 Co-Pay (see Vision Service Plan section)</td>
<td>• $15 Co-Pay per visit Routine exams are also covered through VSP at a $20 Co-Pay (see Vision Service Plan section)</td>
<td>• $20 Co-Pay for routine eye examinations and corrective lenses are covered through VSP (see Vision Service Plan section) Non-routine same as Physician Visit</td>
</tr>
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<td></td>
<td>• Chiropractic Services In-Network: No Charge Out-of-Network: Maximum Allowable Amounts and other limitations apply (see “Benefits and Limitations” section) Maximum of 20 visits per calendar year for both In and Out-of-Network</td>
<td>• $15 Co-Pay per visit Routine exams are also covered through VSP at a $20 Co-Pay (see Vision Service Plan section) Available through ASH Networks only (see page 79)</td>
<td>• $15 Co-Pay per visit Routine exams are also covered through VSP at a $20 Co-Pay (see Vision Service Plan section) Available through ASH Networks only (see page 85)</td>
<td>• In-Network: $15 Co-Pay per visit Out-of-Network: 30% Coinsurance plus Deductible</td>
</tr>
<tr>
<td></td>
<td>• Physical Therapy Same as Physician Visits Out-of-Network: Maximum Allowable Amounts and other limitation apply (see “Benefits and Limitations” section) Maximum of 16 visits per year per injury; 2nd injury needs approval; visit limit applies to both In and Out-of-Network</td>
<td>• No charge</td>
<td>• $15 Co-Pay per visit (through OptumHealth/UHC); Out-of-Network: 30% Coinsurance plus Deductible 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</td>
<td>• In-Network: $15 Co-Pay per visit (through OptumHealth/UHC); Out-of-Network: 30% Coinsurance plus Deductible 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</td>
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<tr>
<td>Health Care Benefits</td>
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<td>Kaiser Permanente California Only</td>
<td>Oxford Health Plans New York, New Jersey and Connecticut Only</td>
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| • Physical Examination (annual) | • Newborn through age 17: No charge. All well child care visits through age 4 are covered. Annual physical exam for ages 5 and above is covered.  
• MPTF/THIN: $5 Co-Pay  
• In MPTF area: Visits for age 18 and older only MPTF/THIN Providers are covered  
• Out-of MPTF area: Visits for age 18 and older are covered like other Physician Visits | • $15 Co-Pay | • $15 Co-Pay | • In Network: No charge  
• Out-of-Network: Not covered except for children under age 19. The benefit is paid after the Deductible plus 30% Coinsurance |
| Home Health Services | Home Health Services | Home Health Services | Home Health Services | Home Health Services |
| • Physician Home Visits | • Same as Physician Visit | • $30 Co-Pay per visit | • No charge; limited to 100 visits per year and three visits per day. | • In Network: $15 Co-Pay  
• Out-of-Network: Deductible plus 30% Coinsurance |
| • Home Health Nurse | • No Co-Pays  
• Coinsurance applies | • $10 Co-Pay 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: 20% Coinsurance; only 60 visits per year with maximum of 4 hours per visit |
<p>| • Hospice | No charge | No charge | No charge | Same as other Home Health Services |</p>
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<th>Health Care Benefits</th>
<th>Family Planning Services (continued)</th>
<th>Maternity Benefits</th>
<th>Family Planning Services</th>
<th>Elective Abortion</th>
</tr>
</thead>
</table>
| MPIHP/Anthem Blue Cross | • $15 Co-Pay per visit
• No charge in hospital | • Covered under specific conditions. See Abortion in the Benefits and Limitations Section | • Not covered | • No Charge for medically necessary abortion
• $150 for elective abortion |
| Health Net California Only | • $15 Co-Pay per visit
• No charge in hospital | • Not covered | • Not Covered | • Covered under specific conditions. See Abortion in the Benefits and Limitations Section |
| Kaiser Permanente California Only | • $15 Co-Pay per visit
• No charge in hospital | • Not covered | • Not Covered | • Covered under specific conditions. See Abortion in the Benefits and Limitations Section |
| Oxford Health Plans New York, New Jersey and Connecticut Only | • In Network: $15 Co-Pay for initial visit, no charge for subsequent one
• Out-of-Network: Covered only in an emergency | • Covered under specific conditions. See Abortion in the Benefits and Limitations Section | • Outpatient: $15 Co-Pay
• Inpatient: No charge | • Maximum Allowable Amount of $350 per abortion for both In- and Out-of-Network |

Maternity Benefits:
- Maternity Benefits
  - Physician applicable只要至少一个
  - Hospital applicable只要至少一个
  - Dependent Children not covered

Family Planning Services:
- Vasectomy
  - Covered under specific conditions. See Abortion in the Benefits and Limitations Section

Elective Abortion
- Covered under specific conditions. See Abortion in the Benefits and Limitations Section
  - Maximum Allowable Amount of $350 per abortion for both In- and Out-of-Network
<table>
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<tr>
<th>Health Care Benefits</th>
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<th>Kaiser Permanente California Only</th>
<th>Oxford Health Plans (Preferred Provider Org.) New York, New Jersey and Connecticut Only</th>
</tr>
</thead>
</table>
| Intrauterine Device (IUD) [Provided in a physician’s office.] | - MPTF/TIH: $5 Co-Pay  
- In-Network in MPTF area: 10% Coinsurance plus $30 Co-Pay  
- In-Network out of MPTF area: 10% Coinsurance plus $15 Co-Pay  
- Out-of-Network in MPTF area: 50% Coinsurance plus $30 Co-Pay  
- Out-of-Network out of MPTF area: 50% Coinsurance plus $15 Co-Pay | - $15 Co-Pay for the insertion and removal of the IUD only; the IUD is not covered | - $15 Co-Pay | - Not covered |
| Mental Health Outpatient | - In Network: $5 Co-Pay per visit  
- Out-of-Network: 50% Coinsurance | - $15 Co-Pay per visit | - $15 Co-Pay per visit  
- $7 Co-Pay per visit for group therapy | - In Network: $15 Co-Pay per visit  
- Out-of-Network: Deductible plus 30% Coinsurance |
| Mental Health Inpatient | - In-Network: No charge  
- Out-of-Network: $100 per admission, then 50% Coinsurance | - No charge | - No charge | - In Network: No charge  
- Out-of-Network: Deductible plus 30% Coinsurance |
MPIHP/Anthem Blue Cross Health Plan Option
As an Active Participant, you have the option of selecting comprehensive medical and hospital coverage available through the MPIHP/Anthem Blue Cross Health Plan option. You should become familiar with the limitations, as well as opportunities, to save out-of-pocket costs by using network Providers.

IN CALIFORNIA:
The Hospital PPO Network in California is provided by Anthem Blue Cross, and the benefits are administered by the MPI Health Plan/Anthem Blue Cross.

The Comprehensive Medical PPO Network in California is provided by Anthem Blue Cross, and the benefits are administered by the MPI Health Plan/Anthem Blue Cross.

OUTSIDE CALIFORNIA:
The Hospital PPO Network outside California is provided by the BlueCard Program, and the benefits are administered by the MPI Health Plan/BlueCard.

The Comprehensive Medical PPO Network Outside California is provided by the BlueCard Program, and the benefits are administered by the MPI Health Plan/BlueCard.

A summary of the plan of benefits, including procedures and processes and covered and non-covered services, is provided on the following pages. We encourage all Active Participants to review this section thoroughly.
Benefits are provided for hospitalizations when reasonable and necessary for the treatment of illness or injury. Hospitalizations related to mental disorders, as listed in the International Classification of Diseases, are administered by OptumHealth Behavioral Solutions (see page 71).

**General Information**

*Claims for Services Rendered in California*

For hospital admission for you or your eligible Dependents, present your Benefit Card. If you do not have your benefit card with you at the time, provide the following information:

- Active Anthem Blue Cross Group number: 277163
- Plan Code: 040
- Certificate Number: “MPI” plus the Participant’s Social Security number

*Claims for services received outside of California* should be submitted to the local Blue Cross/ Blue Shield office. For BlueCard Providers nationwide, call 800.810.BLUE (2583).

**Skilled Nursing/Extended Care Facility**

The benefits described under Inpatient Care are available in an Anthem Blue Cross contracting 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.

For more information, call MPI Health Plan, 855.ASK.4MPI (855.275.4674)

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.** *(Please see Case Management, page 56.)*

**Emergency Outpatient Care**

Covered hospital emergency room charges, including all covered services performed in the emergency room, are paid at 90% of the Allowable Amounts, less a $100 Co-Pay, if not admitted. Allowable Amounts are the Usual, Customary, and Reasonable (UCR) Rate as determined by either Anthem Blue Cross or BlueCard for Out-of-Network Providers and the negotiated rate for Anthem Blue Cross or BlueCard Providers. Be advised, that upon admission, payment will be based on coverage rates by Provider categories as described on page 55. (If admitted directly to the hospital, the $100 emergency room Co-Pay is waived.)

Emergency treatment rendered in facilities other than a licensed acute care hospital, such as urgent care centers and after hours centers, will be paid under the Comprehensive Medical Benefit. *(See page 48.)*

Some hospitals operate clinics within their facility. That allows them to separate treatment areas for true emergencies from those for lower acuity medical issues. The result is that in a clinic, there is greater likelihood patients will be seen by a physician sooner and still get the level of treatment they need.

However, when a Participant is seen in one of these clinics, rather than in the emergency department, the covered benefit for a clinic visit is paid by the Plan the same as a doctor’s office visit is paid.

**Inpatient Care**

Benefits for Inpatient Care at Anthem Blue Cross contracting hospitals include:

- Room Charge (semi-private)
- Intensive Care
- Nursery Expenses

Other charges - supplies, medication, diagnostic x-rays and laboratory tests, operating room, anesthesia supplies, physiotherapy, and inhalation therapy required in connection with the conditions being treated. *(See section entitled “Hospital Care/Admissions,” page 41.)*

**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 Allowable Amounts determined by the Plan. Charging this difference is referred to as Balance Billing.
Childbirth
The MPI Health 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. The law also prohibits a plan from requiring a health care practitioner to obtain authorization from the Plan for prescribing a length of stay which is less than that legal minimum.

As a result, Covered Expenses also include bed and board and other necessary services and supplies for a mother and her newborn child for up to 48 hours following a normal vaginal delivery and up to 96 hours following a Cesarean section. No authorization is needed from the Plan in order to be covered for these amounts of time.

Medicare
When you or your Dependents are entitled to Medicare benefits, present your Hospital Benefit Card and Medicare Card to obtain admission to the hospital. The hospital will bill Anthem Blue Cross and Medicare directly. For more information concerning Medicare, see the “Coordination of Benefits” section of this book, page 52.

Surgical Centers
To determine whether a non-hospital surgical center is contracted with Anthem Blue Cross, contact in advance:

Services Rendered in California:
• MPI Health Plan, 855.ASK.4MPI (855.275.4674)
• www.anthem.com/ca

Services Rendered Outside of California:
• Anthem Blue Cross, 800.810.BLUE (2583)
• www.anthem.com/ca

Services Not Covered
The following is a summary of some services which are not covered.
• 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 Benefits of the Plan.

Information of Note
• Certain other services supplied by hospitals are not covered by your Hospital Benefit, but may be included as covered medical expenses under your Comprehensive Medical Benefit. These include doctor, surgeon, and anesthesiologist charges as well as certain special surgical or orthopedic supplies, and ambulance service.
• Coordination of Benefits (COB) will apply in all situations in which the patient has other group health coverage.
The Plan provides benefits for specific medical services that have been approved by the MPIHP Board of Directors. Comprehensive Medical Benefits cover reasonable and necessary medical services in connection with the diagnosis and treatment of any non-industrial illness or injury.

**Covered Services**

In order for a service to be covered, it must be a service for which the Plan has established a benefit, and the service must be medically necessary and reasonable. To determine if a particular service is reasonable and necessary, 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” 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*;
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 questionable. In addition, the Plan’s medical consultants look to treatises and the 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. **Contacting the Plan Office in writing for verification of coverage is strongly recommended.**

*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.

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 page 66 of this *Summary Plan Description*. **Decisions made by the Benefits/Appeals Committee are final and binding upon all parties, including Provider(s) of service.** Covered services include physician fees for office, home or hospital care, including the attending physician, consulting Specialist, surgeon, Assistant Surgeon and anesthesiologist. **Laboratory tests and other diagnostic studies must be ordered by a physician.**

**Second Surgical/Medical Opinion**

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 opinions should be sought from a Specialist in the same medical field as the physician who made the original recommendation.

**Services Not Covered**

The comprehensive benefit does not cover:

- 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 Food and Drug Administration (FDA) for the specific diagnosis.
- Experimental and investigational services, treatments, medications or devices.

*(See “Non-Covered Services and Items,” page 63.)*
Experimental and Investigational Exclusion
The term “Experimental and 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.

Preauthorization

Preauthorization is not required, but we strongly advise that you seek confirmation of coverage from the Plan before proceeding with a course of treatment.

Some services/procedures are excluded from coverage because they are not rendered in accordance with the generally accepted professional standards for the specific diagnosis.

We strongly recommend that the Plan be contacted in writing prior to proceeding on a course of treatment. The Medical Review Department of the MPI Health Plan may request that a patient have an Independent Medical Evaluation (IME) prior to issuing approval or denial.

Any decision of the Plan may be appealed under the Claims Appeals Procedures. As previously stated, decisions made by the Benefits/Appeals Committee are final and binding upon all parties, including Provider(s) of service.
Submission and Payment of Claims
Claims 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 may result in the denial of your Claim. A request for review of any adverse decision on a Claim must be made within 180 days of the date on the Explanation of Benefits (EOB) form.

Claims filed with the Plan should be addressed as follows:

<table>
<thead>
<tr>
<th>Claims Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem Blue Cross</td>
</tr>
<tr>
<td>P.O. Box 60007</td>
</tr>
<tr>
<td>Los Angeles, CA 90060-0007</td>
</tr>
</tbody>
</table>

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

Time Limits for MPIHP to Process Claims

<table>
<thead>
<tr>
<th>What is the general deadline for initial determination?</th>
<th>30 days from the Plan’s receipt of the completed Claim.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any extensions?</td>
<td>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.**</td>
</tr>
<tr>
<td>What is the deadline if additional information is needed?</td>
<td>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.</td>
</tr>
</tbody>
</table>

Filing Claims with MPIHP Contract Providers
There are a number of health care options available to you through companies with which the Plan contracts, such as HMOs, Oxford Health Plans, BlueCard (with respect to services rendered outside of California), dental, vision, and others. Claims for health care services made available through these entities are ordinarily handled by the entities themselves, rather than by MPIHP. For those entities, the time frame for Claims review depends on what type of Claim is being filed. Descriptions of how those different types of Claims are handled appear later in this document. As these are minimum guidelines for these contract Providers, you should also review the material in this Summary Plan Description which is specific to the Providers, as well as the Evidence of Coverage of the contract Provider.

Time frames for the contract Providers to process your health Claims depend on the type of Claim filed. Such Claims fall into the following categories:

Claims Not Requiring Preauthorization
This is the type of Claim that is filed after the service has been provided and where no Preauthorization is required.

* 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), to determine qualification for a benefit, this number of days is 45.

** 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), to determine qualification for a benefit, this number of days is 30, with the possibility of an additional 30-day extension.
Claims That Require Preauthorization
These contract Providers require Preauthorization in a number of instances. Those circumstances are delineated in the sections of this Summary Plan Description applicable to such Providers as well as in separate materials you received from them, all of which you should review.

Note: The guidelines for processing Claims involving Medicare benefits may differ somewhat. Any differences will be described in the Evidence of Coverage for the applicable plan.

<table>
<thead>
<tr>
<th>Time Limits for MPIHP Contract Providers to Process Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims Not Requiring Preauthorization</strong> (Post-Service Claims)</td>
</tr>
<tr>
<td>What is the general deadline for initial determination?</td>
</tr>
<tr>
<td>Are there any extensions?</td>
</tr>
<tr>
<td>What is the deadline if additional information is needed?</td>
</tr>
</tbody>
</table>

* In the case of a Claim where “disability” must be determined by MPIHP or an MPIHP contract Provider (as opposed to a neutral third party such as Social Security or California State Disability) to determine qualification for a benefit, the time limit is 45 days.

** In the case of a Claim where “disability” must be determined by MPIHP or an MPIHP contract Provider (as opposed to a neutral third party such as Social Security or California State Disability) to determine qualification for a benefit, an extension of 30 days is permitted, with the possibility of an additional 30-day extension.
Required Claims Communication
Initial Benefits Determinations, which are in any manner adverse, will include the following:

1. The specific reason or reasons for any adverse determination.
2. Reference to the Summary Plan Description 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 it 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 description of any additional material or information that would be needed to perfect the Claim, and why that material or information is needed.

Claim Questions
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. If you have any questions about the processing of or decision concerning your Claim you should contact the MPI Health Plan at 855.ASK.4MPI (855.275.4674).

Foreign Claim
For covered services, Comprehensive Plan Benefits apply anywhere in the world. It is important to have the foreign Provider include all supporting medical information along with the bill. Services rendered outside of the United States must be submitted on a Blue Cross foreign Claim form, available on the MPIPHP website (www.mpiphp.org). Send the completed form to:

BlueCard Worldwide Service Center
P.O. Box 261630
Miami, FL 33126 USA

Medical services incurred while on a cruise ship must be submitted to Anthem Blue Cross.

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. This provision does not apply to individual health insurance policies.

A process known as order of benefit determination is used to coordinate the benefits of both plans where duplicate coverage exists. The order of benefit determination is that the benefits of the plan that covers the individual as an Employee, member or subscriber other than as a Dependent are determined before those of the plan which covers the individual as a Dependent. If the primary plan benefits paid more than MPI would have paid, no additional payment will be made by MPI. If the primary plan paid less than MPI would have paid, MPI will pay up to the MPI benefit less the amount paid by the primary insurance or the remaining Coinsurance, whichever is less. (See “Coordination of Benefits,” page 50, for details.)

Allowable Amount
The Allowable Amount is the maximum amount that the plan will consider for payment for a covered service. For In-Network Providers, the Allowable Amount is the contracted rate between Anthem Blue Cross or the BlueCard Program and the In-Network Providers. For Out-of-Network Providers, the Allowable Amounts are determined by either Anthem Blue Cross for services provided in California or by the Local BlueCard Network for services provided outside of California.

The Out-of-Network Allowable Amount is based on an analysis of Usual, Customary, and Reasonable (UCR) rates for a specific geographic area. The Allowable Amount is set at the 70th percentile, which means that the UCR rates are greater than or equal to the billed charges for 70% of the Providers in the geographic area.

The Allowable Amount is never more than the billed charge for the service. Using an Out-of-Network Provider may subject the Participant to Balance Billing. UCR rates are subject to change. The Plan will pay Claims based on the rate in effect at the time of service.

Physician Services
MPIHP/Anthem Blue Cross/The BlueCard Program - PPO Participants

You still have free choice of doctors, but if you choose to go to a Blue Cross Contracting Provider, you may have lower out-of-pocket expenses. To find an Anthem Blue Cross Contracting Provider in your area, visit the website at www.anthem.com/ca or call the MPI Health Plan at 855.ASK.4MPI (855.275.4674) and specify the type of physician needed. You will be given the name and number of a physician in your area.

The Plan has continued Preferred Provider Organization (PPO) arrangements with The Industry Health Network (TIHN) of the Motion Picture & Television Fund. (Please see page 69 for listing.) These Providers have agreed to a fee schedule for Plan Participants and their eligible Dependents which requires only a $5 Co-Pay.

This agreement applies only to covered services rendered by doctors within those groups. If, while being treated by a group doctor, you need the service(s) of a Specialist not available at the group, and the doctor you are referred to is not a network-Contracting Provider, the payment for covered services rendered will be based on the second or third categories listed under “Coverage Rates by Professional Provider Categories,” on the next page.
The Anthem Blue Cross Provider Network Outside California Non-HMO/POS Participants
The Plan and the BlueCard Program have entered into an agreement to provide Health Plan Participants with access to quality care and significant out-of-pocket savings nationwide, while continuing with the current benefits, administration and customer service.

You still have free choice of doctors, but if you choose to go to a BlueCard Provider, you may have lower out-of-pocket expenses. To find a BlueCard Provider in your area, visit the website at www.anthem.com/ca or call toll-free: 800.810.BLUE (2583) and specify the type of physician needed. You will be given the name and number of a physician in your area. The BlueCard Provider must submit its bills to its local BlueCard Program office.

Coverage Rates by Provider Categories

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Coverage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motion Picture &amp; Television Fund (MPTF) Providers or The Industry Health Network (TIHN) of the Motion Picture &amp; Television Fund Contracting Providers (Referral from MPTF required)</td>
<td>100% of the contracted rate less a $5 Co-Pay, where applicable, for each office visit</td>
</tr>
<tr>
<td>Anthem Blue Cross and the BlueCard Program (outside California) Providers (who do not contract with TIHN)</td>
<td>90% of the contracted rate less the $30 (for Participants residing in the MPTF service area) or $15 (for Participants residing outside of the MPTF service area) Co-Payment per visit</td>
</tr>
<tr>
<td>Out-of-Network providers.</td>
<td>50% of either the 70th percentile of UCR or the Anthem Blue Cross/BlueCard fee schedule less the Co-Payment per visit (i.e., $30 Co-Payment if the Participant resides in the MPTF service area defined on page 69 but chooses not to use one of the MPTF Health Centers or TIHN Providers) or $15 Co-Pay if the Participant lives outside the MPTF service area. The patient is also responsible for any Balance Billing, i.e., the difference between the billed and Allowable Amounts.</td>
</tr>
</tbody>
</table>

See page 69 for more information regarding the MPTF Service Area.

