PROFESSIONAL MUSICIANS, LOCAL 47

AND EMPLOYERS' HEALTH AND WELFARE FUND

GENERAL INFORMATION BOOKLET

YOUR WELFARE PROGRAM

SUMMARY PLAN DESCRIPTION

OF

BENEFITS

JANUARY 2011

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TRUST ADMINISTRATOR'S OFFICE:

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

This Summary Plan Description (SPD) has been prepared to give you basic information concerning the benefit plans (collectively the Plan) available to you through the Professional Musicians, Local 47 and Employers' Health and Welfare Fund (The Fund). Summarized in this booklet are Eligibility requirements which you must satisfy in order to qualify for benefits, the benefit plans themselves, and the procedures for review or appeal of claims. This booklet also provides information about the administration of the Plan and your rights under the law.

This SPD and the summary plan descriptions set forth in separate summary booklets for each benefit issued by the Fund's current providers, and any other provider with whom the Fund may contract in the future to provide benefits, shall constitute the Summary Plan Description of your employee benefit Plan. If you lose or do not have this booklet or any other booklet constituting the Summary Plan Description, you may call the Trust Administrator's Office to request another copy.

Currently the Fund's providers are Health Net, Landmark Healthplan(Landmark), Delta Dental, Gerber Life, The Prudential Insurance Company of America ("Prudential").

Detailed information about Life and Accidental Death and Dismemberment benefits (provided through Prudential Life), Medical benefits (provided through Health Net), Dental benefits (provided through Delta Dental of California and DeltaCare USA), Chiropractic/Acupuncture benefits (provided through Landmark Healthplan) and Vision benefits (provided through Gerber Life and administered by MES Vision) are described in summary through this SPD and a more detailed description of those benefits are set forth in separate booklets for each benefit which will be issued to you, by each carrier that will be providing you with benefits, after your successful enrollment for those benefits. These booklets may also be found on the Fund's website at www.pacfed.com/musicians. Together these benefits /insurance coverages, plus any other coverage the Trustees may implement, constitute the Plan.

Health Net offers a Preferred Provider Organization (PPO) Plan for Participants residing outside the State of California. Proof of residence is required to enroll in this plan. Chiropractic, Acupuncture, Dental and Vision benefits are not available to those residing outside the State of California.

The legal and policy terms of the group master contracts issued to the Fund, by the providers, will prevail in interpretation of benefit questions and other questions relative to benefits provided by the Plan.

The Summary Plan Description is being given general distribution to be certain everyone who is entitled to receive a copy does so. Because of this, you may receive a Summary Plan Description whether or not you are currently eligible for benefits.

You are cautioned that no Employer or Union, nor any representative of any Employer or Union, is authorized to (i) interpret the various insurance policies, agreements, or the coverages provided by these documents, (ii) act as an agent of the Trustees in any matter relating to these contracts, agreements, or coverages; (iii) act as an agent of the Trust or Trustees with regard to any other matter relating to the administration of the Trust or any benefit plan administered or sponsored by the Trust. The Trustees are charged with the responsibility of interpreting the provisions of the Plan and possess the discretion to establish those rules and regulations as the Trustees deem are necessary and appropriate to assist in the administration and interpretation of the Plan. They are also responsible for determining the Plan's schedule of benefits.

The Trustees will determine appeals regarding denial of eligibility and any other matters the Trustees determine is properly before them. The benefit providers will determine all appeals concerning the denial of a specific benefit. Please review the Evidence of Coverages and/or Explanation of Benefit documents to determine the proper appeal process for each carrier.

Accordingly, any questions you may have pertaining to your participation in the Plan, which is sponsored by the Professional Musicians, Local 47 and Employers' Health and Welfare Fund should be directed to the Fund Administrator's Office, and those questions are subject to final interpretation by the Trustees. Any questions regarding the specific benefits provided by the Plan summarized in the Summary Plan Description should be directed to the appropriate Provider. The Fund’s providers have the discretion to interpret the plans of insurance that provide the benefits offered by the Fund and those plans of insurance are subject to final interpretation by such Provider. A list of the Providers is contained in this booklet.

The Summary Plan Description is only a summary of the Plan. If there is a conflict between this summary and the complete Plan, the provisions of the Plan govern.