Schedule of Allowable Amounts
Professional fees are limited as to the amount for each medical, diagnostic or surgical service which may be considered an Allowable Amount.

Surgical Services
The Allowable Amount for surgical procedures for Out-of-Network Providers is based on the UCR Charge in effect at the time the Claim is incurred.

Allowable Amounts for multiple surgical procedures performed during the same surgical session are calculated in the following way:

1. Major/primary procedure at the rate of 100% of the Allowable Amount, payable at the professional rate of 50%.
2. All subsequent allowable procedures are calculated at the rate of 50% of either the 70th percentile of the UCR Charge or Anthem/BlueCard fee schedule, payable at the rate of 50%.

All Anthem Blue Cross and BlueCard Providers must refer to their contract to determine Allowable Amounts. (These Providers are paid at 90% of the contracted rate unless they are also an outpatient MPTF/TIHN Provider, then they are paid at 100% by the Plan less the Co-Pay)

Assistant Surgeon
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
- 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 Assistant Surgeon is 20% of the surgical allowance.

Anesthesiologists
Allowances for anesthesiology are based on anesthesia procedure codes and anesthesia time to arrive at the Allowable Amount.

Surgical Suites/Surgery Centers
Surgical suites and surgery centers that are Out-of-Network are subject to a special payment schedule. Benefits will be 25% of UCR surgical allowance to include facility and supplies, payable at 50%.

Co-Payment
Co-Payments (Co-Pays) apply to many services. A $5 Co-Payment will apply to MPTF/THN-referred providers, a $15 Co-Payment ($30 Co-Payment if the Participant resides in the designated MPTF service area - see page 69) will be applied to all visits/treatments, including, but not limited to the following:

- Office
- Osteopathic care will require a $15 Co-Pay per visit regardless of location.
- Physical therapy
- Cardiac rehabilitation
- Pulmonary rehabilitation
- Speech therapy
The Participant is also responsible for the balance owed after the Plan payment, up to the billed charges for Out-of-Network Providers, i.e., Balance Billing.

The Co-Payment also applies to services rendered to those individuals who have met the Plan’s maximum out-of-pocket amount. (See below.)

Yearly Out-of-Pocket Maximum for Comprehensive Medical Benefits
MPI Health Plan limits the amount you will have to pay on an annual basis to make up the difference between the percentage of the Allowable Amounts paid by the Plan and the percentage of the Allowable Amounts 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 maximum out-of-pocket is $1,000 for In-Network expenses for hospital and professional charges combined. (Co-Payments do not count toward the Out-of-Pocket Maximum. They must always be paid.) In-Network means MPTF, TIHN, Anthem Blue Cross or BlueCard Contracting Providers.

2. Out-of-Network: There is no limit on Out-of-Pocket costs if a patient uses Out-of-Network physicians or hospitals, except in an emergency. In an emergency, the Out-of-Pocket Maximum for the emergency room facility Allowable Amounts or the hospital facility Allowable Amounts when admitted through the emergency room is $1,000 per emergency. There is no Out-of-Pocket Maximum for Out-of-Network professional charges, even in an emergency.

3. The $100 emergency room Co-Pay will be waived if you are admitted to the hospital, but the $100 Co-Pay upon admission to the hospital for an overnight stay will still apply. In addition, the Plan will pay 90% of the Allowable facility Amount (In- or Out-of-Network). The maximum out-of-pocket is $1,000 of the Allowable Amounts for the facility only. Out-of-Network professional charges are payable at 50% of Allowable Amounts. If you are not admitted to the hospital, services performed in the emergency room, whether a contracted facility or not, will be paid at 90% of the Allowable Amount for covered services, less the $100 Co-Pay.

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

Overpayments
Every effort is made to assure prompt and accurate payment of your Claims. If we discover our payment(s) was incorrect (overpaid due to other health carrier payments, third-party liability, incorrect billings, miscalculations, etc.), 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’s: 1) providing false or incomplete information, or 2) failing to provide information within the time frames required under the terms of this Summary Plan Description (for example, timely notice of divorce or Dependent change). 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 shall continue to run 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 our request, the amount of Overpayment (including interest, if applicable) will be deducted from all future benefit payments for you or your eligible Dependents until the Overpayment and any interest have been recovered.
Billing Errors
If you suspect you are the victim of billing errors, immediately do the following:

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

MPI Health Plan Claims Department
P.O. Box 1999
Studio City, CA 91614-0999

Your cooperation and vigilance will help the MPI Health Plan maintain your high quality benefits.

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 MPI Health Plan must be in writing, along with a $5 payment for bank charges. A $5 per check payment will also be required for copies of cancelled 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 MPI Health Plan must be made in writing. Requests must be made within seven (7) years of the original check issuance date. Upon verification that the check has not cleared the Plan’s bank nor already been reissued, the Plan will issue a replacement check. This policy applies to Participants and Providers. The Plan will be unable to issue a replacement check more than seven (7) years after the original check issuance date.
Order of Benefit Determination
Like most group medical plans, your benefits through the Motion Picture Industry Health Plan (MPI Health Plan) are subject to a provision against duplication with other Employer group health plans. This provision does not apply to individual health insurance policies.

A process known as order of benefit determination is used to coordinate the benefits of both plans where duplicate coverage exists. The order of benefit determination is that the benefits of the plan that covers the individual as an Employee, member or subscriber other than as a Dependent are determined before those of the plan which covers the individual as a Dependent.

Your other health plan will calculate its payment, and then MPIHP will calculate its normal benefit payable. If your other health plan already paid more than the MPIHP would have paid had MPIHP been primary, no additional payment will be paid toward that bill.

If the primary plan paid less than MPI would have paid had MPI been primary, MPI will pay up to the MPI 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 out-of-pocket expense for the patient. This same rule applies to prescription drug coverage if you are eligible for prescription drug coverage under another health plan.

Payment Priority
The first of the following rules which applies determines which plan is primary:
1. A plan without a Coordination of Benefits provision is considered primary.

When both plans have Coordination of Benefits rules, the following applies:
2. A plan in which you are enrolled as an Employee rather than as a Dependent is primary.
3. If you are not separated or divorced, you are the natural parents and your children are enrolled in both parents’ Employers’ plans, including the MPI Health Plan, the Plan uses special rules to determine which plan pays benefits first. In most cases, the Plan uses the “Birthday Rule” in which 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. 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.
4. If your children are covered under MPIHP/Anthem Blue Cross and another plan in which one parent is a Participant and the other parent is not, the Birthday Rule does not apply. Instead, the MPI Health Plan uses the following list to determine which plan pays benefits first:

Benefits are 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.

5. 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.
6. In most cases, a plan in which you are enrolled as an active Employee or subscriber rather than as a COBRA Participant is primary.

7. If you are the insured in more than one plan, the plan covering the individual for the longest period of time is considered primary.

8. If none of the above rules determines which plan is primary, the Allowable Amounts shall be shared equally between the plans. When applying this rule, the Motion Picture Industry Health Plan will not pay more than it would have paid had it been primary.

When you or your eligible Dependents have any other Employer group health plan, the MPI Health Plan will coordinate with the other group plan.

Spouse/ Same-Sex Domestic Partner Eligibility
A Participant’s spouse or same-sex domestic partner who is eligible for a health insurance plan through his/her own Employer is not eligible for primary health care coverage through the MPI Health Plan. The Plan coverage will be coordinated as a secondary plan for your spouse or same-sex domestic partner if the spouse or domestic partner enrolls in his/her Employer’s plan.

It is important to note that if a Participant’s spouse/same-sex domestic partner is eligible for any type of health coverage (Indemnity Health Plan, HMO, POS, PPO, etc.) through his/her Employer but did not enroll in such plan, the MPI Health Plan will not provide any coverage for that spouse. The Participant’s spouse/same-sex domestic partner is required to take the medical-hospital and prescription drug benefit coverage from his or her Employer. The spouse/same-sex domestic partner will continue to be covered for dental and vision benefits through the MPIHP as primary.

This rule will apply even if the spouse/same-sex domestic partner is required by his or her Employer to pay all or a portion of the Premium cost for coverage. Of course, if he or she is not employed or is employed but not eligible for a health insurance plan provided by the Employer, the MPI Health Plan will remain the primary coverage.
**Spouse/Same-Sex Domestic Partner Eligibility Determination Requirements:**
In order to determine spouse or same-sex domestic partner eligibility for other health insurance coverage, all Participants and those with same-sex domestic partners covered by the MPI Health Plan must periodically provide to the Plan the following documents:

- If the spouse/same-sex domestic partner is unemployed, the Plan will require a sworn declaration attesting to the fact.
- If the spouse/same-sex domestic partner is employed, the Plan will require certification from his/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/her spouse/same-sex domestic partner 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.

**Please Note:** If, for any reason, an MPI Health Plan Participant fails to furnish the required spousal or same-sex domestic partner information, that Dependent will automatically be excluded from all eligibility, including eligibility for medical, hospital, dental, vision, and prescription drug coverage. The MPI Health Plan will assume the spouse or same-sex domestic partner has other health coverage. Therefore, it is extremely important that the required information be provided in a timely manner.

**Spouse/Same-Sex Domestic Partner Coordination of Benefits**
If a Participant’s spouse or same-sex domestic partner is eligible for and/or enrolled in a health plan provided by his/her own Employer, the MPI Health Plan will pay benefits only after his/her Employer’s plan issues its benefit payment. That is, the spouse’s or same-sex domestic partner’s health coverage will be considered primary for the spouse/same-sex domestic partner, and the MPI Health Plan will be secondary.

**Eligibility and Coordination of Benefits for Dependent Children:**
If a spouse or domestic partner enrolls his/her Dependent child(ren) in his/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 in an earlier month in the year. If the spouse’s/same-sex domestic partner’s birthday is earlier than the Participant’s, his/her insurance will be considered primary. If the Participant’s birthday comes first, the MPI Health Plan will be primary for the Dependent child(ren).

If a spouse or domestic partner enrolls in his/her Employer’s health coverage, and child Dependents can be enrolled at no additional charge, such Dependents must be enrolled. If they are not enrolled under these circumstances, the MPI Health 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/domestic partner’s Employer’s health plan, only if one of the following occurs:

- The spouse/domestic partner declines coverage under his/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/domestic partner under that plan.

- There is an additional cost for covering Dependent children.
- There is no coverage available for the child under the Employer’s plan.

**Note:** It is important that you and your Dependents enroll for any Employer group health plan available to complete your medical coverage program.

**Dual MPI Coverage**
Participants or Dependents who are eligible for both primary and secondary coverage under the Plan may receive an alternative Coordination of Benefits provision for medical benefits only if they both pay the required Premiums for Dependent coverage. For the HMOS, they must also both elect the same HMO to receive 100% coverage. For Oxford, one person must choose the MPIHP/Anthem plan. Then, only the person choosing the MPIHP/Anthem plan would receive 100% coverage. The person electing the Oxford plan would receive his/her normal benefits. If both Participants elect MPIHP/Anthem Blue Cross, and the covered service is provided by an In-Network Provider, then MPI will pay 100% of the Allowable Amount, and the Participant will pay nothing. If your covered service is provided by an Out-of-Network Provider then MPI will:

- Determine the Allowable Amount for the Claim
- Determine the primary payment amount as 50% of the Allowable Amount less any applicable Co-Payment
- Determine the secondary payment amount as 50% of the Allowable Amount less any applicable Co-Payment
- Pay both the primary and secondary payment amounts

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 (EPO), Health Maintenance Organizations (HMO), Point of Service (POS), and Preferred Provider Organizations (PPO) Coordination**
If the primary carrier of you, your spouse or eligible Dependent child is an EPO, HMO, POS or PPO plan, but the choice is made to be treated by a non-EPO/HMO/POS/PPO Provider for services that are available from the EPO/HMO/POS/PPO network, the MPI Health Plan will make no payment as secondary payer.

The Plan will only consider out-of-pocket Deductibles and those services that are not available through the EPO/HMO/POS/PPO Provider. The MPI Health Plan must receive a written denial from the EPO/HMO/POS/PPO carrier to consider payment of out-of-pocket Deductibles and services not available through the EPO/HMO/POS/PPO Provider.

**Please Note:** Failure to follow the guidelines of your EPO/HMO/POS/PPO does not constitute a “not-available” service.
Medicaid Coverage Coordination
If you or your covered Dependents are covered under a state’s Medicaid program, the Plan will be primary and will pay benefits before Medicaid. Medicaid is a state plan for medical assistance approved under Title XIX of the Social Security Act of 1965, as amended.

The MPI Health 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 MPI Health Plan and will honor any subrogation rights that a state has to recoup such mistaken payments.

Medicare Coordination
When you or any of your eligible Dependents have any coverage under governmental programs or any coverage required or provided by any statute available, the MPI Health Plan will coordinate with the other program (except with respect to Medicare Part D, as described below). If the other plan would be the primary (first) payer, the Plan will not pay any benefit without a copy of an Explanation of Benefits statement issued by the other group plan.

If Medicare (Parts A and/or B) is the primary payer, and you or your eligible Dependents have chosen not to enroll in any portion of Medicare, the MPI Health Plan’s payable amount will be reduced by the estimated value of the benefits Medicare would have paid had you enrolled.

Once the Medicare coverage is exhausted for the Participant and Dependents whose primary insurance is Medicare, MPHIP will not cover those specific services either. For example, Medicare limits inpatient hospital benefits to 90 days per year with a 60 day lifetime reserve. It also limits the skilled nursing facility stays to 100 days per year. Medicare limits Mental Health inpatient hospital benefits to 190 days per lifetime. Non-covered Medicare items that are normally covered by MPHIP such as acupuncture, hearing aids and hearing exams will be covered.

Active Participant Eligible for Medicare Parts A and B
If you, an Active Participant, 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 MPI Health Plan is ordinarily the primary payer in other words, your Claims go to the Plan first if:
   a. You are currently working for an Employer or are covered by the MPI Health Plan as an Active Participant; or
   b. You first become eligible for Medicare benefits because you have end-stage renal disease (ESRD); in this case, the MPI Health Plan is the primary payer for the first 30 months you are eligible for Medicare due to ESRD; at the end of this period, in most cases Medicare will be the primary payer.

2. The MPI Health Plan pays secondary and Medicare is the primary payer if:
   a. The Dependent eligible for Medicare is your same-sex domestic partner (unless the domestic partner is Medicare-eligible based on a physical disability); or
   b. Your Dependent does not have ESRD and you are not currently working (considered an Active, working Participant).

3. If your Dependent is over age 65 and the MPI Health Plan would otherwise be the primary payer, he or she may elect Medicare as the primary payer of benefits. If he or she does, benefits under the Plan will terminate.

Retired Participants Eligible for Medicare Parts A and B
When you are age 64 and retired, you will need to apply for Medicare Parts A and B. Medicare Part A provides inpatient hospital benefits, and Medicare Part B pays for necessary doctor’s services, outpatient hospital services, and other medical services and supplies not covered by Part A.

You must enroll in Medicare Parts A and B when you reach age 65.

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

If you are age 65 or older and have applied for and established your monthly Social Security benefit, you ordinarily do not have to file an additional application for Medicare coverage. Medicare will mail you a card indicating that you have coverage under Parts A and B. You pay Medicare a monthly Premium for Part B coverage. Your Premiums for Part B coverage are ordinarily deducted from your Social Security benefits, if you get them. It’s important that you enroll in both Medicare Parts A and B because at age 65, Medicare will become your primary payer if you are not actively employed. In other words, your Claims go to Medicare first. If Medicare denies payment for a service that the MPI Health Plan considers eligible, the Plan may pay up to its normal benefit amount.

This same rule applies if your doctor or hospital does not submit bills to Medicare on your behalf. Medicare will not pay benefits for care received outside the United States. Contact your local Social Security office for more information on Medicare benefits.
**Medicare Part D**

Medicare Part D is a government-sponsored, voluntary prescription drug benefit program. MPIHP does not coordinate benefits with any Medicare Part D program.

Enrollment in the Part D Program by Medicare-eligible individuals is **not required**. In most cases, the Medicare Part D benefit will not provide any advantages over your MPIHP prescription drug plan through Express Scripts because your current out-of-pocket expenses are ordinarily much lower than they would be under the Medicare Part D Program.* It is important that you review your personal financial and medical situation to feel comfortable with your choice.

If you do not enroll in the Medicare Part D Program, you will continue to be covered by the MPIHP’s comprehensive pharmacy benefit, administered by Express Scripts.

A person enrolled in the Medicare Part D Program will not be covered by the MPIHP prescription drug benefit. Medicare will replace MPIHP prescription drug coverage for that person, and there will be no Coordination of Benefits with MPIHP regarding prescription drug benefits. Enrollment in Medicare Part D will not, however, affect you or your eligible Dependents’ eligibility for benefits with the MPIHP, other than prescription drug benefits.

**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 benefits will be payable nor paid under any coverage of the MPI Health Plan unless you contractually agree in writing, in a form satisfactory to the MPI Health Plan, to do all of the following:

1. Provide the MPI Health 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 MPI Health 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 MPI Health Plan in connection with any Recovery (as described and defined below) from the Recovery;
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 MPI Health 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 the Claim against the third party, and notify the MPI Health Plan, in writing, within ten (10) days after any Recovery has been obtained; and
7. Direct any legal counsel retained by you or any other person acting on your behalf 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 and facilitate the reimbursement to the MPI Health Plan of the monies owed it (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 MPI Health 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 Overpayment is resolved. *(Please refer to page 48 under Overpayments.)*

In addition to any other remedy, the MPI Health Plan may enforce the terms of the Plan described in this section through a court action to assure that the benefits paid by the Plan, and where applicable, interest, are fully reimbursed.

The MPI Health Plan may also require the filing of periodic reports regarding the status of your 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 uninsured or underinsured motorist coverage, related to the illness or injury, without reduction for any attorneys’ fees paid or owed by you or on your behalf, and without regard to whether you or your Dependent have been “made whole” by the Recovery. The Plan will not pay any portion of the Participant’s or his/her eligible 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 the name of the Participant or his/her eligible Dependent, other than uninsured or underinsured motorist coverage. The Recovery includes all monies received regardless of how held, and includes monies directly received by the Participant or eligible Dependent, as well as any monies held in any account or trust on their behalf, such as an attorney-client trust account or special needs trust. The Participant (and eligible Dependent, if applicable) shall pay to the MPI Health 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 MPI Health Plan is not reimbursed from the Recovery, the Participant (and eligible 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 MPI Health Plan in connection with the illness or injury exceed the amount of the Recovery, neither the Participant nor his or her eligible Dependents shall be responsible for any benefits paid in excess of the amount of the Recovery, other than interest as described below.

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* You may qualify for government assistance to help pay for some of the costs not covered by the Medicare benefit. Further information is available at www.socialsecurity.gov or by calling the Social Security Administration at 800.772.1213.
Your acceptance of benefits from the MPI Health 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 have not been “made whole” by the Recovery, or that your 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 incur in connection with your Claims against the third party.

The Participant shall be obligated to pay interest to the MPI Health 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 MPI Health Plan is paid either from the Recovery or by the Participant.

**Workers’ Compensation**
The MPI Health 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 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 MPI Health 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 MPI Health 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 MPI Health 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 MPI Health 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 MPI Health 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 MPI Health 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 MPI Health 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 MPI Health 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 MPI Health 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 MPI Health 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 fails to, in a timely fashion:

1. Notify the MPI Health Plan of the filing of a Workers’ Compensation Claim;
2. Provide the MPI Health Plan with a copy of the Workers’ Compensation Claim Form or Application;
3. Complete and return a Questionnaire Form;
4. Notify the MPI Health Plan of the approval of a Workers’ Compensation Award;
5. Provide the MPI Health Plan with a copy of a Workers’ Compensation Award;
6. Notify the MPI Health Plan of the approval of a Workers’ Compensation Compromise and Release;
7. Provide the MPI Health 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 MPI Health Plan in litigating its lien rights before the Workers’ Compensation Appeals Board; or
9. Provide complete and accurate information on the Questionnaire Form.
**Coverage Rates by Provider Categories**

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Coverage Rate</th>
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<tbody>
<tr>
<td>Motion Picture &amp; Television Fund (MPTF) Providers or The Industry Health Network of the Motion Picture &amp; Television Fund (TIHN) Contracting Providers (Referral from MPTF required)</td>
<td>Covered services are paid by the Plan at the rate of 100% of the contract rate, less the patient’s $5 Co-Payment for each office visit/treatment.</td>
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<tr>
<td>Anthem Blue Cross and the BlueCard Program (outside California) Providers (who do not contract with TIHN)</td>
<td>Covered services are paid by the Plan at the rate of 90% of the contract rate, less the patient’s $15 (if the patient resides outside the MPTF service area) or $30 (if the patient resides in the MPTF service area) Co-Payment, per visit. The patient is also responsible for the 10% of the contracted rate not covered by the Plan.</td>
</tr>
<tr>
<td>Out-of-Network Providers</td>
<td>Covered services are paid by the Plan at the rate of 50% of the 70th percentile in the UCR schedule or the Anthem Blue Cross/BlueCard fee schedule. The $15 or $30 Co-Payment per visit still applies ($30 Co-Payment if the Participant resides within the MPTF service area defined on page 69 but chooses to not use one of the MPTF Health Centers or receive a Referral to use a TIHN Provider). The patient is also responsible for the 50% of the Allowable Amount not covered by the Plan and for any Balance Billing above the Allowable Amount.</td>
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**Acupuncture**

Acupuncture is only covered when services are rendered by a certified acupuncturist or medical doctor. Laboratory tests or diagnostic studies are not covered when ordered by an acupuncturist. A maximum of twenty (20) acupuncture treatments are covered per calendar year. The Maximum Allowable Charge for an Out-of-Network Provider is $94.50 per date of service, covered by the Plan at 50%, less a $15 Co-Pay. Acupuncture is available through certain MPTF Health Centers.