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

Participants have no vested or accrued rights under the Plan.

Insured benefits are provided to the extent of contributions actually received or collected by the Fund. In order that the Fund may carry out its obligation to maintain within the limits of its resources a program dedicated to providing benefits for all participants, the Board of Trustees expressly reserves the right, in its sole discretion at any time and from time to time:

- to terminate or amend the amount or conditions of eligibility for any benefit, or to

terminate or change any benefit even though such changes may affect claims that have already occurred;

- to terminate the Plan even though such changes may affect claims which have already occurred;
- to amend or rescind any other provision of the Plan, and; to revoke or suspend the status of an employer, payroll company or payroll agent as an entity or individual from which/whom the Fund will accept and process contributions.

The existence and continuation of Plan benefits depends on the continuation of contributions being made to the Fund pursuant to various collective bargaining agreements between the Unions the American Federation of Musicians and Professional Musicians, Local 47 and the participating Employers. If those agreements terminate or if contributions are terminated or significantly reduced for any reason, the rights of all participants with respect to benefits will be determined by the Board of Trustees. The Board of Trustees can determine to terminate the at any time in its sole and absolute discretion without any further obligations whatsoever to any participants or beneficiaries of the Fund.

DEFINITIONS

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

Co-Premium means the portion of the monthly premium that is required to be paid by the eligible Employee for themselves or their eligible Dependent(s).

Coverage Period means the annual period – generally January 1 through December 31 - during which qualified participants and their enrolled dependents receive benefits under the Plan. The Trustees reserve the right to modify the Coverage Period.

Dependent means those eligible Dependents of the Participant as specified below:
(1) your wife or husband; (2) Domestic Partner, (3) the Participant's children, including adopted children, and stepchildren, children under age 26, provided the covered child is not eligible for their own employer sponsored health coverage. .

Domestic Partner means an individual who is personally related to the Participant by a domestic partnership that meets the following requirements: (a) both partners are 18 years of age or older and of the same sex (or of the opposite sex and one or both partners are eligible for Social Security benefits and one or both partners are over the age of 62); (b) the partners have a common residence and are not related by blood in a way that would prevent them from being married in California; (c) neither partner is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved or adjudged a nullity; (d) both individuals are capable of consenting to the domestic partnership; (e) both persons have filed a Declaration of Domestic Partnership with the Secretary of the State of California. A copy of the Domestic Partnership will be required by the Fund's Administrative Office when a Participant seeks to enroll a Domestic Partner as his/her Dependent.

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

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

Member means a person who is eligible for Medical Plan benefits by virtue of employer contributions.

Open Enrollment Period is the period in which you can select a different medical and/or dental provider. You may also add or delete dependent coverage at this time. These changes may occur only once in any twelve (12) month period.

Participant means a Member who has enrolled in and is receiving benefits from the Plan.

Plan means, collectively, the Fund's Trust Agreement, this Summary Plan Description as well as the medical, dental, vision and other group policies of insurance through which the Fund provides benefits.

Provider or Carrier means one or more entities with which the Fund contracts for providing medical, dental, vision and life insurance.

Qualifying Period means the period of time – generally October 1 through September 30 – during which employer contributions are remitted to the Fund, for covered employment rendered during that period, for the purpose of determining participant eligibility.

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

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

Trust or Fund Administrator means PacFed Benefit Administrators, Inc.

Trustees mean a group of individuals consisting of an equal number of Union and Employer representatives, who oversee the Trust Fund.

Union means Professional Musicians, Local 47.

RELATIONSHIP BETWEEN FUND AND HEALTH CARE PROVIDERS

No healthcare provider is an agent or representative of the Fund. The Fund does not control or direct the provision of healthcare services and/or supplies to Participants and Dependents by any of its providers. The Fund makes no representation or guarantee of any kind concerning the skills or competency of any healthcare provider. The Fund makes no representation or guarantee of any kind that any provider will furnish healthcare services or supplies that are malpractice-free.

The foregoing statement applies to any and all healthcare providers and all entities (and their agents, and representatives) which contract through the Fund to offer health-related services or supplies to Participants and Dependents, including, but not limited to, Health Net, Delta Dental Plan, Landmark Healthplan, Gerber Life and Prudential Life.