**Artificial Cervical Discs**

Artificial cervical discs may be covered if medically necessary and FDA requirements are met.

**Aquatic Therapy**

Aquatic therapy is considered a physical therapy modality and is subject to applicable plan benefit limits. *(See “Physical/ Occupational/Aquatic/Osteopathic Manipulative Therapies, (Outpatient),” page 60.)*

**Birth Control Devices**

The Plan will cover birth control devices provided in a doctor’s office. This includes the allowable office visit charge and any other Allowable Amount associated with the birth control procedure or injection. *(Please see “Express Scripts,” section starting on page 115, for prescription birth control information.)*

**Bone Mineral Density Measurement**

Bone density scans are covered for post-menopausal women, men or women with clinical evidence of vertebral osteoporosis, and men or women with certain medical conditions.

**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 condition.*
Case Management
Case Management is a process by which a nurse coordinator works with the patient, the family and the attending physician to develop an appropriate treatment plan and to identify and suggest alternatives to acute inpatient hospital care. 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. If you choose Case Management, the plan may pay for certain benefits through the Case Management program that would not otherwise be covered. These might include extended physical/occupational/aquatic therapy or home health care.

Because this program is voluntary, if a treatment plan is suggested by the Case Management coordinator, you, your family and your physician must all agree to the recommended plan. The purpose of the program is to benefit the patient. If you or your physician does 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.

In California, all requests for Case Management must be approved by the MPI Health Plan. If you are interested in learning about Case Management, call the MPI Health Plan at 855.ASK.4MPI (855.275.4674).

Participants requesting Case Management outside California may call BlueCard Access: 800.810.BLUE (2583) for information on Case Management.

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, $34 per follow-up treatment, and $159 per year for x-rays. Follow-up office visit charges are not covered.

Not Covered: Measures which constitute the practice of medicine by a chiropractor • Studio calls • On-site calls • Home visits • Exercise at a gym or similar facility. 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 medical doctor).

Please Note: Orthotics are not a covered benefit when prescribed by a chiropractor.

HMO Participants
Chiropractic care is available through ASH Networks for Participants and eligible Dependents enrolled in the MPI Health Plan’s HMOs, i.e., Health Net or Kaiser Permanente. The chiropractic care benefits are provided as follows:
• Up to 20 visits per calendar year are covered, regardless of condition or conditions.
• Participants and eligible Dependents may self-refer to an ASH Networks chiropractor for a $15 per visit Co-Payment.
• Use of an Out-of-Network chiropractor is not a covered benefit.
• ASH networks pay all Allowable Amounts, minus the $15 Co-Payment, directly to the approved Provider.

HMO List of Network Providers
• www.ashcompanies.com
• Customer Service at 800.678.9133

The Plan does not make any recommendations regarding the use of chiropractors affiliated with ASH Networks, Inc. but merely provides this information for use at your own discretion.

POS Participants
Participants enrolled in Oxford must access chiropractic care through Oxford.

Colonoscopy
Screening colonoscopy is covered every ten years for most individuals age 50 and over, and for some high-risk individuals at an earlier age. Generally, an anesthesiologist is not required for the procedure and is not covered without specific medical indications. Virtual colonoscopy is covered as a screening examination only.

Cosmetic Surgery
(See “Reconstructive/Cosmetic Surgery” page 61.)

Dental Treatment
Your dental plan describes your standard dental coverage. Dental treatment is not covered under your comprehensive medical benefits. Accidental injuries to natural teeth are covered by the dental plan you choose if services are provided within 180 days following the date of the accident. (See the “Dental Plan Options” section page 97.)

Medical Services Provided by Dentists
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 physicians and are covered under the Comprehensive Medical Plan: myalgia, myositis, migraine, trigeminal neuralgia, sleep apnea, and temporomandibular joint disorder.
Oral appliances are not covered for the treatment of malocclusion or bruxism. Dental implants may be covered in cases of trauma, ablative surgery or congenital anomalies. Prosthetic rehabilitation of dental implants including abutments and crowns are not covered under the medical benefit.

**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. Services that exceed this amount should be preauthorized and have reports submitted for the services to be performed.

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

*Please Note:* Coverage for insulin pumps will be determined based on medical necessity. We strongly recommend that insulin pumps be preauthorized. Replacement insulin pumps are covered only for medical necessity such as inadequate control or defective equipment.

**Diagnostic Imaging and Laboratory Tests**
Diagnostic x-rays, CT scans, MRI (Magnetic Resonance Imaging), PET scans, and laboratory tests for illness or injury are covered when reasonable and necessary and ordered by the treating licensed medical doctor. Confirmation of medical necessity for any diagnostic testing may be required at the discretion of the Plan.

*Please Note:* 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 medical doctor).

**Durable Medical Equipment**
Some medical equipment that is rented or purchased may be a covered benefit of this Plan. Purchase of equipment is limited to once every two years if medically indicated, except in situations where the patient’s change in size requires new equipment sooner. Total payment for equipment rental cannot exceed the allowable purchase price of the item. New purchases or repairs of items currently being used are not covered if the original item is still under warranty.

*Please Note:* The fact that the item is prescribed by physician does not, of itself, guarantee coverage and payment.

Requirements and limitations of this benefit are as follows:
1. You must obtain a prescription from the treating physician.
2. Benefits for medical equipment are subject to review for medical necessity and appropriateness for the condition being treated.

If there is a question regarding medical necessity, the Medical Review Department may request a clarification letter from the treating physician.

When more than one option is available, the most cost-effective alternative will be covered. Replacements are covered only for medical necessity such as inadequate control or for defective equipment.

**Over-the-counter, general use/convenience items are not covered.**

Listing every item that is considered general use/convenience items is not possible; however, 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 physician.
Emergency Room Treatment
Emergency room treatment will be paid at the rate of 90% of Allowable Amount, less a $100 Co-Pay, waived if admitted to the hospital on an inpatient basis. Balance Billing can apply for Out-of-Network facilities and Providers.

Genetic Testing
Genetic testing is a covered benefit in limited cases, as described below:

1. Prenatal testing ordered by an obstetrician for evaluation of carrier states.
2. Newborn testing as directed by the state.
3. Testing for congenital abnormalities in utero (by amniocentesis or chorionic villus sampling).
4. BRCA 1 and BRCA 2 testing for evaluating risk of development of breast or ovarian cancer if there has been genetic counseling and the tests are recommended by a Physician Medical Geneticist.
5. Hereditary Non-Polyposis Colorectal Cancer (HNPCC) and Familial Adenomatous Polyposis (FAP) testing for evaluating risk of development of colon cancer if there has been genetic counseling and the test is recommended by a Physician Medical Geneticist.

All other genetic tests are specifically excluded unless the Benefits/Appeals Committee determines, based on the advice of a Physician Medical Geneticist and the Plan’s Medical Director, that there is a high likelihood that the results of the genetic test will materially affect the patient’s treatment.

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. (HMO enrollees must have their hearing tested through their HMO.) You will be responsible for a portion of the hearing aid cost. For an Anthem Blue Cross Provider, the Plan will pay 90% of the contracted rate, up to a maximum Allowable Amount of $1,386 per ear. For Out-of-Network Providers, the Plan will pay 100% of the 70th percentile of UCR, up to a maximum of $1,386. This benefit covers one hearing aid per ear, once every three (3) years.

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, as well as practical services that help everyone make the most of the final months of life.

Hospice teams include physicians, 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 MPI Health Plan benefits as their primary coverage
• Have no other Home Hospice coverage available (this would include Medicare or any other health plan that has a hospice benefit)
• Are not enrolled in Health Net, Kaiser or Oxford
• Have a treating physician who indicates that the patient is likely to have less than six months’ life expectancy
• Indicate their desire to have hospice services provided in the home

Hospice services provided in the home through the MPI Health 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

Childhood Immunizations
The following childhood immunizations are a covered benefit for Dependents from birth through age 22 or as otherwise limited below:

• Chicken pox
• Haemophilus influenzae type B (Hib)
• Hepatitis A and B
• Human papillomavirus (HPV) (females and males, ages 9 through 26).
• Influenza
• Measles
• Meningitis
• Mumps
• Pneumococcus
• Polio
• Rotavirus
• Rubella
• Tetanus, diphtheria, pertussis
Adult Immunizations
• Tetanus, Diphtheria, Pertussis booster every ten years
• Influenza
• Pneumovax: For persons with chronic medical conditions from age 19, including chronic pulmonary disease, including smokers and persons with asthma, cardiovascular disease, diabetes, chronic liver disease, chronic kidney disorder, immunosuppressive disorders, asplenia and a one-time revaccination after five years as recommended by the CDC on a limited basis
• Hepatitis A and hepatitis B vaccine: For patients with hepatitis C
• Meningitis vaccination: Participants and their eligible Dependents of any age are covered if:
  – Their spleen is non-functional or has been surgically removed
  – They suffer from specific immune deficiencies
  – They have been diagnosed as being HIV-positive
• Shingles vaccine: For persons age 60 and older

If the immunization is associated with an office visit, then the visit Co-Payment will apply.

Lens Replacement Following Cataract Surgery
Coverage of a new spectacle lens for the surgically-treated eye after undergoing cataract surgery is a covered benefit through the MPI Health Plan. This benefit does not include new frames.

Mammography
One routine/screening mammography per calendar year will be covered. Follow-up mammography for a specific medical condition is a covered benefit. A digital mammogram is covered at the same allowance as a standard mammogram.

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 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.

Elective termination of pregnancy (abortion) will be covered if any one of the following is present:

1. A serious medical condition exists in the mother such that the pregnancy is a major threat to her health.
2. The fetus has severe chromosomal or anatomical abnormalities which a neonatologist, perinatologist, or geneticist certifies are not compatible with life.
3. The fetus has severe chromosomal or anatomical abnormalities that are a major threat to the mother’s physical health.

Documentation to support the above will be required from the physician recommending termination of the pregnancy. Coverage will apply only when the procedure is performed within the duration of pregnancy allowed by state law.

Full maternity benefits for the delivery are payable only if the Participant or Dependent spouse is eligible at the time of delivery or termination of the pregnancy. The in-hospital, initial newborn exam is covered; follow-up hospital visits for a well newborn are not covered.

The Plan will not 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, nor 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 newborn earlier than 48 hours (or 96 hours as applicable).

To avoid delays in coverage for your newborn baby, remember to provide an official copy of the birth certificate to the California MPI Health Plan office as soon as possible after your baby is born. It is the parents’ responsibility to provide it.

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

Birth records from your hospital are acceptable. The Plan must have the official hard copy.

Please Note: No maternity benefits are available for Dependent children or surrogates.

Mental Health and Chemical Dependency
The Motion Picture Industry Health Plan has arranged for mental health and chemical dependency benefits through OptumHealth Behavioral Solutions (OHBS), a United Health Group company, for eligible Active Participants and covered Dependents.

Through the Optum network of Participating Providers, the following services are available:
• Professional counseling
• Outpatient and inpatient mental health care
• Chemical dependency (drug and alcohol) treatment, including detoxification

Optum professionals can help with issues that interfere with your home or work life by providing treatment options for marriage and family problems, crisis situations, stress management, anxiety, alcohol or drug abuse, depression and more. (See page 71.)

Preauthorization
We strongly recommend that you get Preauthorization for the non-routine services listed on page 73. It is best to call OptumHealth Behavioral Solutions at 888.661.9141 and find out if your Provider is already on the OHBS network and if your service is considered non-routine. An OptumHealth 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.
HMO/POS Enrolled Participants
Participants who have selected one of the Health Maintenance Organizations (HMOs) or Oxford (a POS) offered by the Plan must use the HMO/POS for mental health and chemical dependency benefits.

Further Information
Additional summary information is available in, “OptumHealth Behavioral Solutions” on page 71. Please refer to the OptumHealth Combined Evidence of Coverage and Disclosure Form book for a complete description of your behavioral health benefits. To request a copy, please call OptumHealth at 888.661.9141. To review or search an online list of OptumHealth network Providers, go to www.liveandworkwell.com, click on “For Our Members,” then click “Provider Directory.”

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

1. The patient must medically require therapeutic 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 (please see page 56).

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

Nutrition Counseling
The Plan will cover up to three nutrition counseling sessions each calendar year for Participants and eligible Dependents. The benefit applies to any medical diagnosis when the counseling is prescribed by a physician and provided by a registered dietitian. This benefit is subject to the applicable Co-Pay. There may be additional out-of-pocket expenses if the dietitian is out-of-network.

Nutritional Support
In the case of any MPI Health Plan Participant or eligible Dependent who is physically incapable of swallowing, gastric tube feeding is a covered benefit upon receipt of physician-verified inability to take food by mouth. The benefit covers at-home feedings only and is in addition to services that may be provided in the hospital.

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

Physical Examinations
If you are age 18 and older and you reside in Los Angeles County, you must use the Motion Picture & Television Fund Health Centers for the Comprehensive Physical Exams covered by this Plan. (See “The Wellness Program,” page 121.)

If you reside outside of Los Angeles County, you may go to the physician of your choice.

Newborn Through Age 17
The Plan covers well child care visits for eligible Dependent children newborn through age 4, and once annually for children age 5 through 17.

HMO/POS Enrolled Participants
Participants who have selected one of the Health Maintenance Organizations (HMOs) or Oxford Health Plans must use either the HMO or the POS in which they are enrolled for their physical examinations.

Physical/Occupational/Aquatic/Osteopathic Manipulative Therapies (Outpatient)
Physical therapy, occupational therapy, aquatic therapy and osteopathic manipulative therapy (Outpatient) are covered only when rendered by a registered physical therapist, an occupational therapist, a doctor of osteopathy or a medical doctor.

A maximum of sixteen (16) physical/occupational/ aquatic therapy treatments are covered per calendar year. Additional treatments will be reviewed for possible coverage based on medical information provided by the treating physician. The initial visit/evaluation is allowed separately and is not included in the 16-treatment limitation.

The maximum Allowable Amount per treatment for an Out-of-Network Provider is $94.50, payable at 50%, less a $15 or $30 Co-Pay.

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, an additional 16 visits for the second incident may be approved upon request and review by the Medical Review Department.

The therapy must be prescribed by a physician, with duration and interval of therapy noted on the prescription. Your physician 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 an M.D.

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

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

HMO/POS Enrollees
Podiatric care is covered under the Plan HMOs (Health Net and Kaiser) as well as Oxford. Participants must check with the HMO or POS in which they are enrolled to obtain covered podiatric care.

Prostheses and Braces
Prostheses and braces are covered under Durable Medical Equipment.

For Participants and Dependents age 17 years and older, replacement is covered once every two years if medically indicated.

For Dependent children age 16 and under, replacement is covered once yearly if medically indicated. (Please see “Durable Medical Equipment,” page 57.)

Reconstructive/Cosmetic Surgery
Cosmetic Surgery is not a covered benefit.

The Plan only covers services for reconstructive surgery when medically indicated:
1. For the treatment of non-industrial illness,
2. For the correction of a congenital malformation,
3. For reconstruction due to accidental injury, and
4. For reconstructive surgery following a mastectomy.

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, expenses for 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. (See page 55 for coverage rates.)

For Services Rendered Outside California, the Participant or Provider must call Anthem Blue Cross at 800.810.BLUE (2583) if Preauthorization is requested.

If the patient is receiving services in California, please call the MPI Health Plan office at 855.ASK.4MPI (855.275.4674).

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.

Sclerotherapy
Sclerotherapy is a covered procedure for the treatment of varicose veins when medically indicated. Benefits will be based upon the documentation of the operative report (and photographs, at the discretion of the Plan). The maximum Allowable Amount for an Out-of-Network Provider is $94.50 per leg, payable at 50%.

Speech Therapy
A maximum of 32 speech therapy treatments are covered per calendar year, under the following conditions:

• For Participants and Dependents of All Ages: Speech therapy benefits only apply to individuals who have experienced a stroke, or who have had an injury or surgery affecting speech. In these cases, speech therapy must be rendered by a licensed speech pathologist and must be prescribed within 90 days of the event.

• For Dependent Children Age 16 Years and Under:
Speech therapy is also covered for the following diagnoses: developmental speech delay, stuttering, autism, apraxia and dysarthria. A speech therapy Referral is also available through the MPTF Health Centers.

Preauthorization is not required but strongly recommended for all non-emergency reconstructive surgeries. Confirmation of coverage should be obtained prior to surgery. In California, this means:

1. A letter of medical necessity by your doctor(s), and possibly, at the discretion of the Plan
2. A confirming Independent Medical Examination (IME) opinion by a physician selected and paid for by the Plan (without the IME, the Plan may not be able to verify medical necessity) and
3. The issuance of a Plan-written determination of coverage to you.

The Plan-appointed independent medical consultant cannot perform the surgery.
Transplants
Transplants are preauthorized by Anthem.

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, contact Anthem Blue Cross at 800.274.7767.

Weight Control
Services rendered in connection with weight control are not covered. The fact that a physician may prescribe or recommend weight control because of the diagnosis of hypertension, heart disease, etc., does not establish coverage.

This Exclusion also includes surgical procedures for weight control. Weight control medication is not a covered benefit.

Wigs/Hair Pieces
Active Participants and their eligible Dependents who have undergone chemotherapy, have undergone radiation therapy to the head, or have another medical condition of the scalp are eligible for reimbursement for one wig/hair piece costing up to $240 per lifetime. The Participant must submit the physician-executed Wig/Prosthesis Certification Form attesting to the fact that the prescribed wig is essential to the patient’s mental health. An itemized bill/receipt must be submitted to the California Plan Office.

For eligible Dependents age 16 or under, provided the circumstances noted above are still applicable, the Plan will cover two (2) wigs/hair pieces, up to $240 per wig/hair piece or a total of $480 per lifetime. For more information about this benefit or to request the required Wig/Prosthesis Certification Form, please call the MPI Health Plan Medical Review Department at 855.ASK.4MPI (855.275.4674). The form is also available on the Plan’s website: www.mpiphp.org.

Please Note: Participants enrolled in Health Net, Kaiser, or Oxford must contact their respective plan to verify their benefits.
Non-Covered Services and Items include, but are not limited to (in alphabetical order):

Abortions (see page 59 for exceptions)
Air purifiers/air filter systems
Alcohol injections for Morton’s neuroma
Apparel (items that serve as apparel, except wigs)
Artificial insemination or related services
Artificial lumbar discs
Autopsy
Bathroom equipment
Biofeedback therapy
Blood pressure devices
Body scans (Imaging)
Breast implants (except as outlined on page 61)
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 (except as outlined on page 61)
Custodial Care
Dental implants (except as outlined on page 57)
Dental services, routine (see your Dental Plan in this Summary Plan Description)
Dermabrasion
Diagnostic tests not related to an illness or injury
Diet analysis
Donor search
E-mail correspondence consultations
Electrolysis
Embryo freezing
Exercise devices/programs
Experimental/Investigational Services, Treatments, Medications or Devices
Extracorporeal shock wave therapy (except for kidney stones)
Eye examinations, refractions (see Vision services benefits in this Summary Plan Description, page 119)
Facials
Facility fees
Food allergy testing (except for children up to age 5 years; Preauthorization is recommended)
Gait analysis (except for pre- and post-op assessment of patients with cerebral palsy)
Gait training
Gastric bypass or any other surgical procedure for obesity
Gender change
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
Herbalists
Home uterine activity monitoring (HUAM)
Homeopathic medicine/treatments
Home or studio/set visits by chiropractors
Hospice, inpatient
Humidifiers
Hydrocollators
Hypnotherapy
Incontinence supplies/diapers
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<tr>
<th>Non-Covered Services and Items (continued)</th>
<th>Over-the-counter items</th>
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<tbody>
<tr>
<td>Infertility (any services related to infertility)*</td>
<td>Over-the-counter medication</td>
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<tr>
<td>Insurance forms (fees for completion/duplication of medical records)</td>
<td>Patient advocate fees</td>
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<tr>
<td>Interpreters</td>
<td>Post-operative care (included in fee for surgery)</td>
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<tr>
<td>Investigational/experimental services</td>
<td>Pregnancy benefits for Dependent children</td>
</tr>
<tr>
<td>In Vitro fertilization (IVF)</td>
<td>Prolotherapy</td>
</tr>
<tr>
<td>Learning disability</td>
<td>Reports (preparation of records, medical reports for school, job, legal, etc.)</td>
</tr>
<tr>
<td>Lost or stolen prescriptions</td>
<td>Retin-A (except for the treatment of acne, acne vulgaris and Darier’s disease.)</td>
</tr>
<tr>
<td>Massage therapy (any services rendered by masseur/masseuse)</td>
<td>Self-injectable medication dispensed in a doctor’s office</td>
</tr>
<tr>
<td>Maternity benefits for Dependent children or surrogates</td>
<td>Services rendered or prescribed by a family member</td>
</tr>
<tr>
<td>Measures which constitute the practice of medicine by a chiropractor</td>
<td>Shower chairs</td>
</tr>
<tr>
<td>Medical photography</td>
<td>Sperm freezing/storage</td>
</tr>
<tr>
<td>Medical social worker (services rendered by)</td>
<td>Stimulators TENS units (other stimulators will be reviewed for medical necessity)</td>
</tr>
<tr>
<td>Medication (oral or self-injectable) dispensed in the doctor’s office</td>
<td>Stop-smoking clinics, treatment</td>
</tr>
<tr>
<td>Medication for services or procedures not covered</td>
<td>Studio calls</td>
</tr>
<tr>
<td>Mineral analysis</td>
<td>Sun lamps</td>
</tr>
<tr>
<td>Missed appointments</td>
<td>Telephone, electronic mail (e-mail) and other consultations which are not made in person</td>
</tr>
<tr>
<td>Naturalists</td>
<td>Third party liability, any services related to an illness/injury for which a third party is legally responsible (see page 53)</td>
</tr>
<tr>
<td>Naturopathic medicine</td>
<td>Traction appliances</td>
</tr>
<tr>
<td>Nicotine dependency clinics, treatment</td>
<td>Travel immunizations</td>
</tr>
<tr>
<td>Nursing assistants (CNA/HHA), nursing aides</td>
<td>Tubal ligation, or revision thereof</td>
</tr>
<tr>
<td>Nutritional supplements, vitamins, minerals, including pediatric formula (not to be confused with “Nutritional Support”)</td>
<td>Vaporizers</td>
</tr>
<tr>
<td>Office visit charges for a wellness exam or physical exam and a medical diagnosis exam on the same day</td>
<td>Urinary drug testing</td>
</tr>
<tr>
<td>On-site calls/studio calls</td>
<td>Vasectomy, or revision thereof</td>
</tr>
<tr>
<td>Operating room technicians</td>
<td>Vitamins and vitamin injections (except vitamin B12 in proven pernicious anemia)</td>
</tr>
<tr>
<td>Orthopedic shoes</td>
<td>Weight control services, drugs, surgeries</td>
</tr>
<tr>
<td>Orthoptic treatment (vision therapy)</td>
<td>Whirlpool baths/equipment</td>
</tr>
</tbody>
</table>

*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 doctor diagnosing a condition as infertility.
All covered MPI Health Plan benefits are provided based on, among other things, medical necessity of the service or procedure. In an effort to eliminate any possible delay or prevent any of our Participants from obtaining the medical services that they require, the MPI Health Plan does not require Preauthorization for any covered benefit. The other contracted networks offered under the Plan (for example, Kaiser, Health Net, Oxford, etc.) have their own Preauthorization guidelines. Please refer to the Evidence of Coverage provided by the carrier or contact them directly to obtain more detailed information.

An MPIHP 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.

Some services may not meet the requirement of medical necessity. To avoid any unnecessary out-of-pocket expenses or payments, it may be in your best interest to verify coverage by the Plan. If you are concerned about the coverage of a proposed service or procedure, please have your physician send a letter of medical necessity to:

Medical Review  
MPI Health Plan  
P.O. Box 1999  
Studio City, CA 91614-0999

Following are some examples of when you would be strongly advised to obtain Preauthorization:
1. Reconstructive Surgery
2. Possible investigative testing and treatment
3. Dental Implants

Contacting the MPIHP California Plan Office in writing for verification of coverage is strongly recommended.

Instructions for Obtaining Preauthorization for Services to be Rendered in California

1. Obtain a letter of medical necessity from your doctor(s) and submit it to the MPI Health Plan Medical Review Department. The letter should include the Participant’s name and Social Security or identification number, the patient’s name, and the procedure or test being contemplated. The letter should also include Provider information such as name, specialty and Tax ID number.

2. The Plan recommends an Independent Medical Examination (that is, an outside independent evaluation and report) prior to authorizing benefits for certain procedures. If Preauthorization is being requested to ensure that reconstructive surgery will be deemed medically necessary and covered, the patient may be required to undergo an Independent Medical Examination by a physician selected by the Plan. (Independent Medical Examinations must be arranged through the Medical Review Department of the Plan in order for the cost to be covered by the Plan.)

3. Receive a written Preauthorization from the Medical Review Department. (Preauthorization is always provided in writing.)

In the case of surgery, unless an Independent Medical Examination takes place before the surgery, the Plan may not have sufficient information from which to conclude that the surgery was medically necessary rather than cosmetic.

Services Rendered Outside California
Any Claim for benefits connected with reconstructive surgery not preauthorized may be denied unless Anthem Blue Cross concludes that the information available clearly establishes the surgery as medically necessary.

If Preauthorization is requested:
- For services outside California: Call Anthem Blue Cross, 800.274.7767.
- For services in California: Call MPIHP 855.ASK.4MPI (855.275.4674).
Filing An Appeal with MPIHP
If you feel that your Claim or request has not been processed correctly by MPIHP, you have 180 days following the receipt of your Explanation of Benefits or other initial adverse determination to make a formal request for review by the 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 us to understand the situation. Your request must be addressed to:

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

The Directors generally schedule meetings once a month to review files. The 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 Committee’s decision in writing.

The failure to file such an appeal within 180 days from your receipt of the initial Adverse Benefit Determination shall constitute a waiver of the right to review 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.

Filing Appeals with MPIHP Contract Providers
There are a number of other health care options made available to you through companies with which the MPI Health Plan contracts, such as HMOs, POS, behavioral health, prescription drugs, dental, vision, and life. Appeals for health care services made available through these entities are ordinarily handled by the entities themselves, rather than by MPI Health Plan. For those entities, the time frame for Claims review depends on what type of Claim is being filed, and we describe for you on the following page how those different types of appeals are handled. You should remember that these guidelines are minimum guidelines for these contract Providers, and so you should also review the material in this Summary Plan Description, which is specific to the Provider as well as the separate materials furnished to you by the Provider. A contract Provider may not, however, under current ERISA guidelines, require you to participate in mandatory binding arbitration in connection with an appeal of an adverse benefit decision.

Time Limits for MPIHP Appeals Processing

<table>
<thead>
<tr>
<th>How long does a Participant have to appeal?</th>
<th>180 days following receipt of a notification of Adverse Benefit Determination.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the appeal deadline by which the Claimant must be notified of an appeals decision?</td>
<td>Appeals will 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 Committee will inform the Participant of the need for a further extension, what those special circumstances are, and the date the appeal will be decided. In that instance the appeal will be decided no later than the date of the third meeting following the appeals request. You will be provided notice of the appeals decision within five days of the decision.</td>
</tr>
</tbody>
</table>

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 MPI Health Plan pays only those benefits established by the Plan’s Directors. The Benefits/Appeals Committee shall have the discretion and final authority to interpret and apply the Plan of Benefits, the Trust Agreement 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 Participants 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.
As indicated on the previous page, time frames for contracted Providers to process your appeals depend on the type of appeal filed.

### Appeals Time Limits for MPIHP Contract Providers

<table>
<thead>
<tr>
<th>How long does a Participant have to appeal?</th>
<th>Claims Not Requiring Preauthorization (Post-Service Claims)</th>
<th>Claims Requiring Preauthorization (Pre-Service Claims)</th>
<th>Urgent Care Claims Requiring Preauthorization (Urgent Care Claims)</th>
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<tbody>
<tr>
<td><strong>How long does a Participant have to appeal?</strong></td>
<td>180 days following receipt of a notification of Adverse Benefit Determination.</td>
<td>180 days following receipt of a notification of Adverse Benefit Determination.</td>
<td>180 days following receipt of a notification of Adverse Benefit Determination.</td>
</tr>
<tr>
<td><strong>What is the appeal deadline by which Claimant must be notified of appeals decision</strong></td>
<td>If one required level of appeal: 60 days from receipt of the appeal.</td>
<td>If one required level of appeal: 30 days from receipt of the appeal.</td>
<td>72 hours from receipt of the appeal.*</td>
</tr>
<tr>
<td></td>
<td>If two required levels of appeal: 30 days from receipt of the appeal for each level.</td>
<td>If two required levels of appeal: 15 days from receipt of the appeal for each level.</td>
<td></td>
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</tbody>
</table>

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

**Note:**

- For appeals involving Medicare benefits, the guidelines for processing appeals may differ somewhat. Any differences will be described in the Evidence of Coverage for the applicable plan.
- Provider initiated appeals (i.e., those appeals that are initiated by a health care Provider rather than a Participant or Dependent) may not be subject to: 1) the limitations set forth above regarding the time within which the MPI Health Plan or a contract Provider must process the appeal (except in the case of an Urgent Care Claim), and 2) certain other rights under the appeals process, unless the health care Provider has been appropriately designated by the Participant or Dependent as his/her authorized representative. Providers are, however, like Participants and Dependents, required to utilize available remedies under the appeals procedures.

**Appeals Determination**

In appeals determinations, processed by either the MPI Health Plan or one of its Contracting Providers, the following information shall be made available:

1. The specific reason or reasons for any adverse determination.
2. Reference to the Summary Plan Description 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.

*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.*
**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 MPI Health 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 contract Provider 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 an MPI Health Plan contract Provider, 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.
MPTF (Motion Picture & Television Fund) provides cost savings and access to Providers with a unique understanding of the needs of Industry Participants and their eligible Dependents. MPTF offers five health centers located in the Los Angeles, California area, and Referrals to The Industry Health Network (TIHN), a group of contracted Specialist and ancillary Providers.

The MPTF service area is based on the Participant’s residence within a defined set of ZIP codes where the five health centers are located. (See below) The ZIP codes were identified based on a comprehensive evaluation of realistic drive times, not on actual distance, to the closest MPTF health center.

The MPTF/TIHN Network
Whether living in the service area or outside the service area, all non-HMO Participants and their eligible Dependents age 13 and older may choose to use any of the five health centers for a $5 out-of-pocket cost for covered services.

There is a strong cost-saving incentive for Participants who live in the service area to use the MPTF facilities and obtain Referrals to TIHN Providers.

The Co-Pay for Participants who live in the service area and choose to use a Provider other than an MPTF network Provider for covered services is $30 per visit plus Coinsurance. There is only a $5 Co-Payment to use the MPTF/TIHN network, so use of that network is strongly encouraged by the MPI Health Plan.

Specialty Services
MPTF/TIHN Primary Care Physicians treat adults and children age 13 and older. For children under age 13, The Industry Health Network (TIHN) has a network of pediatricians available. For a Referral to one of these Specialists, call 800.876.8320, Monday through Friday.

To access maternity benefits, Participants and their eligible spouses need to schedule an appointment with a MPTF/TIHN Primary Care Physician who will provide a TIHN Referral to an obstetrician. (Please Note: The MPI Health Plan has no pregnancy/maternity benefits available for Dependent children.)

Selecting a Provider, Scheduling an Appointment
For help selecting a Provider or to schedule an appointment, please call the nearest Health Center. Be sure to identify yourself as an MPI Health Plan Participant when you call, and take your insurance card with you to your appointment.

Using an Out-of-Network Provider
Please keep in mind that there will be occasions when, while being treated by a MPTF/TIHN doctor, you may need the services of a Specialist not available in the network. If you choose to see a Specialist outside the TIHN network, these doctors will be covered at 50% of the Allowable Amount for Out-of-Network Providers or 90% in the case of In-Network Providers less your Co-Pay.

Work Injury Visits
You may not be required to complete a Claim form when you visit a Medical Group doctor; however, to establish possible work-related injury/illness, third party liability, Coordination of Benefits, or to clarify the reason for seeking services, you may be requested by the Plan Office to complete a Claim form. Please do so promptly to avoid any undue delay in the processing of your Claim.
Services Rendered by this Group are Subject to the Coverage Limitations and Exclusions as Outlined in this *Summary Plan Description*.

MPTF (Motion Picture & Television Fund) Health Centers  
Customer Service: 800.876.8320  
www.mptf.com

<table>
<thead>
<tr>
<th>Health Center</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bob Hope Health Center</td>
<td>323.634.3850</td>
</tr>
<tr>
<td>335 North La Brea Avenue</td>
<td></td>
</tr>
<tr>
<td>Los Angeles, California 90036</td>
<td></td>
</tr>
<tr>
<td>Social Services Department........</td>
<td>323.634.3888</td>
</tr>
<tr>
<td>Physical Therapy...................</td>
<td>323.634.3826</td>
</tr>
<tr>
<td>Radiology............................</td>
<td>323.634.3850</td>
</tr>
<tr>
<td>Toluca Lake Health Center</td>
<td>818.556.2700</td>
</tr>
<tr>
<td>4323 Riverside Drive</td>
<td></td>
</tr>
<tr>
<td>Burbank, California 91505</td>
<td></td>
</tr>
<tr>
<td>Social Services Department........</td>
<td>818.295.3312</td>
</tr>
<tr>
<td>Physical Therapy...................</td>
<td>818.295.3355</td>
</tr>
<tr>
<td>Radiology............................</td>
<td>818.295.3320</td>
</tr>
<tr>
<td>Santa Clarita Health Center</td>
<td>661.284.3100</td>
</tr>
<tr>
<td>25751 McBean Parkway, Suite 210</td>
<td></td>
</tr>
<tr>
<td>Valencia, California 91355</td>
<td></td>
</tr>
<tr>
<td>Social Services Department........</td>
<td>818.295.3312</td>
</tr>
<tr>
<td>Physical Therapy...................</td>
<td>661.284.3155</td>
</tr>
<tr>
<td>Westside Health Center</td>
<td>310.996.9355</td>
</tr>
<tr>
<td>1950 Sawtelle Boulevard, Suite 130</td>
<td></td>
</tr>
<tr>
<td>Los Angeles, California 90025</td>
<td></td>
</tr>
<tr>
<td>Social Services Department........</td>
<td>323.634.3888</td>
</tr>
<tr>
<td>Physical Therapy...................</td>
<td>310.231.3001</td>
</tr>
<tr>
<td>Jack H. Skirball Health Center</td>
<td>818.876.1050</td>
</tr>
<tr>
<td>(formerly Woodland Hills Health Center)</td>
<td></td>
</tr>
<tr>
<td>23388 Mulholland Drive</td>
<td></td>
</tr>
<tr>
<td>Woodland Hills, California 91364</td>
<td></td>
</tr>
<tr>
<td>Social Services Department........</td>
<td>818.876.1080</td>
</tr>
<tr>
<td>Pharmacy................................</td>
<td>818.876.1040</td>
</tr>
<tr>
<td>Physical Therapy...................</td>
<td>818.876.1007</td>
</tr>
<tr>
<td>Radiology............................</td>
<td>818.876.1011</td>
</tr>
</tbody>
</table>

The facilities listed are not available to Participants who choose 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.
How OptumHealth Behavioral Solutions Benefits Work

At OptumHealth Behavioral Solutions (OHBS), our mission is to provide our members with quality behavioral health care and excellent customer service. To access Behavioral Health care, you can contact OHBS customer service at 888.661.9141, 24 hours a day. We encourage members to contact OHBS to see if their Provider is an OHBS contracted Provider or if there is a Participating Provider who is right for them.

### Schedule of Benefits

#### In Network Mental Health Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Deductible</td>
<td>No Charge</td>
</tr>
<tr>
<td>Inpatient per admission fee</td>
<td>No Charge</td>
</tr>
<tr>
<td>Inpatient, residential, and partial/day treatment</td>
<td>365 days unlimited</td>
</tr>
<tr>
<td>Outpatient mental health</td>
<td>365 visits unlimited</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>$5 Co-Payment per visit</td>
</tr>
</tbody>
</table>

#### Out-of-network Mental Health Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Deductible</td>
<td>No Charge</td>
</tr>
<tr>
<td>Inpatient per admission fee</td>
<td>$100</td>
</tr>
<tr>
<td>Inpatient Coinsurance</td>
<td>50% applies after the per admission fee</td>
</tr>
<tr>
<td>Inpatient, residential, and partial/day treatment</td>
<td>365 days unlimited</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>365 visits unlimited</td>
</tr>
<tr>
<td>Outpatient Coinsurance</td>
<td>50%</td>
</tr>
</tbody>
</table>

#### Network Chemical Dependency Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Deductible</td>
<td>No Charge</td>
</tr>
<tr>
<td>Inpatient per Admision Fee</td>
<td>No Charge</td>
</tr>
<tr>
<td>Inpatient, residential, and partial/day treatment</td>
<td>365 days unlimited</td>
</tr>
<tr>
<td>Outpatient chemical dependency</td>
<td>365 visits unlimited</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>$5 Co-Payment per visit</td>
</tr>
</tbody>
</table>

#### Out-of-Network Chemical Dependency Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Deductible</td>
<td>No Charge</td>
</tr>
<tr>
<td>Inpatient per admission fee</td>
<td>$100</td>
</tr>
<tr>
<td>Inpatient Coinsurance</td>
<td>50% applies after the per admission fee</td>
</tr>
<tr>
<td>Inpatient, residential, and partial/day treatment</td>
<td>365 days unlimited</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>365 visits unlimited</td>
</tr>
<tr>
<td>Outpatient coinsurance</td>
<td>50%</td>
</tr>
</tbody>
</table>
### How to Obtain Behavioral Health Services
To get Behavioral Health Services, you should first call OHBS at 888.661.9141. Customer Service Agents and Licensed Care Advocates are available 24 hours a day. When you contact OHBS Customer Service, an OHBS 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, OHBS Participating Provider near your home or work that meets your needs. 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. Please note that 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 73. It is best to call OHBS and find out if your Provider is already on the OHBS network and if your service is considered non-routine.

An OptumHealth 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?
In an emergency, if you are unable to contact OHBS, get help or treatment immediately. This means you should call “911” or go directly to the nearest medical facility for treatment. Then, we recommend calling 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 OHBS at 888.661.9141 to confirm that your Provider is In-Network and your service is routine.

### Who Are OHBS Participating Providers?
OHBS’s Participating Providers include hospitals, group practices and individual professionals. All Participating Providers are carefully screened and must meet strict OHBS licensing and program standards. For a listing of OHBS Participating Providers, go to www.liveandworkwell.com; access code: MPIPHP, or call toll-free 888.661.9141.

---

<table>
<thead>
<tr>
<th>Comparison of Behavioral Health Options</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-Network Outpatient Therapy</strong></td>
<td><strong>In Network Outpatient Therapy</strong></td>
</tr>
<tr>
<td>May choose any behavioral health provider</td>
<td>Must choose from the 65,000 behavioral health providers in the OptumHealth Behavioral Health network</td>
</tr>
<tr>
<td>Preauthorization for non-routine services is recommended (call 888.661.9141). MPI Health Plan will pay 50% of the fee based on the 75th percentile of the UCR Charge.</td>
<td>Preauthorization for non-routine services is recommended and is performed by the In-Network Provider.</td>
</tr>
</tbody>
</table>
| The Participant will be responsible for whatever portion of the charges is not paid by MPI Health Plan. | Participant financial responsibility is limited:  
• $5 Co-Payment per visit  
• No Coinsurance |

### What if I Get a Bill?
You should not get a bill from your OHBS Participating Provider because OHBS’s Participating Providers have been instructed to send all their bills directly to OHBS for payment. You may, however, have to pay a Co-Payment to the OHBS Participating 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 OHBS 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.

OHBS will not pay for Out-of-Network bills or Claims given to us that are more than one year old. Mail bills or Claims to:

**OptumHealth Behavioral Solutions**  
**Claims Department**  
P.O. Box 30755  
Salt Lake City, UT 841300

### Covered Services
Behavioral Health Services must be:

- Incurred while the Participant is eligible for coverage under this plan
- OHBS will pay for the following Behavioral Health Services furnished in connection with the treatment as outlined in the Schedule of Benefits provided the criteria above are met:
  1. **Inpatient Hospital Benefits/Acute Care and Partial Hospital Benefits**
  2. **Inpatient Physician Care**
  3. **Physician 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 OHBS.
5. **Laboratory Services:** Diagnostic and therapeutic laboratory services.

6. **Inpatient Prescription Drugs:** Inpatient prescription drugs are covered only when prescribed by an OHBS Participating Provider while the Member is confined to a facility for Behavioral Health Treatment.

7. **Injectable Psychotropic Medications:** Injectable psychotropic medications are covered if prescribed by an OHBS Participating 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 OHBS:

1. All services not specifically included in the OHBS Schedule of Benefits

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 OHBS, 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

6. Treatment for a reading disorder, mental retardation, 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, EMDR, guided imagery, marathon therapy, primal therapy, Rolffing, 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 member 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

22. Counseling for adoption, custody, family planning or pregnancy in the absence of a DSM-IV diagnosis

23. Counseling associated with or in preparation for a sex change operation

24. Sexual therapy programs, including therapy for sexual addiction, the use of sexual surrogates, and sexual treatment for sexual offenders/perpetrators of sexual violence

25. Private room and/or private duty nursing unless OHBS determines that they are medically necessary

26. All non-prescription and prescription drugs, except those prescribed by an OHBS Provider as part of a Participant’s inpatient treatment at an OHBS participating facility

27. Surgery or acupuncture
28. Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not medically necessary

29. Neurological services and tests, including, but not limited to, EEGs, Pet scans, beam scans, MRIs, skull x-rays and lumbar punctures

30. Treatment sessions by telephone or computer
   Internet services

31. Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations, or career counseling

32. Nutritional supplements, vitamins, minerals, counseling

33. Speech and occupational therapy

34. Methadone treatment

35. Biofeedback, including EEG and neurofeedback

**Responding To Your Concerns**

Our 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 the OHBS 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 OHBS toll-free number. You can also file a complaint in writing to:

OptumHealth Behavioral Solutions
P.O. Box 2839
San Francisco, California 94126
Attn: Appeals Department
Fax: 800.984.7584
Phone: 800.505.8826
HEALTH PLAN ALTERNATIVES

As an Active Participant, you have the option of selecting comprehensive medical/hospital coverage through the Motion Picture Industry Health Plan/Anthem Blue Cross or one of the alternative plans. A summary of the plan of benefits provided through Health Net, Kaiser and Oxford Health Plans is included on the following pages. We encourage you to compare all plan options thoroughly before choosing your coverage. See the chart “Active Medical Plan Benefit Comparison At-A-Glance” starting on page 32.