ELIGIBILITY

PARTICIPANT ELIGIBILITY PROVISIONS

Effective with the qualifying period beginning October 1, 2010, initial eligibility shall be achieved when a total of at least $1,200 of employer contributions have been reported and paid during the (12) consecutive month qualifying period immediately preceding October 1st in any year.

Qualification and Eligibility Periods are as follows:

Qualifying Period:	Eligibility Period:
Contributions for work Performed during these months. OCTOBER 1st through SEPTEMBER 30TH	Will qualify you for eligibility during these months. JANUARY 1st through DECEMBER 31ST

The minimum amount of Employer contributions necessary for a musician to qualify in the twelve (12)-month period (October 1st through September 30th) will be $1,200. If there are insufficient Employer contributions in the current qualifying period, there will be a look-back period of twelve (12) months. If there are any unused contributions in the twelve (12) month look-back period (the previous October 1st through September 30th) a maximum of $600 will be carried forward to the current period to achieve eligibility. Unused Employer contributions are defined as either (i) a carry-over, from the prior qualifying period, of employer contributions received on behalf of a member in excess of the amount needed to qualify, up to a maximum of $600 or (ii) the amount of employer contributions received on behalf of a member in the previous qualifying period, up to a maximum of $600, when a member did not qualify. In no circumstance will contributions be carried forward more than one period.

The Trustees reserve the right to modify the amount of employer contributions required during any eligibility period for purposes of obtaining eligibility for coverage.

Example 1. Joe has $1,300 contributed by his Employer(s) in the qualifying period October 1, 2010 through September 30, 2011. He will be eligible for benefits January 1 through December 31, 2012. Joe will also have $100 to carry-forward to the next period should he fall short of the qualifying amount.

Example 2. Sally has $800 contributed by her Employer(s) in the qualifying period October 1, 2010 through September 30, 2011. She had $800 contributed in the previous twelve months October 1, 2009 through September 30, 2010. Sally may carry-forward $400, the amount necessary to qualify. She will have nothing to carry-forward to the future period. (i.e. $800 present qualifying period contributions, plus $400 carry forward from the previous period satisfies the $1,200 qualifying amount.)

Combining Husband and Wife Credits

Husband and wife musicians, who fail to achieve eligibility and who perform under one or more Agreements calling for contributions to the Fund, may elect to have their contributions combined within the Qualifying Period for the purpose of achieving eligibility; whoever has the higher contributions will be the eligible member. It is the responsibility of the musicians to notify the Administrative office in writing of their desire to combine contributions. Please note that once the coverage year commences (i.e., January 1st) a husband and wife cannot combine their contributions to obtain eligibility for that coverage year.

Example 3. Bob and Mary are married. They are both musicians working under Local 47 contracts. Bob had $800 in Employer contributions, in the current period, and was determined to be ineligible. Mary also had $800 in Employer contributions, in the current period, and was also determined to be ineligible. Mary can borrow from her spouse the amount necessary to become eligible. Mary borrows $400 of Bob's contributions making her eligible for benefits and Bob may be covered as a dependent. The $400 left in Bob's account may be used next period should he (or they) need it to qualify for eligibility.

You may only carry forward your excess contributions to the next immediate qualifying period in the amount necessary to meet the qualifying amount. The maximum amount that may be carried forward is $600.

SPECIALS RULES GOVERNING THE ATTRIBUTION OF CONTRIBUTIONS REMITTED UNDER AFM COLLECTIVE BARGAINING AGREEMENTS

Some collective bargaining agreements negotiated and enforced by the American Federation of Musicians ("AFM") require that employer contributions be made to the Fund in connection with the performance of covered services. In most cases, these contributions are attributed to the eligibility account of each participant based upon the date of the engagement or the date services were rendered.

Under certain AFM agreements – most notably the Commercial Announcement (or "Jingles" Agreement) – the Fund will generally attribute employer contributions, to the eligibility account of the covered musician, to the dates on which the contractual broadcast cycle requires that the contributions be made. However, where such contributions are received by the Fund on or after January 1st of any year, the contributions will be attributed towards eligibility for the next succeeding coverage year.