HEALTH NET®
800.522.0088

KAISER PERMANENTE®
800.464.4000

OXFORD HEALTH PLANS®
800.444.6222

The Claims review process, with respect to any Adverse Benefit Determinations made by any of these plans, will be handled according to the specific description of that process furnished by that plan (provided on the following pages and in your Evidence of Coverage), as well as the applicable time requirements and criteria described on pages 44 and 66. You should pay particular attention to any Preauthorization requirement, since that affects the applicable time frames for review. Claims review for benefits available under Medicare may be handled slightly different.
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 (IP). Most covered services are provided to you at no cost. Your dental, vision, chiropractic, wellness and prescription drug benefits under the Plan remain in effect.

If you are newly eligible, the California Plan Office will provide you with a directory of Health Net Participating Providers, services and facilities with your Summary Plan Description. To enroll, you must complete the Health Net portion of your Selection Form and return it to the California Plan Office. Upon enrollment and return of your beneficiary cards, your Health Net benefit identification cards will be issued to you directly by Health Net, and your dental/vision/prescription cards will be issued by the Plan Office. You will also be sent an Evidence of Coverage. Since the physician list is subject to change, you may contact Health Net at any time at the above-listed number for an updated copy. If you select Health Net for your health benefits, the Evidence of Coverage you receive upon enrollment with the Plan or with this Summary Plan Description will become part of your Summary Plan Description.

Health Net 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 Physician (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, Health Net offers its members some unique benefits, such as a 20% discount for eyewear at LensCrafters, a toll-free audio library of helpful health information, and discounts on memberships at Family Fitness® Centers. Please contact Health Net for further information.

The following is a partial list of Health Net benefits and Exclusions:

### Annual Out-of-Pocket Maximum for Certain Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>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:</td>
<td></td>
</tr>
<tr>
<td>For self-only enrollment (a family of one member)</td>
<td>$1,500 per calendar year</td>
</tr>
<tr>
<td>For a family of two members</td>
<td>$3,000 per calendar year</td>
</tr>
<tr>
<td>For a family of three or more members</td>
<td>$4,500 per calendar year</td>
</tr>
</tbody>
</table>

### Deductible or Lifetime Maximum

<table>
<thead>
<tr>
<th>Plan Services</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

### Professional Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits to physician, physician’s assistant or nurse practitioner in PM or IP</td>
<td>$15</td>
</tr>
<tr>
<td>Newborn office visits</td>
<td></td>
</tr>
<tr>
<td>Periodic health evaluations</td>
<td>$15</td>
</tr>
<tr>
<td>Emergency services</td>
<td>$35</td>
</tr>
<tr>
<td><em>(waived if admitted to a hospital)</em></td>
<td></td>
</tr>
<tr>
<td>Annual well-woman visit* <em>(Self-Referral to a gynecologist associated with member’s PPG or IP)</em></td>
<td>$15</td>
</tr>
<tr>
<td>Vision and hearing exams</td>
<td>$15</td>
</tr>
<tr>
<td>Specialist’s consultations</td>
<td>$15</td>
</tr>
<tr>
<td>Physician’s visit to member’s home <em>(at discretion of physician)</em></td>
<td>$30</td>
</tr>
<tr>
<td>Physician’s visit to hospital or skilled nursing facility</td>
<td>$0</td>
</tr>
</tbody>
</table>

* Covered services are medical history and diagnosis, physical exams, including breast and pelvic exams, and pap smears. Additional visits or tests require PPG or IP authorization.
Professional Services continued

Immunizations in relation to foreign travel or occupational requirements .......................................................... 20%
Other immunizations ......................................................................................................................................... $0
Allergy testing ....................................................................................................................................................... $0
Allergy serum ....................................................................................................................................................... $0
Allergy injection services .................................................................................................................................. $0
Injections for infertility ......................................................................................................................................... 50%
All other injections ............................................................................................................................................... $0
Surgeon/Assistant Surgeon in hospital or PPG or IP ......................................................................................... $0
Administration of anesthetics ........................................................................................................................... $0
X-ray and laboratory procedures ....................................................................................................................... $0
Short-term neuromuscular rehabilitation therapy .............................................................................................. $0
(include physical, speech, occupational and inhalation therapy which will result in significant improvement of the condition)

Care for Conditions of Pregnancy
Prenatal care and postnatal office visits .............................................................................................................. $15
Physician’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 .................................................................................................................................................. $150
Genetic testing of fetus ......................................................................................................................................... $0
Circumcision of newborn males ........................................................................................................................ $0

Family Planning
All infertility services (all services that diagnose, evaluate or treat infertility) ...................................................... 50%
Sterilization of females ......................................................................................................................................... $150
Sterilization of males .......................................................................................................................................... $50

Care for Mental Disorders
Outpatient mental health consultation (unlimited for severe and non-severe conditions) ..................................... $15

Other Services
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 (non-experimental and non-investigational) ................................................ $0
Chemotherapy ....................................................................................................................................................... $0
Renal dialysis ....................................................................................................................................................... $0
Home health services (Co-Payment begins on the 31st day of care) ..................................................................... $10
Hospice services ................................................................................................................................................... $0

Hospitalization
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 ................................................................................................................ $0
Maternity care ...................................................................................................................................................... $0
Outpatient services .............................................................................................................................................. $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
Urgent care center services** ................................................................................................................................ $35
Hospital inpatient services ................................................................................................................................ $0
Hospital outpatient services ............................................................................................................................... $0

** The Co-Payment will not be required if the member is admitted as a hospital inpatient directly from the emergency room or urgent care center.
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 member (i.e., Participant or Dependent) diagnosed with the severe mental illnesses of pervasive developmental disorder or autism is covered. The treatment must be prescribed by a licensed physician 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 member 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 paraprofessionals who are supervised and employed by the treating qualified autism service provider.

Chiropractic Care

Chiropractic care is available through American Specialty Health (ASH) for Participants and eligible Dependents enrolled in Health Net.

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.

ASH networks pay all Allowable Amounts, minus the $15 Co-Payment, directly to the approved Provider. Providers submit Claims to the American Specialty Health Networks, Inc.: P.O. Box 509002, San Diego, California 92150-9002.

For the name of an approved ASH chiropractor near you, please use the website or phone number below.
List of ASH Providers
- www.ashcompanies.com
- Customer Service at 800.678.9133

Not Covered:
- 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 medical doctor. No more than 20 chiropractic treatments are covered per calendar year, regardless of condition or conditions.

The Plan does not make any recommendations regarding the use of chiropractors affiliated with ASH Networks, Inc., but merely provides this information for use at your own discretion.

Hearing Aids

Health Net Participants and their eligible Dependents considering hearing aids may obtain them through the MPI Health Plan. You must first have a hearing test by a qualified audiologist, which will be paid through Health Net. Then you may utilize the services of a qualified hearing aid distributor, which will be paid through the MPI Health Plan.

Maximum Allowable Amount: $1,386 per ear, payable once every three (3) years

Anthem Blue Cross contracting: Payable at 90% of the contracted rate, up to the maximum Allowable Amount. (To find a Blue Cross Contracting Provider, visit www.anthem.com/ca.)

Out-of-Network: Payable at 50% of $1,386 per ear
Co-Pay: $0

Limitations and Exclusions

Health Net Does Not Cover

1. Any services not authorized by the member’s selected PPG or IP in accordance with procedures established by the PPG or IP and Health Net
2. Cosmetic or transsexual 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 “Dental Plan Options,” page 97.)
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” on page 115.)
15. Disposable supplies for home use
16. Orthotics which are not custom made to fit the body
17. Contraceptive devices (Fitting examinations and the insertion of vaginal contraceptive devices are covered.)
18. Hearing aids (See page 58.)
19. Contact lenses or corrective eyeglasses (See “Vision Service Plan” on page 119.)
20. 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 member to receive conception by artificial means; includes gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT) and any other procedures; collection, preservation or purchases of sperm or ova (Artificial insemination is covered when a female member or her male partner is infertile.)
21. Any services or supplies not specifically listed in the member’s Evidence of Coverage as covered services or supplies
22. 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 Appeals and Grievance Department
P.O. Box 10342
Van Nuys, CA 91410-0348

If your concern involves the Mental Disorders and Chemical Dependency program, call Managed Health Network (MHN) at 800.227.1000, or write to:

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

If your concern involves the chiropractic program, call American Specialty Health (ASH) at 800.678.9133, or write to:

American Specialty Health
Attention: Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

Please include all information from your Health Net Identification Card and the details of the concern or problem.

We will:

• Confirm in writing within five calendar days that we received your request.
• Review your complaint and inform you of our decision in writing within 30 days from the receipt of the grievance. For conditions where an immediate and serious threat to your health, including severe pain or the potential for loss of life, limb or major bodily function, exists, 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 Department of Managed Health Care. There is no requirement that you participate in Health Net’s grievance process prior to applying to the 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 Department of Managed Health Care for assistance or to request an Independent Medical Review or initiate binding arbitration, as described below. 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 Department of Managed Health Care (Department) if you believe that health care services eligible for coverage and payment 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 Independent Medical Review (IMR) will be reviewed by the Department to confirm that it meets all the eligibility requirements of the law for IMR which are set out below:

1. 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 Physician 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 provide 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 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 Independent Medical Review (IMR) of Health Net’s decision from the 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 Physician 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 Physician 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 Health Net’s 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 Physician 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 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 this 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 forego 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.

*Effective July 1, 2002, members who are enrolled in the Motion Picture Industry Health 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.*
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.

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 member, Health Net may assume all or a portion of a member’s share of the fees and expenses of the Arbitration. Upon written notice by the member 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 above.

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

Reminder: Your Claims review and appeals will ordinarily be handled based on the general guidelines and time frames provided on pages 44 and 66, above, with your Claims and appeals submitted to Health Net. However, in addition to reading this Health Net section of your Summary Plan Description, 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.
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 dental, vision, chiropractic, wellness and prescription drug benefits under the MPI Health Plan remain in effect.

To enroll in the Kaiser Permanente plan, you must complete the Kaiser Permanente portion of your Selection Form and return it to the MPI Health 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 at the above telephone number for an advance copy of Kaiser Permanente information to assist you in your selection of medical/hospital plans. If you select Kaiser Permanente for your health benefits, the Evidence of Coverage you receive upon enrollment with the MPI Health Plan or with this Summary Plan Description will become part of your Summary Plan Description.

The following is a partial list of Kaiser Permanente benefits and Exclusions:

### 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

### Plan Services

#### Professional Services (Plan Provider office visits)

Routine preventive care:

- Physical exams .......................................................................................................................................................... $15 per visit
- Well-child visits (through age 23 months) .................................................................................................................. $15 per visit
- Family planning visits .................................................................................................................................................. $15 per visit
- Scheduled prenatal care visits and first postpartum visit ............................................................................................... $15 per visit
- Eye exams for refraction ............................................................................................................................................... $15 per visit
- Hearing tests ................................................................................................................................................................ $15 per visit
- 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

- Outpatient surgery and certain other outpatient procedures .......................................................................................... $15 per procedure
- Allergy injection visits ...................................................................................................................................................... No charge
- Allergy testing visits .......................................................................................................................................................... $15 per visit
Plan Services (continued)

You Pay

Other
Most vaccines (immunizations) ................................................................. No charge
X-rays and lab tests ................................................................................. No charge
Health education:
  Individual visits ............................................................................ $15 per visit
  Group educational programs ...................................................... No charge

Hospitalization Services
Room and board, surgery, anesthesia, x-rays, lab tests, and drugs ....................... No charge

Emergency Health Coverage
Emergency department visits ................................................................ $35 per visit

Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient. (See “Hospitalization Services,” above for inpatient cost sharing.)

Ambulance Services
Ambulance services ........................................................................... No charge

Mental Health Services
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
Inpatient detoxification ........................................................................ No charge
Outpatient individual visits ................................................................ $15 per visit
Outpatient group visits ........................................................................ $5 per visit

Home Health Services
Home health care (up to 100 visits per calendar year) ........................................ No charge

Facility Option
Skilled nursing facility care (up to 100 days per Benefit Period) ....................... No charge
Hospice care ........................................................................................ No charge

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.

Note: Specific information on benefits not included on this chart can be obtained from Kaiser directly. The services and items in this chart are covered benefits only if, in the judgment of a Kaiser physician, they are medically necessary to present, diagnose or treat a medical condition. A service or item is medically necessary only if a Kaiser physician determines that its omission would adversely affect a member’s (i.e., Participant’s or Dependent’s) health.

There are Exclusions, limitations and reductions to benefits. Please see your Kaiser Evidence of Coverage Service Agreement 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 Service Agreement.
Behavioral Health Treatment for Autism
We cover 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 Plan physician, or is developed by a Plan Provider who is a psychologist.
• The treatment is provided under a treatment plan prescribed by a Plan Provider who is a qualified autism service provider.
• The treatment is administered by a Plan 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, we 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.

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.

ASH networks pays all Allowable Charges, minus the $15 Co-Payment, directly to the approved Provider. Providers submit Claims to the American Specialty Health Networks, Inc.: P.O. Box 509002, San Diego, California 92150-9002.

For the name of an approved ASH chiropractor near you, please use the website or phone number below.

List of ASH Providers
• www.ashcompanies.com
• Customer Service at 800.678.9133

Not Covered:
• 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 medical doctor. No more than 20 chiropractic treatments are covered per calendar year, regardless of condition or conditions.

The Plan does not make any recommendations regarding the use of chiropractors affiliated with ASH Networks, Inc. but merely provides this information for use at your own discretion.

Hearing Aids
Kaiser Participants and their eligible Dependents considering hearing aids may obtain them through the MPI Health Plan.

You must first have a hearing test by a qualified audiologist, which will be paid through Kaiser. Then you may utilize the services of a qualified hearing aid distributor, which will be paid through the MPI Health Plan.

Maximum Allowable Amount: $1,386 per ear, payable once every three (3) years

Anthem Blue Cross contracting: Payable at 90% of the contracted rate, up to the maximum Allowable Amount. (To find a Blue Cross Contracting Provider, visit www.anthem.com/ca.)

Out-of-Network: Payable at 50% of $1,386 per ear

Co-Pay: $0
Kaiser Permanente Southern California Plan Hospitals and Medical Offices

At most of the Plan Facilities listed below, 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 Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan hospitals provide inpatient services and are open 24 hours a day, seven days a week.
- Emergency services are available from Plan hospital emergency departments as described in Your Guidebook (please refer to Your Guidebook for Emergency Department locations in your area).
- Same–day urgent care appointments are available at many locations (please refer to Your Guidebook for Urgent Care locations in your area).
- Many Plan medical offices have evening and weekend appointments.
- Many Plan facilities have a Member Services Department (refer to Your Guidebook for locations in your area).

The following is a list of Plan Hospitals and Medical Office Plans in our Southern California service area. Additional Plan Medical Offices are listed on our website at www.kp.org. This list is subject to change at any time without notice.

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<th>Type</th>
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<tr>
<td>San Diego</td>
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San Marcos | Medical Offices
Santa Ana | Medical Offices (2 locations)
Santa Clarita | Medical Offices
Simi Valley | Medical Offices
Temecula | Medical Offices
Thousand Oaks | Medical Offices (2 locations)
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 | Hospital and Medical Offices (2 locations)
Yorba Linda | Medical Offices
Dispute Resolution

Grievances
We are committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with our member services representatives at most Plan facilities, or you can call our Member Service Call Center.

You can file a grievance for any issue. Here 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 us to cover the services.
- A Plan physician has said that services are not medically necessary and you want us 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-Plan Provider that we did not authorize (other than emergency care, post-stabilization care, or out-of-area urgent care), and you want us to pay for the care.
- We 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, and you want to appeal our decision.
- You are dissatisfied with how long it took to get services, including getting 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 we 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 our 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.
    Special Services Unit
    P.O. Box 7136
    Pasadena, CA 91109

    – By calling our Member Service Call Center at 1.800.464.4000 or 1.800.390.3510 (TTY users call 1.800.777.1370)
  - For all other issues, you can submit your grievance in one of the following ways:
    – To the Member Services Department at a Plan Facility (please refer to Your Guidebook for addresses)
    – By calling our Member Service Call Center at 1.800.464.4000 (TTY users call 1.800.777.1370)
    – Through our website at www.kp.org

We will send you a confirmation letter within five days after we receive your grievance. We will send you our written decision within 30 days after we receive your grievance. If we do not approve your request, we will tell you the reasons and will inform you about additional dispute resolution options.

Please Note: If we resolve your issue to your satisfaction by the end of the next business day after we receive your grievance orally, by fax, or through our website, and a member services representative notifies you orally about our decision, we 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 grievance
You or your physician may make an oral or written request that we expedite our 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. We will inform you of our 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, we will inform you of our decision within 24 hours.

You or your physician must request an expedited decision in one of the following ways, and you must specifically state that you want an expedited decision:

• Call our Expedited Review Unit toll free at 1.888.987.7247 (TTY users call 1.800.777.1370), 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.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170

  • Fax your written request to our Expedited Review Unit toll free at 1.888.987.2252.

  • Deliver your request in person to your local Member Services Department at a Plan Facility.

If we do not approve your request for an expedited decision, we will notify you, and we will respond to your grievance within 30 days. If we do not approve your grievance, we will send you a written decision that tells you the reasons and informs you about additional dispute resolution options.

Please 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 (Department) directly at any time without first filing a grievance with us.

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 physician opinions. When appropriate, we will request medical records from Plan Providers on your behalf. If you have consulted with a Non-Plan Provider and are unable to provide copies of relevant medical records, we will contact the Provider to request a copy of your medical records. We will ask you to send or fax us a written authorization so that we can request your records. If we do not receive the information we request in a timely fashion, we will make a decision based on the information we have.

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 our authorization form. Authorization forms are available from your local Member Services Department at a Plan Facility or by calling our Member Service Call Center. Your completed authorization form must accompany the grievance.

• You may file for your Dependent under age 18; except that he or she must appoint you as his or her authorized representative if he or she 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 he or she must appoint you as his or her authorized representative if he or she 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 physician may request an expedited grievance as described under “Expedited Grievance” in this “Dispute Resolution” section.

Department of Managed Health Care Complaints
The California Department of Managed Health Care 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 (TTY users call 800.777.1370) and use your health plan’s grievance process before contacting the Department. 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 Department 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 Department also has a toll-free telephone number (888.HMO.2219) and a TDD line (877.688.9891) for the hearing and speech impaired.

The Department’s Internet 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 this Evidence of Coverage. 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 this Evidence of Coverage or a Member Party’s relationship to Kaiser Foundation Health Plan, Inc. (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 physician
- 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.  
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 our 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**

Health Plan 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 our 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.
If you select Oxford Health Plans for your hospital and medical benefits, **you are covered for hospital and medical benefits through the Oxford Freedom Network.** Most covered services are provided to you at minimal or no cost. Your dental, vision, chiropractic, wellness and prescription drug benefits under the MPI Health Plan remain in effect.

If you are newly eligible, the California Plan Office will provide you with a directory of Oxford Health Plans’ Participating Providers, services and facilities with your Summary Plan Description. To enroll, you must complete the Oxford portion of your Selection Form and return it to the California Plan Office. Upon enrollment and return of your beneficiary cards, your Oxford benefit identification cards will be issued to you directly by Oxford Health Plans, and your dental/vision/prescription cards will be issued by the California MPI Health Plan Office. Since the physician list is subject to change, you may contact Oxford at any time at the above-listed number for an updated copy. If you select the Oxford Plan for your health benefits, the Certificate of Coverage and Member Handbook (also referred to as “Evidence of Coverage” in this Summary Plan Description) you receive upon enrollment with the Plan or with this Summary Plan Description will become part of your Summary Plan Description.

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 Physician (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 Health Plans 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 over 400 premier day spas in the U.S. and over 280 resort locations worldwide, free registration at Weight Watchers®, and discounts on eye care and eye wear through General Vision Services. Please contact Oxford Health Plans for further information.

The following is a partial list of Oxford Health Plans* benefits and exclusions:

<table>
<thead>
<tr>
<th>Plan Services</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Care Benefits</strong></td>
<td><strong>In Network</strong></td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>None</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>None</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>None</td>
</tr>
<tr>
<td>Primary Care Physician election</td>
<td>Required</td>
</tr>
<tr>
<td>Hospital Preauthorization</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
</tr>
<tr>
<td>Room and Board Intensive Care Semi-Private Room</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>Extended Care</strong></td>
<td></td>
</tr>
<tr>
<td>Room and board in a skilled deductible nursing facility</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

* The In-Network benefits are provided through your Certificate of Coverage & Member Handbook issued to you by Oxford Health Plans (NY) Inc. In order for a covered service to be covered In-Network, the service must be obtained in accordance with the terms and conditions of the Certificate. All covered services must be provided or arranged by the Participant’s or Dependent’s Primary Care Physician (PCP) or participating network Obstetrician/Gynecologist (OB/GYN).