For example, if the Fund receives contributions remitted under the Commercial Announcement Agreement on December 20th for a broadcast cycle that occurred prior to September 30th of the same year, the contributions will be attributed towards determining qualification for the coverage year starting January 1st. On the other hand, if the same contributions are received by the Fund on or after January 1st, the contributions shall be used to determine eligibility for following coverage year (starting January 1st of the *next* year).

A copy of the Fund's complete written Policy governing the attribution of contributions under the Commercial Announcement Agreement is available upon request from the Fund's Administrative Office.

IMPORTANT NOTICE SPECIFIC TO CONTRIBUTIONS REMITTED TO THE FUND PURSUANT TO AN AGREEMENT NEGOTIATED BY THE AMERICAN FEDERATION OF MUSICIANS

Some collective bargaining agreements negotiated by the American Federation of Musicians ("AFM") require that contributions be remitted to the Fund for certain covered work. These same AFM collective bargaining agreements also provide that the required contributions may be remitted to a health and welfare fund sponsored by the musician's home local union. As a result, the Fund may maintain what are known as "reciprocity" arrangements with health and welfare funds sponsored by other AFM local unions. These reciprocity arrangements may allow for the transfer of contributions that were erroneously made either to the Fund (for a non-Local 47 musician) or to a health and welfare fund sponsored by another AFM local union, so that the contributions are received and credited to the health and welfare fund where the covered musician actually resides. However, these transfers of contributions are generally not automatic: The Fund may not know that

contributions were mistakenly remitted to another health and welfare fund or that it erroneously received contributions on behalf of a covered musician who participates in a health and welfare plan sponsored by another AFM local union. In either event, you may request the Fund, in writing, to (i) seek the transfer of contributions from another health and welfare fund to the Fund (so long as the Fund maintains a reciprocity arrangement with the other health and welfare fund) or (ii) transfer contributions the Fund has received on your behalf to a health and welfare fund sponsored by another AFM local union (so long as the Fund maintains a reciprocity arrangement with the other health and welfare fund). Your request for the transfer of contributions should be made prior to September 30th, in any eligibility year, to allow the Fund sufficient time to request/initiate the transfer of contributions prior to the Fund's annual eligibility determination.

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

Under the Fund's rules and regulations as well as governing law a third party payroll company may only remit contributions to the Fund, on behalf of an Employer, where the Employer has properly documented the fact that it is appointing the payroll company as its agent for the processing of all payroll, including contributions to the Fund and the Employer has entered into an appropriate agreement, that requires contributions to the Fund, with either Local 47 or the American Federation of Musicians. Moreover, any contributions processed by a payroll company must be in connection with covered employment (i.e., a musical engagement covered by a Local 47 contract or collective bargaining agreement). In the absence of such appropriate documentation, e.g., a written agreement/designation between the Employer and the payroll company, the Fund reserves the right to reject any and all contributions remitted to it by a third party payroll company. Please note that the rejection of contributions may affect an Employee's ability to obtain coverage for benefits through the Fund.

Employee Reporting Procedure

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

It is each Employee's responsibility to notify the Fund of engagements performed. Contributions not received at the close of the qualifying period are not "timely", and may not be applied to the prior qualifying period and therefore, affect your eligibility in the Plan. To ensure timely collection and allocation of all contributions and to avoid disruption in or loss of coverage, the Employee must comply with the following procedure:

1. Immediately report engagements to Local 47 or the Fund by completing a Member Self Reporting Form (Member Self-Reporting forms are available at the Local 47 office, the Trust Fund office or www.pacfed.com/musicians) and
2. Request, from the Trust Administrator's Office, at the close of the most recent qualifying period a list of employer contributions for that period; and
3. Review the list of employer contributions for accuracy; and
4. Notify the Fund on or before November 20th with additional information concerning unreported contributions. This information should, at a minimum, include the (I) dates of the employment for which the employee claims the Fund should have

received contributions; (ii) the name of the employer(s), and; (iii) the amounts which the employee claims the Fund should have received on his/her behalf.

5. Provide the Fund with any additional information to aid in collection.

If you fail to follow the above procedure your eligibility for coverage may be lost or otherwise adversely affected. This could occur since contributions collected after the start of the enrollment period will usually be applied to the next qualifying period.

Example 1. An engagement was performed on July 1, 2009, the employee DID NOT file the Engagement Reporting Form; the contributions were received at the Fund Administrator's Office on March 2, 2010, months past the due date.