** The Out-of-Network benefits are provided through your Supplemental Certificate of Coverage & Member Handbook issued to you by Oxford Health Insurance, Inc. Covered services are reimbursed only in accordance with its terms and conditions.
### Health Care Benefits

<table>
<thead>
<tr>
<th>Plan Services</th>
<th>In Network*</th>
<th>Out-of-Network**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within Service Area</td>
<td>$25 per visit (waived if admitted to a hospital)</td>
<td>$25 per visit (waived if admitted to a hospital)</td>
</tr>
<tr>
<td>Outside Service Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Professional Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Visits Hospital/Office Surgeon</td>
<td>$15 Co-Pay</td>
<td>Deductible plus 30% Coinsurance</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>No charge when medically necessary</td>
<td>Covered services will be covered as In-Network</td>
</tr>
<tr>
<td><strong>Chiropractic Services</strong></td>
<td>$15 per visit, visits are subject to medical necessity</td>
<td>Deductible plus 30% Coinsurance, visits are subject to medical necessity</td>
</tr>
<tr>
<td><strong>Comprehensive Physical Examination (CPE) age 13 and older</strong></td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Diagnostic X-rays, CT Scans, (Magnetic Resonance Imaging), PET Scans and Laboratory Tests</strong></td>
<td>No charge at participating laboratories</td>
<td>MRI Deductible plus 30% Coinsurance</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>No charge when preauthorized by Oxford in advance and ordered by a participating Oxford physician</td>
<td>Deductible plus 30% Coinsurance</td>
</tr>
<tr>
<td><strong>Family Planning Services</strong></td>
<td>Maximum allowance of $350 per abortion</td>
<td>Deductible plus 30% Coinsurance, maximum allowance of $350 per abortion, once per year</td>
</tr>
<tr>
<td>Therapeutic and Elective Abortion</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intrauterine Device (IUD)</strong></td>
<td>IUD device not covered</td>
<td>IUD device not covered</td>
</tr>
<tr>
<td><strong>Tubal Ligation</strong></td>
<td>No charge, reversal not covered</td>
<td>Deductible plus 30% Coinsurance, reversal not covered</td>
</tr>
<tr>
<td><strong>Vasectomy</strong></td>
<td>No charge</td>
<td>Deductible plus 30% Coinsurance</td>
</tr>
<tr>
<td><strong>Home Health Services</strong></td>
<td>$15 Co-Pay for 60 visits per year with up to 4 hours per visit</td>
<td>20% Coinsurance for 60 visits per year with up to 4 hours per visit</td>
</tr>
<tr>
<td><strong>Home Health Nurse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physical Therapy</strong></td>
<td>Outpatient: $15 Co-Pay for 90 visits per condition per lifetime; Inpatient: No charge for 60 days per condition per lifetime</td>
<td>Deductible plus 30% Coinsurance, Outpatient: 90 days per condition per lifetime; Inpatient: 60 days per condition per lifetime</td>
</tr>
<tr>
<td><strong>Pregnancy Benefits (Regardless of Complications, i.e., C-section) for both Mother and Child, Including Pre and Post-Natal Care and Delivery</strong></td>
<td>$15 per initial visit only</td>
<td>Deductible plus 30% Coinsurance</td>
</tr>
<tr>
<td><strong>Well-Child Care</strong></td>
<td>No charge</td>
<td>Deductible plus 30% Coinsurance for Dependents age 19 and under</td>
</tr>
<tr>
<td><strong>Well Woman Exams (Annual CPE)</strong></td>
<td>No charge for 2 exams annually</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Mammograms</strong></td>
<td>No charge</td>
<td>Deductible plus 30% Coinsurance, One per year; age limits apply</td>
</tr>
</tbody>
</table>

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* The In-Network benefits are provided through your Certificate of Coverage & Member Handbook issued to you by Oxford Health Plans (NY) Inc. In order for a covered service to be covered In-Network, the service must be obtained in accordance with the terms and conditions of the Certificate. All covered services must be provided or arranged by the Participant’s or Dependent’s Primary Care Physician (PCP) or participating network Obstetrician/Gynecologist (OB/GYN).

** The Out-of-Network benefits are provided through your Supplemental Certificate of Coverage & Member Handbook issued to you by Oxford Health Insurance, Inc. Covered services are reimbursed only in accordance with its terms and conditions.
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-Pay: 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 the Plan’s Allowable Amount.

1. Out-of-Network Benefits: Out-of-Network benefits are unlimited during the entire time the Participant is covered.
2. 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 physician. Only basic models of blood glucose monitors are covered unless the Participant or Dependent has special needs relating to poor vision or blindness.
4. 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.
5. 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.
6. Transplants: In-Network coverage is available only at facilities specially approved and designated by Oxford Health Plans (NY), Inc. to perform these procedures.
7. Home Health Services: 60 visits per contract year; a visit of up to four hours is one visit.
8. 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.
9. Skilled Nursing Facility Services: Unlimited days per calendar year.
10. Hospice Services: 210 days per lifetime.
11. 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 Primary Care Physician, 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 Services 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 (3) business days of its determination.

Failure to Preauthorize
If you fail to obtain Preauthorization for an Out-of-Network benefit, when Preauthorization is required as specified in the summary table above, 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, the Plan 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 UCR, 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

IMPORTANT: This notice is not a contract. It is only a summary of your coverage under the Oxford Point of Service Plan. Please read your Oxford Certificate of Coverage for a full description of your covered services, Exclusions and other terms and conditions of coverage.

Complaint Procedure
If you have any complaint, have a question about your benefits, or wish to appeal any Adverse Benefit Determination, you should contact Oxford at 800.444.6222 or One Penn Plaza, 8th Floor, New York, NY 10119.

Your Claim and any appeal will be handled by Oxford within the time requirements and criteria for review, as set forth on pages 44 and 66.

If you feel Oxford did not properly handle your matter, you may also have the right to an external review of its decision if:

• The Claim was denied as medically unnecessary, or

• The Claim was denied as involving experimental or investigational procedures, and the patient’s condition is life-threatening or disabling.

If applicable, the insurer or HMO must deliver an external review application to the patient in these two cases. Patients have 45 days from the date they receive the denial of coverage to file for external review with the New York State Insurance Department. The Department will assign review to one of its certified external appeals agents who are medical professionals not affiliated with the insurer or HMO. Contact Oxford for more details.
In addition to your comprehensive medical and hospital coverage, the MPI Health Plan provides you with dental health coverage regardless of which health plan you select. If you are an eligible Active Plan Participant, you are automatically enrolled in Delta Dental’s PPO Dental Plan, with its nationwide network of dentists. The plan benefits are explained on the following pages.

If you reside in California, you may choose from either Delta Dental PPO or DeltaCare USA. We make no recommendation regarding your choices, but we suggest it is in your best interest to take time to familiarize yourself with the information provided in order to make a selection that most appropriately fits your individual circumstance and meets your needs. A Dental Plan Comparison Chart is provided on page 100 to allow you to make direct benefit comparisons.

The Claims review process, with respect to any Adverse Benefit Determinations made by any of these plans, will be handled according to the specific description of that process furnished by that plan (provided on the following pages), as well as the applicable time requirements and criteria described on pages 44 and 66. You should pay particular attention to any Preauthorization requirement, since that affects the applicable time frames for review.
Dental Plan Options

Active Plan Participants who reside outside California should read the Delta Dental Preferred Provider Organization (PPO) plan information in this section carefully in order to fully understand the benefits and limitations of your dental coverage.

Those who reside in California, regardless of whether you have selected comprehensive medical and hospital coverage under an HMO or non-HMO plan, have a choice of dental plans. A summary of each is provided on the following pages. We make no recommendation regarding your choices, but we suggest it is in your best interest to take time to familiarize yourself with the information provided in order to make a selection that most appropriately fits your individual circumstance and meets your needs.

Delta Dental PPO

DeltaCare USA
(California only)

Preferred Provider Organization
Pre-paid

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 Selection Form to use if you wish to switch to the pre-paid plan. If you become eligible at the beginning of any given month, you must return the MPI Health Plan Selection Form no later than the end of that same month in order for your enrollment in the pre-paid plan to be effective the beginning of the following month.

When first eligible, the member is automatically enrolled in the Delta Dental PPO. If the member wants to switch to the pre-paid plan, he or she must complete the MPI Health Plan Selection Form, which is included in the eligibility packet. Enrollment in the pre-paid plan is effective the first of the month coinciding with or following the Plan’s receipt of the member’s pre-paid selection.

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. You may be able to reduce your cost by using one of the 127,000 Delta-affiliated dentists, and further reduce your out-of-pocket expense by using one of the 60,000 Delta Dental PPO dentists in the nation.

The pre-paid 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 “pre-paying” 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 pre-paid plan, you may use ONLY the dentist you select.

The MPI Health 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 contain a brief summary of benefits. You may contact the dental plans directly for advance information. You will find a comparison of the dental plans on the next page.

If you select DeltaCare USA, upon enrollment in that plan, DeltaCare will send you a dental ID card.
Dental Plan Comparison Chart

<table>
<thead>
<tr>
<th>Available Nationwide</th>
<th>Available in California Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delta Dental PPO</strong> 888.335.8227</td>
<td><strong>DeltaCare USA</strong> 800.422.4234</td>
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</tbody>
</table>

**Dentists Available**
The dentist of your choice, anywhere in the world. (Using Delta PPO dentists may reduce your out-of-pocket expense.)

Must use selected DeltaCare affiliated dentist only; dentists located throughout California

**Costs to You for More 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

**Maximum**
$2,000 per person, per calendar year

No annual maximum

**Orthodontics**
Eligible Dependent children only
Pays 50% of Usual, Customary and Reasonable Rates
$1,000 lifetime maximum

Eligible Dependent:
Children: $1,100
Adults: $1,500
Start-up Fee: $ 250

Primary Differences
The dental plans available for your selection are not identical. The following is a comparison of the primary differences between them. Note that DeltaCare USA is available in California only. The Directors make no recommendation regarding the plans but make them available so you may select the one most suited to your needs.

Upon enrollment, you may call your chosen dental plan for a complete list of all benefits and coverage, with applicable Exclusions and limitations and a complete listing of affiliated dentists, or you may request complete information prior to enrollment directly from the dental plan(s) at the telephone numbers indicated below.
You do not need to enroll in the Delta Dental PPO. As an Active Participant, you and your eligible Dependents will be automatically enrolled in Delta if you do not select the pre-paid dental plan.

More than 127,000 dentists in active practice nationwide are Delta Dentists, and more than 60,000 dentists participate nationwide in the Delta Dental PPO. You are free to choose any dentist for treatment, but it is to your advantage to choose a Delta 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. Delta Dentists have treatment forms on hand and will complete and submit the forms to Delta free of charge. If you go to a non-Delta Dentist, Delta cannot assure you what percentage of the charged fee may be covered.

For assistance in selecting a Delta Dentist, call 800.4AREA-DR (800.427.3237)
A list of Delta Dentists is also available using Delta Dental's website: 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 Active 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 will provide payment for these services at the percentage indicated, up to a maximum of $2,000 for each enrollee in each calendar year. Payment for orthodontic services is limited to a lifetime maximum of $1,000 and is for Dependent children only.

Covered Fees
It is to your advantage to select a dentist who is a Delta 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 Dentist. Payment to a Delta Dentist will be based on the applicable percentage of the lesser of the fee actually charged or the accepted Usual, Customary and Reasonable Rate that the dentist has on file with Delta.

Payment to a dentist outside of California who agrees to be bound by Delta’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 Delta Dentists in California.

Payment to a California dentist who is not a Delta 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’s Dentists.

Extension of Benefits
All benefits cease on the date coverage terminates except that Delta will pay for single procedures or orthodontic procedures which commenced while you were eligible.

Choosing Your Dentist
Delta shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, Delta cannot ensure your dentist’s use of precautions against the spread of such diseases, nor can Delta compel your dentist to be tested for HIV or to disclose test results to Delta or to you. Delta 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 Dentist;
• Having your dentist obtain predetermination from Delta 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 Co-Payment share. 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:

- Delta Group Number: 3229 Active
- You are covered under the Motion Picture Industry Health Plan
- Primary Enrollee’s Social Security or identification number (which must also be used by Dependents)
- Primary Enrollee’s date of birth
- Any other dental coverage you have.

Definitions

Annual Deductible: The amount you must pay for dental care each year before Delta’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 summary.

Contract: The written agreement between the Plan and Delta to provide dental benefits. The Contract, together with this SPD, form the terms and conditions of the benefits you are provided to you.

Covered Services: Those dental services to which Delta will apply benefit payments, according to the Contract.

Delta Dentist: A dentist who has a signed agreement with Delta as Customary and Reasonable. He or she agrees to charge Delta patients these accepted fees.

Delta PPO Dentist: A Delta Dentist with whom Delta has a written agreement to provide services at the In-Network level and who agrees to charge Delta patients the PPO fees.

Dues: The money the Plan pays to Delta each month for you and your Dependent’s dental coverage.

Effective Date: The date the program starts.

Eligible Dependent: Any of the Dependents of an Eligible Employee who is eligible to enroll for 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 (Primary Enrollee) or Eligible Dependent (Dependent Enrollee) enrolled to receive benefits.

Maximum: The greatest dollar amount Delta 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 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 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 California Director of the Department of Managed Health Care.

If the Contract is terminated for any cause, Delta 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 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 for the services you plan. A predetermination does not guarantee payment. It is an estimate of the amount Delta 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.

Delta will inform your dentist exactly how much of the proposed charges Delta 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, 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 us know before the dental work is begun. In this way, we can review your appeal thoroughly.

**Payment**
Delta will pay Delta Dentists directly. Delta’s agreement with Delta Dentists makes sure that you will not be responsible to the dentist for any money Delta owes. However, if for any reason, Delta fails to pay a dentist who is not a Delta Dentist, you may be liable for that portion of the cost. If you have selected a non-Delta Dentist, Delta will pay you. Payments made to you are not assign able (in other words, Delta will not grant a request to pay non-Delta Dentists directly).

Payment for any single procedure which is a covered service will only be made upon completion of that procedure. Delta 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 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 may be able to help you resolve the situation.

Delta may deny payment of an Attending Dentist’s Statement for services submitted more than twelve (12) months after the date the services were provided. If a Claim is denied due to a Delta 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 (unless you failed to advise the dentist of your eligibility at the time of treatment). Delta does not pay participating Dentists any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

The processes Delta uses to determine or deny payment for services are distributed to all Delta 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’s dentist consultants. If any Claims are not covered, or if limitations or Exclusions apply to services you have received from a Delta 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’s processing policies.

**I Diagnostic and Preventive Benefits**

**80% of Usual, Customary and Reasonable Rate**

**Definition**

**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. Oral examinations are benefits only twice in a calendar year.
b. Prophylaxes (cleanings), fluoride treatments or procedures that include cleanings are available twice each 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 benefits only 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 a benefit only when made in connection with subsequent orthodontic treatment covered under this program.

**II Basic Benefits**

**80% of Usual, Customary and Reasonable Rate**

**Definition**

**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 benefits 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.
III Crown, Jackets, Inlays, Onlays and Cast Restoration Benefits
80% of Usual, Customary and Reasonable Rate

**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 (5) years.

IV Prosthodontic Benefits
80% of Usual, Customary and Reasonable Rate

**Definition**
Construction or repair of fixed bridges, partial dentures and complete dentures are benefits if provided to replace missing, natural teeth.

**Limitations**
1. Prosthodontic appliances are benefits only once every five (5) years, unless Delta 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.
2. Delta 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.
3. Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered by your program. However, if implants are provided along with a covered Prosthodontic appliance, Delta will allow the cost of a standard partial or complete denture toward the cost of the implants and the Prosthodontic appliances when the prosthetic appliance is completed. If Delta makes such an allowance, Delta will not pay for any replacement for five (5) years following the completion of the service.

V Orthodontic Benefits
50% of Usual, Customary and Reasonable Rate

**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 full-time student (student documentation is required).

**Limitations**
1. If orthodontic treatment is begun before you become eligible for coverage, Delta’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.

VI Dental Accident Benefits
85% of Usual, Customary and Reasonable Rate

**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 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 Does Not Cover**
Delta 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 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), implants (materials implanted into bone or soft tissue), 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 an Enrollee has any questions about the services received from a Delta Dentist, Delta recommends that he or she first discuss the matter with the Dentist. If he or she continues to have concerns, the Enrollee may call or write Delta. Delta 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 the Enrollee and the group. If an Enrollee has any question or complaint regarding the denial of dental services or Claims, the policies, procedures and operations of Delta, or the quality of dental services performed by a Delta Dentist, he or she may call Delta toll-free at 800.765.6003, contact Delta through the website, www.deltadentalins.com, or write Delta at P.O. Box 997330; Sacramento, CA 95899-7330; Attention: Customer Service Department.

If an Enrollee’s Claim has been denied or modified, the Enrollee may file a request for review (a grievance) with Delta within 180 days after receipt of the denial or modification. In writing, the correspondence must include the group name and number, the Primary Enrollee’s name and Social Security or identification number, the inquirer’s telephone number and any additional information that would support the Claim for benefits. The correspondence should also include a copy of the treatment form, Notice of Payment, and any other relevant information. Upon request and free of charge, Delta will provide the Enrollee with copies of any pertinent documents that are relevant to the Claim, a copy of any internal rule, guideline protocol, and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the Claim.

Delta’s review will take into account all information, regardless of whether such information was submitted or considered initially. Certain cases may be referred to one of Delta’s Regional Consultants, to a review committee of the dental society or to the state dental association for evaluation. Delta’s review shall be conducted by a person who is neither the individual who made the original Claim denial, nor the subordinate of such individual, and Delta will not give deference to the initial decision. If the review of a Claim denial is based in whole or in part on a lack of medical necessity, an experimental treatment, or a clinical judgment in applying the terms of the contract term, Delta shall consult with a dentist who has appropriate training and experience. The identity of such dental consultant is available upon request.

Delta will provide the Enrollee a written acknowledgement within five days of receipt of the request for review. Delta will make a written decision within 30 days of receipt or inform the Enrollee of the pending status if more information or time is needed to resolve the matter. Delta will respond, within three days of receipt, to complaints involving severe pain and imminent and serious threat to a patient’s health. An Enrollee may file a complaint with the California Department of Managed Health Care after he or she has completed Delta’s grievance procedure or after he or she has been involved in Delta’s grievance procedure for 30 days. An Enrollee may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to the Enrollee’s health.

The California Department of Managed Health Care is responsible for regulating health care service plans. If the Enrollee has a grievance against Delta, the Plan, he or she should first telephone Delta at 800.765.6003 and use Delta’s grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to an Enrollee. If the Enrollee needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the plan, or a grievance that has remained unresolved for more than 30 days, the Enrollee may call the Department for assistance. Enrollees may also be eligible for an Independent Medical Review (IMR). If the Enrollee is 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 Department also has a toll-free telephone number (888. HMO.2219) and a TDD line (877.688.9891) for the hearing and speech impaired. The Department’s Internet 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.

**Second Opinions**
Delta 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 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 will also authorize a second opinion after treatment if an Enrollee has a complaint regarding the quality of care provided.

Delta 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 to perform the clinical examination. When Delta 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 for payment. Delta 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 know if you have dental coverage in addition to this Delta 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. For 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 Customer Services Department at 888.335.8227.

This Evidence of Coverage constitutes only a summary of the dental plan. The dental plan contract must be consulted to determine the exact terms and conditions of coverage.
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 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 the telephone number listed above.

**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)

**Orthodontics:**

Children to age 19.................................$ 1,100 (from age 19-23, if full-time students)

Adults....................................................$ 1,500

**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

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* Plus actual lab costs of precious metals
** Excluding $250 start-up fees
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’s Customer Service department at 800.422.4234, or the complaint may be addressed in writing to:

DeltaCare USA 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’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 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 if 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 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 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 will provide the Enrollee written notification regarding the disposition or pending status of the complaint within three days.

If you have completed DeltaCare’s grievance process, or you have been involved in DeltaCare’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 Department 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 your health plan, you should first telephone your health plan at 800.422.4234 and use your health plan’s grievance process before contacting the Department. 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 Department 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 Department also has a toll-free telephone number (888.HMO.2219) and a TDD line (877.688.9891) for the hearing and speech impaired. The Department’s Internet 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 MPI Health 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.
In addition to your comprehensive medical and hospital coverage and dental benefits, the Plan also provides you with life insurance, prescription drug, vision, and wellness benefits. As an Active Participant, you receive all these benefits when you meet eligibility requirements and fill out the appropriate paperwork. Descriptions of those benefits, including limitations, are provided in this section of your Summary Plan Description.

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The Claims review process, with respect to any Adverse Benefit Determinations made by any of these plans, will be handled according to the specific description of that process furnished by that plan (provided on the following pages), as well as the applicable time requirements and criteria described on pages 44 and 66. You should pay particular attention to any Preauthorization requirement, since that affects the applicable time frames for review.
Life Insurance for Employees
The Plan insures you as an eligible Employee Participant in the amount of $10,000 of life insurance 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 112.)

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 a Health Plan beneficiary card 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.
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, The Union Labor Life Insurance Company (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 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;
2. Who has been Totally Disabled for at least 9 months; and
3. 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; 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.

“Totally Disabled” and “Total Disability” mean the Participant’s complete inability, due to Injury or Illness, to engage in any business, occupation or employment for which the Participant is qualified, or becomes qualified by reason of education, training, or experience, for pay, profit, or compensation.

The Participant must submit satisfactory written proof (the “Initial Proof”) of Total Disability within 12 months from the date Premium payments on behalf of such Participant cease, but in no event more than 24 months from the date Total Disability began.

The Initial Proof must show that the Total Disability:
1. Began while the Participant was insured under this Policy;
2. Began before the attainment of age 60; and
3. Has rendered the Participant Totally Disabled for at least nine (9) consecutive months.
Notice of Application for Waiver Determination
The Union Labor Life Insurance Company 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 MPI Health 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 MPI Health 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 Initial Proof. Such proof must be sent to The Union Labor Life Insurance Company at the Participant’s own initiative; Union Labor Life shall not be required to request such proof.

Right to Require Examination
The Union Labor Life Insurance Company, 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 twenty-four (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 MPI Participant Services Center at 855.4MPI (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 MPI Health Plan 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 Plan’s physician disagrees with your physician, the physicians will jointly select a third physician to perform an examination. The decision of that physician will be final and binding upon all parties. In addition, you must supply the 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;
9. If the terminal medical condition is caused by intentional self-inflicted injury or attempted suicide.

Neither the Plan nor The Union Labor Life Insurance Company 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.

Additional provisions under The Union Labor Life Insurance policy may apply. Please contact the California Plan Office 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. The Union Labor Life Insurance Company 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 directly or indirectly, or in whole or in part, by any of the following:

1. Bodily or mental illness or disease of any kind;
2. Poison or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
3. Suicide or attempted suicide while sane or insane;
4. Intentional self-inflicted injury;
5. Participation in, or the result of participation in, the commission of an assault or a felony, or a riot, or a civil commotion;
6. War or act of war, declared or undeclared; or any act related to war, or insurrection;

7. Service in the armed forces of any country while such country is engaged in war; or

8. Police duty as a member of any military, naval, or air organization.

Note: While self-paying through COBRA, there is no death or dismemberment benefit or life insurance. (See page 18.)

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 MPI Health Plan shall be fully discharged 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 California Plan Office:

Participant Services Center
Attn: Eligibility
Motion Picture Industry Health Plan
P.O. Box 1999
Studio City, CA 91614-0999
855.ASK.4MPI (855.275.4674)
Prescription drug benefits for the MPI Health Plan Participants and their eligible Dependents are administered by Express Scripts. To obtain benefits, simply present your Express Scripts prescription benefit card when filling a prescription at your pharmacy.

Express Scripts has established a customized, national network of participating pharmacies to serve you and your eligible Dependents. To locate an Express Scripts participating pharmacy convenient to you, visit the Express Scripts website at www.express-scripts.com. Click on “Locate a Pharmacy” on the left side of the page. Registration to the site is optional and free. After you register, you can search by ZIP code or by state and city.

Eligibility
If you or your Dependents are eligible for benefits under the rules and regulations of the MPI Health Plan (regardless of which health plan you select), you are all also eligible for the prescription drug benefits described in this Summary Plan Description.

Please Note: Any person enrolled in the Medicare Part D prescription drug benefit program will not be eligible for any benefits under MPIHP’s Prescription Drug Benefit.

General Coverage
Medications which are reasonable and necessary for the diagnoses, which require a physician’s prescription by law, are covered. (Please note the list of items not covered which follows below.)

Initially, you may receive up to a 30-day supply of your medication (according to the amount prescribed by your physician), with the cost, less Co-Payment, paid by the Plan.

Refills: The Plan will pay for one refill at a retail pharmacy for up to a maximum 30-day supply in accordance with the number of refills and quantity indicated by your physician, less Co-Payment. (New prescriptions will be required in instances where federal and/or state laws forbid refills.)

Filling long-term 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 pharmacy Co-Payment. After the second purchase, you will pay the entire cost for a long-term drug if you continue to purchase it at a participating retail pharmacy but if you use your Express Scripts mail-order pharmacy, you will pay your mail-order Co-Payment for up to a 90-day supply.

Filling short-term medications: You may obtain all your short-term drugs, such as antibiotics, at a participating retail pharmacy. You will pay your participating retail pharmacy Co-Payment for these medications.

Costs and Co-Payments
The Co-Payment amount is paid by you to the pharmacy at the time your prescription is filled. Your Co-Payment is as follows:

<table>
<thead>
<tr>
<th>Active Health Plan</th>
<th>Retail Co-Pay (Up to a 30-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs</td>
<td>$10</td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>$25</td>
</tr>
<tr>
<td>All Other Brand Drugs</td>
<td>$40</td>
</tr>
</tbody>
</table>

If a generic drug is available but you or your physician choose the brand name, you must pay the difference in cost between the generic and the brand-name drug, plus your generic Co-Payment.

Limit of Two Retail Purchases for Maintenance Prescription
Participants will be allowed to fill each maintenance prescription only twice at a retail pharmacy. Thereafter, coverage will require use of the Express Scripts mail-order pharmacy service for refills. For continued retail purchases beyond the allotted two, the Participant will pay 100% of the cost of the medication.

Other Covered/Not Covered Items Covered

• The following items, which do 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.
  — Disposable lancets
  — Flu vaccination
  — Other Immunization covered by the Plan (see pages 58 and 59)

* and ** See page 117.
• Retin-A* (for acne vulgaris and Darier’s disease only)
• Compound-drugs containing at least one legend ingredient
• Prescription drugs derived from vitamins, when they require a physician prescription by government regulation. This does not include over-the-counter vitamins, even if they are prescribed.**
• Any other drug which, under applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber.

— All erectile dysfunction drugs are covered benefits for male Participants and their eligible male Dependents. Up to six pills per consecutive 30-day period through an Express Scripts affiliated pharmacy are covered when accompanied by an appropriate prescription from an accredited physician who prescribed the drug for the treatment of impotence. Up to 18 pills per consecutive 90-day period through the Express Scripts service are covered. (See “Express Scripts Mail-Order Pharmacy,” below for ordering information.)

— Birth control pills and devices.
— Zyban 180-day supply per lifetime.
— Chantix 180-day supply per lifetime.

Not Covered
• Any medication that is considered preventive
• Medication that may be purchased without a prescription (even though your physician writes a prescription for it)
• Medication dispensed in the physician’s office.
• Vitamins, minerals or food supplements (even if a prescription is required)
• Amphetamines*** and anorectics (drugs used for weight control purposes)
• Drugs used for the treatment of infertility (See Non-Covered Services and Items.)
• Injectable drugs, unless self-administered (Exceptions: chemotherapy injectables, insulin, Glucagon, injectable antivirals specifically indicated for treatment of HIV/AIDS, interferon beta-1b [Betaseron] and sumatriptan [Imitrex])
• Drugs prescribed, other than Zyban and Chantix, whose only use is for smoking cessation
• Drugs used for cosmetic purposes
• Experimental drugs or drugs which have not been approved by the U.S. Food and Drug Administration (FDA)
• 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
• Blood and blood plasma, immunization agents, gamma globulin
• Appliances, prosthetics, devices, bandages, heat lamps, braces, splints, cosmetics, dietary supplements, health and beauty aids
• Proton pump inhibitors: Prescription medications such as Nexium and Prevacid, commonly used for the treatment of heartburn/acid reflux, are not a covered benefit
• Non-sedating antihistamines: Prescription medications such as Clarinex and Allegra, used for the treatment of allergies and other sinus-related health issues, are not a covered benefit.
• 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 Food and Drug Administration (FDA) for the specific diagnosis.
• Experimental and investigational services, treatments, medications or devices.

In Addition
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 Motion Picture Industry Health Plan coverage, will not be covered. Replacement of lost or stolen prescription medication will not be covered.

Reimbursement Process
If you pay for a prescription and would like to be reimbursed, you must complete an Express Scripts Prescription Direct Drug Claim Form and submit it to Express Scripts at the address on the back of the form. Claims must be submitted within 12 months from the date of fill. Failure to timely file may result in the denial of your Claim.

Please note, however, that you will be reimbursed at the rate of 85% of the Allowable Amount, 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-MPI Health Plan” coverage will be considered his or her primary plan for coordination purposes. (This does not apply to dual-coverage couples, where each has Express Scripts coverage through the MPI Health Plan.)

For those who do 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

* and ** and *** See page 117.
less than the Express Scripts plan would allow, you may receive a check for the difference, minus the MPIHP Co-Pay.

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 physicians’ services, there are some limited medications/treatments that are covered and will be coordinated through MPIHP’s prescription drug plan.

**Express Scripts Mail-Order Pharmacy**
Express Scripts provides the option of a mail-order prescription service, for you and your eligible Dependents for the dispensing of maintenance medications.

If a generic equivalent is available but you choose the brand name, you must pay the difference in cost between the generic and the brand name drug, plus your Co-Payment.

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**Active Health Plan Express Scripts**

**Mail-Order Co-Pay**

(90-day supply)

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs</td>
<td>$25</td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>$65</td>
</tr>
<tr>
<td>All Other Brand Drugs</td>
<td>$100</td>
</tr>
</tbody>
</table>

**How to use Express Scripts by mail**
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 doctor before you order by mail.

**Easy Steps to Order by Mail**

1. Your prescription: Ask your doctor to write your prescription(s) for up to a 90-day supply, plus refills for up to one year, as 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 doctor for a prescription for a 30-day supply that you can fill at a participating Express Scripts network pharmacy.
   - If you or your doctor submit a prescription for less than a 90-day supply, you will receive the lesser amount at the 90-day Co-Pay cost.

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 By Mail” form and the appropriate Co-Pay to Express Scripts.
     - Visit www.mpiphp.org to print the form.
     - You may submit a check or money order, or fill out the credit card authorization on the order form.
     - Call Express Scripts at 800.987.5247 to obtain Co-Pay amounts.
   - Order by fax: Ask your doctor to call 888.327.9791 for instructions on how to fax a prescription.
     - Only a doctor may fax a prescription.
     - You will be billed by Express Scripts for your Co-Pay.

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.express-scripts.com to view available prescription refills in the personalized “Order Center” or within your “Prescription History.”
     - From the Order Center, simply check the box next to the item(s) you want to order and follow the on-screen instructions to check out.
     - From Prescription History, click on the “Add to Cart” icon next to the prescription number and follow the on-screen instructions to check out.
     - You may pay by credit card online.
   - By telephone: Call 800.473.3455 to use the automated refill system.
   - By mail: Use the refill order included with your previous shipment. Mail it with your Co-Pay to Express Scripts in the return envelope provided.

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*If Retin-A has been prescribed for the diagnosis of acne vulgaris, an exception may be made to this non-covered status. Satisfactory written documentation in the form of clinical office notes or narrative confirming the diagnosis, together with a clinical quality photograph must be sent to the MPI Health Plan Medical Review Department before or after the purchase of the prescription if coverage is to be provided.

**Distinguishes medications derived from vitamins and used for the treatment of specific diagnoses from those used as nutritional supplements. For example, although Vitamin D is available over-the-counter in low doses, it is available only by prescription in significantly higher dosage for those with glandular and bone diseases, as well as for individuals with kidney dialysis. Some prenatal vitamin prescriptions prescribed in higher dosages fit this criteria as well.

***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 MPI Health Plan Medical Review Department either before or after the purchase of the prescription if coverage is to be 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. This means that if you obtain your specialty medications other than from the Express Scripts Special Care Pharmacy, 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 doctor’s office (where allowable by law), if your doctor 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 800.501.7260 between 8:00 a.m. and 8:00 p.m., Eastern time, Monday through Friday. If you prefer, have your doctor call 800.987.4904.

Patient Safety and Support Programs
On behalf of the Plan, Express Scripts has various patient safety and support programs 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.

Out of the Country
If you are planning a trip out of the country, ensuring that you have the medications you need while you are away from home requires a little advance planning. If your normal 30-day retail prescription won’t last throughout your stay, consider using Express Scripts’ mail-order service, through which you may obtain up to a 90-day maximum supply. Since the service is limited to delivery to U.S. addresses, you will need to fill your prescription prior to leaving. Remember, if you have recently filled a 30- to 90-day prescription, you may not be eligible to refill that same prescription until the supply is used. If you will be out of the country for an extended period, there is another option with a few simple steps to follow:

1. Before you leave, pay for the required additional prescription(s) yourself at your local Express Scripts pharmacy or any of the over 54,000 Express Scripts pharmacies nationwide.
2. Retain the pharmacy receipt(s), which indicates the medication(s) purchased along with the quantity received and dollar amount paid.
3. Upon return, but within 12 months from the date of fill, forward the following information to the California MPI Health Plan Office: Medical Review Department, P.O. Box 1999, Studio City, California 91614-0999:
   a. The prescription receipt(s),
   b. A completed Express Scripts Prescription Direct Drug Claim Form, which can be obtained by calling 800.987.5247 or visiting Express Scripts’ website at www.express-scripts.com, and
   c. A signed statement indicating that the medication was used while you were out of the country.

The Plan will instruct Express Scripts to reimburse you up to the Allowable Amount, less any Co-Payments that apply, as long as the following conditions are met:
1. You were eligible for Plan benefits during the time period the medications were used.
2. There are no duplicate prescriptions or duplicate quantities of the medications processed for those dates of service.

Remember, if you fill a prescription at a pharmacy that is not part of the Express Scripts participating network, you will be reimbursed at 85% of the Allowable Amount, less the Co-Payment. Reimbursement is based on generic or lower-cost brand-name products, if either is available.

Further Information/Disputes
If you have any questions regarding your Prescription Drug Benefit, call Express Scripts toll-free at 800.987.5247, or call the California Plan Office at 855.ASK.4MPI (855.275.4674).

If you have any questions about whether a pharmaceutical item is covered, we encourage you to contact the California MPI Health Plan Office, in writing, in advance of attempting to purchase the item. While Preauthorization is not required, it can help to clarify for you what is or is not a covered item.

If you believe that you improperly paid for a pharmaceutical item from an Express Scripts pharmacy, you may file a Claim, in writing, for benefits with the MPI Health Plan. The Claim, and any appeal from an adverse determination of the Claim, shall be handled as described on pages 44 and 66.

Please make sure the Participant’s Social Security or identification number appears on all Claim forms and correspondence.

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 MPI Health Plan, the prescription will be returned to you. (Please see “Other Covered/Not Covered Items” on page 115.)
VSP has an extensive nationwide network of doctors who agree to provide the finest ophthalmic care and eyewear to patients covered by VSP. VSP is designed to encourage you and your Dependents to maintain your vision through regular eye examinations and to help with vision care expenses for required glasses or contact lenses. If you are an eligible Active Participant or Dependent under the rules of the Motion Picture Industry Health Plan, you are eligible for the vision care plan described in this summary.

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 doctor. 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 12 months from your last date of service.
- Spectacle lenses are covered once every 12 months from your last date of service (single vision, lined bifocal and lined trifocal). Photochromic/tints are covered for all, and polycarbonate lenses are covered for Dependent children. There is an average 20% to 25% discount on non-covered lens options.
- Frames are covered once every 24 months from your last date of service. Your frame allowance is $145. If you select a frame with a cost that exceeds the allowance, the overage will be discounted by 20%.
- Plan 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 your last well vision exam.

**Elective contact lenses are available once every 12 months from your last date of service and are in lieu of glasses (spectsctle lenses and frames).** The routine eye exam will be paid in full, and an allowance of $105 will be provided toward the cost of your contact lens exam (fitting and evaluation) and contact lenses.
- Any costs exceeding the allowance are the responsibility of the patient. Special rebates are available on select brands of contacts. Visit vsp.com for details.

- The Plan offers a 15% discount on a network doctor’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 network doctor who provided the exam.

**Medically necessary contact lenses are covered in full when prescribed by a VSP doctor for one of the following conditions:**

With certain conditions of anisometropia, aphakia, high ametropia, nystagmus or other medical conditions that inhibit the use of glasses.

**Appointments**

Call the VSP network doctor of your choice for an appointment, identifying yourself as a VSP patient. The network doctor 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 doctor, visit www.vsp.com or call VSP at 800.VSP.7195 (800.877.7195). If you are not eligible for benefits at the time you call for an appointment, the doctor’s office will communicate that information to you when it has been determined.

**Options**

The following options are available to Participants and their eligible Dependents at an additional out-of-pocket cost:

- Blended lenses
- Oversize 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 protection lenses
Not Covered
There is no benefit for professional services or eyewear connected with:

- Orthoptics or vision training and any associated supplemental testing
- Two pair 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

Using 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
The MPI Health Plan Offices do not process vision Claims. They are processed by VSP.

VSP’s Grievance System
Pursuant to California Health and Safety Code Sections 1368 and 1368.02, Vision Service Plan would like to inform each of its subscribers/enrollees of the following information.

If a Participant/eligible Dependent (hereafter “enrollee”) has a complaint/grievance (hereafter “grievance”) regarding VSP service or Claim payment, the enrollee may communicate the grievance to VSP by using the form which is available by calling VSP Customer Service Department’s toll-free number, 800.877.7195, Monday through Friday, 5:00 a.m. to 8:00 p.m., and Saturday, 6:00 a.m. to 5:00 p.m. Pacific Standard Time. Grievances may be filed in writing with VSP at 3333 Quality Drive, Rancho Cordova, CA 95670.

Upon receipt of a verbal or written grievance, VSP will respond in writing to the enrollee acknowledging receipt and/or disposition of the grievance within five business days. If a resolution cannot be reached within 30 days, a 15-day interim notification will be sent to the enrollee informing him or her of the resolution’s status. (VSP will keep all grievances and their responses thereto on file for seven years.)

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number 800.400.0815 to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service’s toll-free telephone number 877.688.9891 (TDD) to contact the Department.

The Department’s Internet website (www.hmohelp.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at 800.877.7195 and use VSP’s grievance process before contacting the Department.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by VSP, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. VSP’s grievance process and the Department’s complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.
The Directors of the MPI Health Plan adopted The Wellness Program for all Health Plan Participants (including HMO enrollees) and their eligible Dependents. The Wellness Program is administered by The Industry Health Network (TIHN) of the Motion Picture & Television Fund (MPTF) and consists of the following programs and services available at no cost to you.

You must call 800.654.WELL (9355) for more information or to make an appointment. These services are available through TIHN only you cannot substitute other private Providers or programs which have not been approved by TIHN. A listing of MPTF Health Center locations may be found in this Summary Plan Description on page 69.

**Preventive Medical Care**
An important aspect of staying healthy and achieving optimal wellness involves early diagnosis and treatment of potential health problems. Comprehensive Physical Exams and discounts on health clubs and yoga studios are all offered through The Wellness Program.

**Comprehensive Physical Exams (MPIHP/Blue Cross Only)**
Participants and their eligible Dependents through age 17 who live in Los Angeles County and wish to use this benefit must use one of the MPTF Health Centers listed on page 68. No voucher is necessary. Simply call the Health Center of your choice and make an appointment. MPTF Primary Care Physicians are experts in preventive care and will discuss general health issues and ways you can lead a healthier life. (Please see page 58 for information applicable to non-HMO Participants living outside Los Angeles County.)

**Comprehensive Health Management Programs**
These programs are higher impact, more intensive courses that will run two to six weeks or more. These courses provide in-depth support, information and motivation.

**“Picture Quitting”: The Entertainment Industry Quit Smoking Program**
“Picture Quitting,” a smoking cessation program, offers tailored, comprehensive smoking cessation services to entertainment industry Employees. This innovative program uses scientifically proven methods to help smokers quit for good. Individual counseling is provided by trained smoking cessation counselors. You will have access to a number of different prescription and over-the-counter medications for nominal Co-Pay. Counselors help smokers identify their personal reasons for quitting and smoking “triggers,” and then develop individualized quit plans. For more information, please contact “Picture Quitting” at 818.640.3935, or to obtain a Referral to the program, talk with an MPTF physician.

**Conquering Insomnia Program –Interactive On-line Program**
Insomnia affects one-third of adults in the U.S. This on-line program uses Cognitive Behavioral Therapy (CBT). CBT has consistently been proven to be the most effective treatment for chronic insomnia. It improves sleep in 75% to 80% of insomnia patients and eliminates sleeping pill use in almost half of patients. This program, developed and tested at Harvard Medical School and the University of Massachusetts Memorial Medical Center, is an interactive, PDF (Adobe Reader) based CBT program for insomnia that is designed as if you are a patient going through a five-session CBT treatment program. You can complete a sleep diary each week of the program, e-mail it, and receive interactive, individualized CBT guidelines.

**Type II Diabetes Management**
Diabetes classes are taught by Certified Diabetes Educators and include a “Carb Counting” course and a two part Comprehensive Diabetes program. In this two-part course, you will learn about the impact of diabetes on your overall health and gain the knowledge and practical tools you need to effectively manage your life.

**Lowering Your Cholesterol**
Taught by a Registered Dietitian, this program will discuss what cholesterol is, where it comes from, how to reduce your risk factors and how to manage it more effectively. You will be given the most updated information, including lab values, nutrition, exercise, medications and supplements, and, most importantly, you will learn how to control your cholesterol.
Lifestyle Enhancement Programs
The Lifestyle Enhancement Series includes programs designed to help reduce unhealthy risk factors and improve your overall health. Expert instructors will conduct sessions in Stress Management, Weight Management, Nutrition & Fitness, and Other Preventive Courses.

**Stress Management Courses include:** “Relaxation & Meditation,” “Qi Gong,” “Guided Imagery,” “Anger Management,” and “How to Deal with Difficult People,” among others topics.

**Weight Management Courses include:** “How To Be a Fat Burning Machine,” “How To Give Up Dieting Forever,” and “Intuitive Eating,” among other topics.

**Nutrition & Fitness Courses include:** “The Mediterranean Diet,” “Eating Clean and Taking Control,” “Nutrition 101,” “Clearing Up the Confusion Among Dietary Supplements,” “Walk/Run for Fitness,” and “The DASH Diet,” among other topics.