> **Result**: The contribution will be applied as of the date it was received, March 2, 2010 to determine the employee's eligibility for the next period (January 1, 2011 through December 31, 2011).

Example 2. An engagement was performed on July 1, 2010, the employee DID file the Engagement Reporting Form and provided any additional information requested by the Fund; the contributions were received at the Fund Administrator's Office on January 2, 2011, months past the due date. If counted the contributions places the member at or over the $900 level for the relevant eligibility period.

> **Result**: The contribution will be applied, as of the date it was earned (July 1, 2010), the employee will be eligible January 2011.

IMPORTANT NOTE: Failing to timely report engagement could result in loss of eligibility.

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ANNUAL ELIGIBILITY REVIEW PROCEDURES

At the close of the annual qualifying period (September 30th of each year), the Trust will make an initial determination as to eligibility for enrollment in benefits for the next coverage period (January 1 through December 31st). In the month of November, notice of eligibility will normally be sent to all employees who meet the eligibility requirements of the Fund.

The Fund will also notify those employees, who have not qualified, but have been determined to be within a reasonable range of potentially qualifying for benefits, of the contributions the Fund has received, on their behalf, during the qualifying period (October 1 through September 30). This statement will usually be sent during the month of November. In the event an employee receives the contribution statement s/he will have until November 20th to supply the Trust with information concerning any contributions the employee claims should have been recorded by the Trust during the qualifying period. This information should, at a minimum, include the (i) dates of the employment for which the employee claims the Trust should have received contributions; (ii) the name of the employer(s), and; (iii) the amounts which the employee claims the Trust should have received on his/her behalf. If you do not receive a contribution statement or eligibility notice by November 15th, contact the Fund's Administrative Office.

Important Note: The contribution statement may only be obtained after the Fund has made an initial eligibility determination (typically November 1). Generally additional information concerning Employer contributions received after November 20th will not be considered by the Trustees.

After all eligibility records and additional information, submitted on or before November 20th, are reviewed by the Trustees, the Trust will make a final determination on all eligibility questions by December 15th (unless modified by the Trustees). Any employee who supplied the Trust with additional information concerning his/her eligibility, on or before the cutoff date of November 20th, will receive a final written determination of eligibility. In the event the denial of eligibility is sustained in the final notice, the employee will then have sixty (60) days from the postmark of the final written determination of eligibility in which to file an appeal with the Trustees. Any appeal from a final denial of eligibility will be processed under the Trust rules governing appeals to the Trustees (See Appeals Procedures in this SPD).

The Trustees will issue a final determination on all such eligibility appeals within 60 days after receipt of the written appeal by the Trust Fund Administrator, unless special circumstances (such as the need to hold a hearing) require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but in no event more than 120 days after receipt of the application for review. Written application for review of an eligibility denial by the Trustees must be received in the office of the Fund Administrator no later than 60 days following receipt by the Participant of the denial of eligibility or the Trust determination to be appealed, or no appeal will be allowed. There is

no automatic right to a personal hearing before the Trustees; they have the sole discretion to determine if a hearing is necessary. The Fund Administrator and the Trustees have the discretion to make decisions regarding eligibility, to make factual determinations, and to construe and interpret the Plan.

ENROLLMENT IN THE BENEFIT PLAN

How a member obtains coverage and becomes a Plan Participant

Once an employee has become a Member who is eligible for benefits as described above, the following is required to obtain coverage through and become a Participant in the Plan:

1. Complete and timely submit an enrollment application for all coverages desired; medical, dental, and vision.
2. Timely submit any required Participant co-premium and dependent premium (should you choose to enroll your dependents).
3. Comply with all other regulations and requirements of the Trust Fund, and Plan.

Currently the Fund, through the Plan, offers medical, dental, vision, chiropractic/acupuncture and life and accidental death & dismemberment benefits. Health Net, Landmark Healthplan , Delta Dental Plans of California, Delta Care USA, Gerber Life and The Prudential Insurance Company of America are the insurers and/or providers of those benefits. (Gerber Life underwrites the vision benefit, which is administered by MES Vision). **The Trustees reserve the right to amend, change, or modify the Plan, the insurers supplying benefits to the Plan and the benefits offered through the Plan.**

As an Eligible Member, and to become an enrolled Participant, you must complete an application for Health Net, Landmark Healthplan , Delta Dental, Gerber Life /MES Vision, if applicable, and timely submit them to the Administrator's office. When enrolling in the Health Net medical plan, you **MUST** complete the ENROLLMENT APPLICATION FORM in full and select a Participating Medical Group or Independent Physician Association from the HMO provider directory. **Eligible Members enrolling in the plan are required to pay a portion of the benefit premium.** You will be notified of the premium due at the time of enrollment.

Enrolling in one of the Plan's HMO benefits requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Plan network and who is available to accept you or your family members. If you do not designate a primary care provider, one will be assigned to you, until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the PacFed Benefit Administrators Inc, at (800) 759-3132.

You may designate a pediatrician as the primary care provider for your children enrolling in the Plan.

You do not need prior authorization from the Fund or Health Net, or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the PacFed Benefit Administrators Inc, at (800) 759-3132.

Cost to Eligible Member

Eligible Members will be required to pay a portion of the premium as a requirement of enrollment. Eligible Members who do not pay the required co-premium will not be enrolled and not become Participants; **thus benefits will not be paid to any member who fails to remit his/her co-premium payment.**

IMPORTANT NOTE:
During the open enrollment period you will be notified in writing of the applicable co-premium schedule. Please note that the co-premium may change from one enrollment period to the next. The Trustees reserve the right to change, modify or eliminate the co-premium.

It is important that you timely send the completed enrollment form and co-premium payment to the Trust Administrator's Office, so that it is received by the Administrative Office on or before December 20th. Services can be delayed or denied unless you have made your selection in writing, all the required information has been correctly filled in and the Administrator's Office timely receives your co-premium payment. The Trust Administrator's Office ***must*** receive ***both*** your completed enrollment form ***and*** your co-premium payment before coverage can commence. **No benefits will be provided if your co-premium payment has not been made within the specified period.**

The Co-Premium Payment Policy

If you do not pay your co-premium in one lump-sum for the year, you may pay a monthly member co-premium. These co-premiums are due the first of the month prior to the month of coverage. Payments are deemed delinquent on the 20th of the month prior to the month of coverage. You will receive a statement, after you have completed enrollment and made your initial premium payment, which explains the payment options available. It is the participant's responsibility to make timely payments. (Please see section on Dependent coverage for information on Dependent premiums.)

The Enrollment Grace Period

The Fund offers an enrollment grace period between December 21st and December 31st. Applications and/or member co-premium payments received during this grace period will be accepted with no requirement that any additional processing fees be remitted to the Fund;

however, if the Fund receives your application and/or member co-premium payment during the December 21st through December 31st grace period there is no guarantee that your enrollment will be recorded with the carrier(s) by January 1 and should services be required in early January you may appear in the carrier's records as ineligible for coverage.

The Reinstatement Period

Applications and/or member co-premium payments received during the month of January will be accepted; however, the Fund shall require the remittance of an additional administrative processing fee (as described below) for either (1) a late enrollment (i.e., receipt of an enrollment application form) or (2) late payment of the required co-premium (i.e. where the required co-premium was not timely remitted along with the participants enrollment form.

Where a Participant has chosen to remit the co-premium on a monthly installment basis, the Participant and dependent co-premiums are due on the first of the month prior to the month of coverage (i.e., co-premium for April is due March 1st). If the Fund does not receive your monthly co-premium payment by the 20th of the month prior to the month of coverage (in the above example by March 20th), the Participant is deemed delinquent. Should the Fund not receive the co-premium by the end of the month (prior to the month of coverage; in the above example by March 31st) the Participant's (and dependent's) coverage will be cancelled and a notice of termination will be sent by the Fund to the Participant.

A "Safe Harbor" has been established, which allows for reinstatement if your coverage is terminated due to late payment of a co-premium. The rules are as follows:

Reinstatement requests must be made in writing, to the Fund's Administrator (***not*** Local 47), and be post-marked no later than 30 days from the date of cancellation listed on the termination notice.

The Administrator is authorized to grant reinstatement provided the (a) delinquent co-premium is received along with (b) the next month's co-premium and (c) the applicable administrative fee.