**Other Preventive Courses include:** “Your Feet Don’t Have To Hurt,” “Bones For Life,” “Brain Boosters,” “The Next Move for Your Back and Neck Pain,” and “High Blood Pressure: What You Can Do About It,” among other topics.

Healthy Family Services

**Family Learning Series**
To promote the well-being of children and families, this program features a panel of experts who cover contemporary issues such as “Encouragement vs. Praise,” “How To Be a Great Dad,” “The ABCs of Solving Family Problems,” “Building a Responsible Child,” “Adult CPR,” and “CPR for Friends and Family.”

Awareness & Learning Resources

**Educational Materials**
The Wellness Program offers a “Minding Your Mental Health” Guide and a “Children’s Self Care” Guide. These guides have self-guided questions and answers to help you know when to access medical care and how to better manage your health.

Material on managing asthma or depression and a calorie counter book are also available by request. Request your free copy by calling The Wellness Program at 800.654.WELL (9355).

**Health Clubs & Classes Discount Program**
Discounts for new memberships are available at various health clubs, fitness facilities, and yoga studios throughout the greater Los Angeles area for MPIHP Participants and Dependents. To obtain a listing of participating clubs and a discount voucher, please contact The Wellness Program at 800.654.WELL (9355).

**Toll-Free Wellness Line**
The Wellness Line is staffed from 8:30 a.m. to 5:00 p.m., Pacific time, Monday to Friday for all services. Phone reservations may be made 24-hours daily. The Wellness Program can be reached at 800.654.WELL (9355).

**For Participants Who Reside Outside the Los Angeles Area**
If you are planning to visit the Los Angeles area, please take advantage of the Wellness services provided. Reserve a space for a seminar or participate in other programs by calling 818.876.1792.
This *Summary Plan Description* describes the MPI Health Plan’s comprehensive medical and hospital benefits of the MPIHP/Anthem Blue Cross Health Plan, Health Maintenance Organization (HMO) and Point of Service (POS) options, prescription drug plan, vision plan, dental plans, life insurance, and wellness program. This section of the book provides valuable reference information on the structure and operation of the MPI Health Plan.

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The Motion Picture Industry Health Plan for Active Participants is a Plan 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 counsel.

**Participating Unions (In numerical order)**

- Security-Police-Fire Professionals of America (SPFPA)
- UNITE HERE (Union of Needletrades, Textiles and Industrial Employees, and the Hotel and Restaurant Employees, and Bartenders Union)
- International Brotherhood of Electrical Workers
- Affiliated Property Craftspersons
- Studio Mechanics (East Coast)
- Plumbers
- Grips and Craft Services
- Script Supervisors & Production Office Coordinators (East Coast)
- Office & Professional Employees International Union (OPEIU)
- International Brotherhood of Teamsters
- International Cinematographers Guild, Publicists, Animation Photographers
- Lab Film/Video Technicians of Motion Picture & TV Industry, Cinetechnicians, Restoration Technicians Group
- Production Sound Technicians, Television Engineers & Video Assist Technicians, Sound Projectionists
- Editors Guild, Story Analysts, Post-Production Sound Personnel
- Costumers
- Make-Up Artists & Hair Stylists Guild
- Studio Utility Employees (Laborers)
- Electrical Lighting Technicians
- Set Painters & Sign Writers
- Plasterers & Cement Finishers
- First Aid Employees
- Art Directors Guild & Scenic, Title and Graphic Artists
- Teamsters (East Coast) (for Casting Directors)
- Animation Guild (Cartoonists)
- Production Office Coordinators, Production Accountants, Script Supervisors & Continuity Coordinators
- Teachers & Welfare Workers
- Costume Designers Guild
- S.E.I.U. Service Employees

**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.
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.

**American Specialty Health Networks, Inc.**
P.O. Box 509002
San Diego, CA 92150-2002
*Administers the chiropractic benefits for Participants enrolled in Health Net and Kaiser.*

**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.*

**Union Labor Life Insurance Company**
(Death Benefits)
The Union Labor Life
8403 Colesville Road
Silver Spring, MD 20910
*Administers Life Insurance
Accidental Death and Dismemberment benefits
(Active Participants Only)*

Self-Insured Benefits
The Motion Picture Industry Health Plan for Active Participants 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**
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 benefits under its Point of Service plan. (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 Indemnity dental benefits*

**Express Scripts**
P.O. Box 30493
Tampa, FL 33630-3493
*Administers the prescription drug walk-in and mail-order programs for the Plan.*

**OptumHealth Behavioral Solutions, Inc.**
A United Health Group Company
P.O. Box 55307
Sherman Oaks, CA 91413-0307
*Administers and provides the mental health benefit for the Plan.*

**The Industry Health Network of the Motion Picture & Television Fund**
23388 Mulholland Drive
Woodland Hills, CA 91364
*Administers The Wellness Program and Case Management on behalf of the Plan. The company also provides access to its Contracting Provider network.*

**Vision Service Plan**
3333 Quality Drive
Rancho Cordova, CA 95670
*Provides access to the vision network and administers the benefit for the Plan.*
Name and Address of Person Designated as Agent for the Service of Legal Process
Gail Stewart
Interim Executive Administrative Director
Motion Picture Industry Health Plan for Active Participants
11365 Ventura Boulevard
Studio City, CA 91604-3148
Service of legal process may also be made upon a Plan Trustee (Director) or the Plan Administrator.

Name and Address of the Administrative Director
Gail Stewart
Interim Executive Administrative Director
Motion Picture Industry Health Plan for Active Participants
11365 Ventura Boulevard
Studio City, CA 91604-3148

Names and Addresses of Directors
See page 129

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 office of the Plan and at other specified 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 Trust 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. (See Claim Submission Guidelines on page 44 and Claims Appeals Procedures on page 66.)

Availability of Documents and Other Important Information
As a Participant in the Motion Picture Industry Health Plan for Active Participants, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

• Examine, without charge, at the Plan 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 updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

• Receive a copy 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 yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

Prudent Actions by Plan Fiduciaries
In addition to creating certain rights for you, 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 caesarean 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). You may still need Preauthorization from the Plan to avoid a reduction of the dollar amount covered by the Plan.
MOTION PICTURE INDUSTRY HEALTH PLAN

BOARD OF DIRECTORS

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Local 728
1001 W. Magnolia Blvd.
Burbank CA 91506

Aric Ackerman
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To help you better understand and access the information in your Summary Plan Description, we have included definitions for some of the terms you will encounter, as well as a cross-reference index that will help you readily locate information you need. We do suggest that you read the book thoroughly in order to fully understand your comprehensive package of benefits.

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132...............................Glossary
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**Active Participant**: An active Employee 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 your health 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 a plan allows for a covered service. For In-Network Providers the Allowable Amount is the contracted rate. For Out-of-Network Providers each medical network determines the Allowable Amount for the MPI Health Plan. The Allowable Amount is always less than or equal to the Billed Charge. Covered services are paid by the Plan at the rate of 50% of either the 70th percentile of the UCR schedule or the Anthem Blue Cross/BlueCard fee schedule. The $15 or $30 Co-Payment per visit still applies ($30 Co-Payment if the Participant resides within the MPTF service area defined on page 67 but chooses to not use one of the MPTF health centers or receive and use a THHN Provider). The patient is also responsible for any Balance Billing.

**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 other than physicians.

**Assistant Surgeon**: An Assistant Surgeon (M.D., D.O., D.P.M.) is eligible for benefits at 20% of the reasonable and customary allowance for the procedure, in those cases where an Assistant Surgeon is medically necessary. An Assistant Surgeon is considered medically necessary when a procedure is at a level of technical surgical complexity that the assistance of another surgeon is required. An Assistant Surgeon is not considered medically necessary when the assistance required is of a manual nature, and can be provided by non-surgeon, paramedical personnel. Paramedical personnel include R.N.s, L.P.N.s, operating room technicians, and physician assistants. Services of surgical assistants (paramedical personnel and surgical technicians) are included in the operating room facility charges and are not eligible for separate benefits.

**Balance Billing**: Balance Billing occurs when a Provider bills a patient for any unpaid balance of the Provider’s charges after an insurer such as the MPI Health Plan has paid its portion of the bill.

**Benefit Period**: The six calendar months commencing the first day of the third month immediately following the applicable Qualifying Period.

**Case Management**: A planned approach to manage services or treatments to an individual with specific health care needs. The goal is to contain costs and promote more effective intervention to meet patient needs and achieve optimum patient outcome.

**Case Manager**: An experienced health care professional (nurse, social worker, doctor or pharmacist) who works with patients, Providers and insurers to coordinate all necessary aspects of health care. Case Managers evaluate necessity, appropriateness and efficiency of services and drugs provided to individual patients.

**Claim**: A bill or Preauthorization request submitted to the Plan.

**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 insurance company and an insured individual. It is usually described in percentages: for example, the plan or insurance company agrees to pay 90% of covered charges 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 (Co-Pay)**: The insured individual’s portion of the cost of his or her care, usually a flat dollar amount, such as $15 per office visit. Under many plans, Co-Payments are made at the time of the service and the Plan pays for the remainder of the fee.

**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 Expenses**: What the Plan will pay for as defined in the contract. For example, some plans exclude coverage for specific services, such as Cosmetic Surgery.

**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 company) covers the costs. Often, insurance plans are based on yearly Deductible amounts.

**Denial of Claim**: Refusal by an insurance company 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. Qualified same-sex domestic partner;
3. 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. If they are eligible for coverage through their own Employer, then they are not eligible for MPI coverage until January 1, 2014.
4. Unmarried children are eligible for dental and vision coverage until they reach the age of 19 (or 23 if a full-time student).
5. Any child required to be recognized under a Qualified Medical Child Support Order.

Durable Medical Equipment: This is medical equipment which is:
1. Ordered by your physician;
2. Primarily used for medical purposes;
3. Able to withstand repeated use;
4. Generally not of use in the absence of sickness or injury; and
5. Appropriate for use in the home.

Eligibility Period: The six-month period of time in which Participants are eligible for the benefits of the MPI Health Plan.
Employee: There are three general requirements to be considered an “Employee” for purposes of participation in the Plans:
1. You must either: (i) work for an Employer and be covered by a Collective Bargaining Agreement which requires Employer contributions to the Plans, or (ii) 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 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: (i) services in the Los Angeles area in the Industry, or (ii) 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.
• 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 IATSE Local 52, Local 161, Local 600 or Local 700 working in the United States.
• 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.

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 Plans 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.

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. Criteria for Provider participation may be the same as those in PPOs, but have a more restrictive Provider selection and credentialing process.

Explanation of Benefits: The Explanation of Benefits statement is a summary of services provided and the amounts paid.

Guild: Any one of the participating Unions or Guilds listed on page 125.

Health Maintenance Organizations (HMOs): Health Maintenance Organizations represent a “pre-paid” 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 physicians 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 physician’s own office (as with IPAs.)

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.

Independent Practice Associations: IPAs are similar to HMOs, except that individuals receive care in a physician’s own office, rather than in an HMO facility.

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 discount.

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 physicians, 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 physicians. The goal is to provide value through a system that provides people access to quality, cost-effective health care.

Maximum Dollar Limit: The maximum amount of money that an insurance company (or self-insured plan) will pay for Claims within a specific time period.

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 insurance plans and medical groups offered by their Employer and have the new insurance 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 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 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 doctor’s office or clinic.

Overpayments: “Overpayment” is the term used to refer to an MPI Health 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:** A Provider who has contracted with the network provider to deliver medical services to individuals covered by the Plan. The Provider may be a hospital, pharmacy or other facility or a physician who has contractually accepted the terms and conditions as set forth by the Plan.

**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. For example, the Plan Month of July 2013 will end on July 20, 2013 (the Saturday before the last Thursday of July). The immediately following Plan Month will then begin on Sunday, July 21, 2013 and end on Saturday, August 24, 2013.

**Point of Service (POS) Plan:** A Point of Service (POS) 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 (HMO) and requires that Participants seek care through a Primary Care Physician (PCP) who is part of the POS network. That PCP 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 physician, but at a greater out-of-pocket cost.

**Preauthorization:** Written approval from an insurer that a procedure or item is a covered expense 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 Motion Picture & Television Fund. Usually the benefit contract provides significantly better benefits (few or no Co-Payments) 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 on an indemnity basis with significant Co-Payments.

**Premium:** The amount paid for 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 Dependents to pay in order to receive coverage from the Plan.

**Primary Care Physician (PCP):** A health care professional (usually a medical doctor) 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 physicians for Specialist care.

**Provider:** Provider is a term used for health professionals who provide health care services such as 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. For example, the applicable Qualifying Period for the Eligibility Period commencing May 1, 2012 was August 21, 2011 through February 18, 2012.

**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 Pension Plan.

**Referral:** Approval or consent by a Primary Care Physician for patient Referral to Ancillary Services and Specialists.

**Retiree Health Benefits:** Benefits provided by the Retiree Motion Picture Industry Health Plan (also referred to as Retiree Plan, Retiree Health, and Retiree Health Plan).

**Second Surgical 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 physician 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.

**Union:** Any one of the participating Unions or Guilds listed on page 125.

**Usual, Customary, and Reasonable (UCR) Rate:** A Provider charge is considered “Usual and Customary and Reasonable” if it is the amount that most physicians 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.
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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.
These Appendices are intended to outline any differences between the MPIHP Active Health Summary Plan Description and your benefits. These Appendices, plus the information contained in the July 2013 MPIHP Active Summary Plan Description, constitute your Summary Plan Description.

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148 Active Former East Coast Local 161 Welfare Fund Participant
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 MPIHP Active Health Summary Plan Description and your benefits. This Appendix, plus the information contained in the July 2013 MPIHP Active Summary Plan Description, constitute your Summary Plan Description.

If you have any questions about your benefits, you may call either MPI Health Plan office.

The Board of Directors
Motion Picture Industry Health Plan

The nature and extent of benefits provided by the MPIHP and the rules governing eligibility are determined solely and exclusively by the Directors of the MPIHP, consistent with applicable law. The 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 MPIHP, consistent with applicable law.

Employees of the MPIHP have no authority to alter benefits or eligibility rules. Any interpretations or opinions given by Employees of the MPIHP are not binding upon the Directors and cannot enlarge or change such benefits or eligibility rules. In accordance with the terms of the Trust Agreement, the Directors reserve the right to change the nature and extent of benefits provided by the MPIHP and to amend the rules governing eligibility at any time, consistent with applicable law.
1. Benefit Maximums

The benefits you received prior to the Merger Date shall not be applied against any benefit maximum established by MPIHP, whether such maximum is determined on an Eligibility Period, lifetime basis or any other period of time.

2. Eligibility for Retiree Health Under MPIHP Rules

If you meet the MPIHP rules for Retiree Health Benefits, you will receive the benefits provided in your MPIHP Retiree Health Summary Plan Description. MPIHP general rules for Retiree Health eligibility are provided in your MPIHP Active and Retiree Summary Plan Descriptions. The calculation of Qualifying Years and hours completed towards satisfying the eligibility rules for retiree benefits under the MPIHP 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 MPIHP 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.
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 (“MPIHP”). Effective July 1, 2002, Participants of the Local 700 Welfare Fund who were eligible (as explained below) received the benefits provided by the MPIHP to all Participants and were subject to the rules of the MPIHP, except as set forth below. Please familiarize yourself with the enclosed Summary Plan Description for the MPIHP 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 because of the transition, as discussed on the next page.

If you have any questions about your benefits, you may call either MPI Health Plan office.

The Board of Directors
Motion Picture Industry Health Plan

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Employees of the MPIHP have no authority to alter benefits or eligibility rules. Any interpretations or opinions given by Employees of the MPIHP are not binding upon the Directors and cannot enlarge or change such benefits or eligibility rules. In accordance with the terms of the Trust Agreement, the Directors reserve the right to change the nature and extent of benefits provided by the MPIHP and to amend the rules governing eligibility at any time, consistent with applicable law.
Merger Transition Rules

1. 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 MPIHP does not permit banking of hours beyond 450. Nevertheless, any 700 Fund Bank converted credits over 450 hours were banked with the MPIHP and kept until used. After July 1, 2002, additional hours cannot be banked until the Local 700 Participant’s bank balance drops below the MPIHP 450 hour limit.

2. 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 (a) they did not have sufficient hours to continue their eligibility or (b) 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.

3. Benefit Maximums

The benefits you received prior to the Merger Date shall be applied, if practical, as determined by MPIHP against any benefit maximum established by MPIHP whether such maximum is determined on an Eligibility Period, lifetime basis or any other period of time.

4. General MPIHP Retiree Health Eligibility Requirements

MPIHP general rules for Retiree Health eligibility are provided in your MPIHP Active and Retiree Summary Plan Descriptions. However, for periods prior to the Merger Date, there are special rules for calculating Qualifying Years and hours for Retiree Health Benefits. Generally, for periods prior to July 1, 2002, your hours and years under the Local 700 Pension Fund will count toward eligibility for MPIHP 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).

5. 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 MPIHP rules when they retire, may qualify and receive the MPIHP Retiree Health Benefit, 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 MPIHP, the retiree benefits payable shall be determined solely under MPIHP rules.
Dear Active Participant,

This Appendix is for those eligible Local 52 Welfare Fund Participants who became Participants of the Motion Picture Industry Health 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 MPIHP plan of benefits because of the merger transition, and is part of your Summary Plan Description. You should also retain your Local 52 Welfare Fund Summary Plan Description, as some of those rules are relevant during the transition period.

If you have any questions about your benefits, you may call either MPI Health Plan office.

The Board of Directors
Motion Picture Industry Health Plan

The nature and extent of benefits provided by the MPIHP and the rules governing eligibility are determined solely and exclusively by the Directors of the MPIHP, consistent with applicable law. The 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 MPIHP, consistent with applicable law.

Employees of the MPIHP have no authority to alter benefits or eligibility rules. Any interpretations or opinions given by Employees of the MPIHP are not binding upon the Directors and cannot enlarge or change such benefits or eligibility rules. In accordance with the terms of the Trust Agreement, the Directors reserve the right to change the nature and extent of benefits provided by the MPIHP and to amend the rules governing eligibility at any time, consistent with applicable law.
Merger Transition Rules

1. Benefit Maximums

The benefits you received prior to the Merger Date shall be applied, if practical, as determined by MPIHP against any benefit maximum established by MPIHP whether such maximum is determined on an Eligibility Period, lifetime basis or any other period of time.

2. General MPIHP Eligibility for Retiree Health

If you retire on or after January 1, 2004, you will qualify for Retiree Health Benefits if you meet the MPI Retiree Fund requirements for Qualifying Years and hours. (See MPIHP Active and Retiree Summary Plan Descriptions.) Generally, for periods prior to the Merger Date, your days and years under the Local 52 Pension Plan will count toward eligibility for MPIHP 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 Qualified 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 MPIHP Retiree Health eligibility.
Dear Active Participant,

The Appendix is for those eligible Local 161 Welfare Fund Participants who become Participants of the Motion Picture Industry Health Plan 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 MPIHP Active Summary Plan Description, and is part of your Summary Plan Description. You should also retain your Local 161 Welfare Fund Summary Plan Description, as some of those rules are relevant because of the transition.

If you have any questions about your benefits, you may call either MPIHP office.

The Board of Directors
Motion Picture Industry Health Plan

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Merger Transition Rules

1. 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 161 Welfare Fund for the period from April 1, 2004 through March 31, 2005. You were allowed to carry over to MPIHP 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 MPIHP Eligibility Periods commencing on or after January 1, 2005. However, the use of such hours is subject to all general MPIHP rules with respect to banked hours. You could begin banking hours under the MPIHP commencing in the Qualifying Period running from April 25, 2004 through October 23, 2004, under general MPIHP rules.

2. 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 MPI Retiree Health Plan requirements for Qualifying Years and hours. These general requirements are described in your MPIHP Active and Retiree Summary Plan Descriptions. Generally, for periods prior to the Merger Date, your days and years under the 161 Pension Fund will count toward eligibility for MPIHP.
California Office Departments
- Audit & Collections: 818.769.0007 x 651
  E-mail: acd@mpiphp.org
- Case Management: 855.ASK4.MPI (855.275.4674)
  E-mail: service@mpiphp.org
- Employer Contracts: 818.769.0007 x 478
  E-mail: employercontracts@mpiphp.org
- Health Claims Inquiries: 855.ASK.4MPI (855.275.4674)
  E-mail: service@mpiphp.org
- Life Insurance Benefits: 855.ASK.4MPI (855.275.4674)
  E-mail: service@mpiphp.org
- Medical Review: 855.ASK.4MPI (855.275.4674)
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Website: www.mpiphp.org

Providers
- ASH-HMO Network: 800.678.9133
  Website: www.ashcompanies.com
- Anthem Blue Cross of California: 800.688.3828
  Website: www.anthem.com
- DeltaCare USA Dental Health Plan: 800.422.4234
  Website: www.deltadentalca.org
- Delta Dental PPO Dental Plan: 888.335.8227
  Website: www.deltadentalca.org
- Express Scripts: 800.987.5247
  Website: www.express-scripts.com
- Health Net: 800.522.0088
  Website: www.healthnet.com
- Kaiser Permanente: 800.464.4000
  Website: www.kaiserpermanente.org
- OptumHealth Behavioral Solutions: 888.661.9141
  Website: www.liveandworkwell.com
- Oxford Health Plans: 800.444.6222
  Website: www.oxfordhealth.com
- Vision Service Plan: 800.877.7195
  Website: www.vsp.com
- The Wellness Program
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