Administrative fees are calculated and imposed as follows:

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

The Fund's Administrative Office shall separately advise you, in writing, of the required administrative fee at the time reinstatement.

Please note that enrollment applications and/or co-premium payments submitted after January **will be returned and not processed**. In the event your late enrollment application and/or co-premium payment is returned, you may file an appeal with the Fund's Board of Trustees. All appeals for late enrollment and/or reinstatement must be in writing, contain a brief statement of the grounds for the appeal, and be post-marked no later than thirty (30) days from the date of the Fund's letter returning your un-processed late application or co-premium payment. Your completed enrollment application and co-premiums through the current period must accompany your appeal. Should your appeal be granted, the processing fee as described above shall apply.

The Trustees reserve the right in their sole and exclusive discretion to grant in whole or in part or deny any application for late enrollment or appeal for reinstatement. Any decision by the Trustees to allow late enrollment or reinstatement shall be conditioned upon the acceptance of such late enrollment by the applicable carrier(s) and payment of the applicable co-premium. Retroactive coverage will not necessarily be granted in the event an application for reinstatement/late enrollment is granted.

PLANS APPLICABLE TO CALIFORNIA RESIDENTS

Medical Plans

Health Net The Trust contracts with Health Net, which offers two plans, a Health Maintenance Organization (HMO) and a Preferred Provider Organization (PPO), that provide benefits to the Trust's participants. When enrolling for benefit coverage through the Trust, a participant must enroll in one, but not both, of these plans. Both plan types are described below.

Option # 1 - HEALTH NET Health Maintenance Organization (HMO)
When choosing the HMO as your plan for coverage you must select a primary care physician for yourself and dependents (if applicable) from a Participating Medical Group (PMG), Independent Physician Association (IPA), or Independent Contract Physician. All services provided to you and your family must be provided through your primary care physician or a pre-authorization made by your primary care physician. You may select a participating pediatrician as your child's primary care provider.

The Health Net HMO evidence of coverage explains emergency and urgent care procedures as well as applicable co-pays.

IMPORTANT NOTE: You must reside in an HMO service area to enroll in any of the HMO plans sponsored by the Fund.

Option # 2 - HEALTH NET Preferred Provider Organization (PPO)
You have a choice at the time you make an appointment with your doctor, to choose a PPO provider listed in the Health Net PPO provider directory or any doctor or your choosing. Your benefits, deductibles and co-payments will be different depending on whether you choose a PPO or non-PPO provider.

PPO Provider

Health Net will provide you with a listing of providers contracted with the Preferred Provider Organization. You may choose a provider from the list. Please read the Evidence of Coverage to determine the amount of deductible, co-payments and co-insurance you are responsible for when utilizing the PPO benefit.

Non-PPO Provider

Under this option you may choose any doctor you like. Health Net will reimburse you a percentage of the usual and customary fee for covered services provided. Please refer to your Evidence of Coverage to determine the amount of the deductible and co-insurance for which you will be responsible. A claim form must be submitted for reimbursement. You may obtain a claim form by contacting the Trust Administrator's Office.

Prescription Drug Benefit

The Trust offers prescription drug benefits through Health Net. These benefits are outlined in the schedule of benefits at the end of this SPD.

Please see Appendix A attached at the end of this SPD for a summary of the Health Net Plan benefits and applicable deductible, co-insurance and co-payment schedules.

In addition to the Health Net prescription drug benefit the Trust offers a co-payment reimbursement program, but ***only*** for certain self-injectable prescription drugs.

Below are the requirements to obtain a reimbursement of your self-injectable prescription drug related out-of-pocket co-payment expenses:

1. The self-injectable prescription drug must be currently listed on the Health Net prescription drug formulary that is applicable to the Health Net plan in you and/or your covered dependent(s) is/are currently enrolled;
2. You or your covered dependent must submit a receipt to the Administrator showing the co-payment paid, the date the co-payment was incurred and the name of the self-injectable prescription drug;
3. You or your covered dependent may not apply for the out-of-pocket reimbursement more than once a month and the Fund will not issue a reimbursement of more than $85.00 per filled prescription. A $15.00 co-payment will be required; therefore your reimbursement will be less the $15.00 co-payment.

The reimbursement policy is effective retroactive to January 1, 2004. Please submit your pharmacy receipt showing your co-payment, the date the co-payment was incurred and the name of the self-injectable prescription drug purchased. The Fund's administrator will then verify that your information meets the Fund's requirement and that the self-injectable prescription drug is covered under the applicable Health Net plan formulary. The Trustees reserve the right to amend, modify, terminate or suspend the injectable drug reimbursement policy.

Chiropractic/Acupuncture

Landmark Healthplan
The Trustees have contracted with Landmark Healthplan (Landmark) for Chiropractic and Acupuncture benefits for Eligible Participants and their covered Dependents enrolled in the Health Net health plan. This benefit provides acupuncture coverage along with limited herbal therapy coverage. You must utilize the Directory of Participating Chiropractors and Acupuncturists in order for your services to be covered.

Please see Appendix A attached at the end of this SPD for a summary of the Landmark Chiropractic/Acupuncture benefit and any applicable co-payment schedules.

Dental Plans

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

PLAN 1 – DELTACARE DENTAL HEALTH MAINTENANCE ORGANIZATION (DHMO)
When you choose to enroll in the DHMO you must select a provider from the directory supplied by DeltaCare USA. To obtain covered services you must see the dentist you selected. Read your Evidence of Coverage from Delta Dental for benefits.

PLAN 2 - DELTA DENTAL PPO
If you elect to enroll in the PPO plan, you have a choice. You may select a provider from the Preferred list or choose any provider you like. When you utilize a PPO Preferred Provider, your benefits will be different than if you select a dentist who is not on the list. Read your Delta Dental Evidence of Coverage for benefits, co-payments, co-insurance and deductibles.

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

Vision Plan

Medical Eye Services
Gerber Life underwrites this Plan's vision benefits, which are administered through MES Vision. Please note that if you desire vision benefit coverage you *must separately enroll* in the Plan's vision benefit program as enrolling in one of the health/medical coverage options *will not* automatically enroll you for participation in the vision benefit.

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

Life and Accidental Death and Dismemberment Insurance

The Prudential Insurance Company of America
All Eligible Participants are enrolled in the Prudential Life and Accidental Death and Dismemberment plan. Dependents are not eligible for this benefit. Your Certificate of Group Insurance details the benefits provided.

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

PLANS APPLICABLE TO NON-CALIFORNIA RESIDENTS

Medical

Health Net Preferred Provider Organization (PPO)
The Trust offers a Health Net PPO plan for Participants who reside out of the State of California.

You have a choice at the time you make an appointment with your doctor, to choose a PPO provider listed in the Health Net PPO provider directory or any doctor or your choosing. Your benefits, deductibles, co-insurance and co-payments will be different depending if you choose a PPO or non-PPO provider.

PPO Provider
Health Net will provide you with a listing of providers contracted with the Preferred Provider Organization. You may choose a provider from the list. Please read the Evidence of Coverage to determine the amount of deductible, co-payments and co-insurance you are responsible for when utilizing the PPO benefit.

Non-PPO Provider
Under this option you may choose any doctor you like. Health Net will reimburse you a percentage of the usual and customary fee for covered services provided. Please refer to your Evidence of Coverage to determine the amount of the deductible and co-insurance for which you will be responsible. A claim form must be submitted for reimbursement. You may obtain a claim form by contacting the Trust Administrator's Office

NOTE: This Plan is specifically limited to eligible Participants who have proof of non-California residency.

Please see Appendix A attached at the end of this SPD for a summary of the Health Net Non-California PPO benefit and any applicable deductible, co-payments and/or co-insurance schedules.

Prescription Drug Benefit (for Non-California Residents)

The Trust offers prescription drug benefits through Health Net. These benefits are outlined in the schedule of benefits at the end of this SPD.

In addition to the Health Net prescription drug benefit the Trust offers a co-payment reimbursement program, but ***only*** for certain self-injectable prescription drugs.

Below are the requirements to obtain a reimbursement of your self-injectable prescription drug related out-of-pocket co-payment expenses:

4. The self-injectable prescription drug must be currently listed on the Health Net prescription drug formulary that is applicable to the Health Net plan in you and/or your covered dependent(s) is/are currently enrolled;
5. You or your covered dependent must submit a receipt to the Administrator showing the co-payment paid, the date the co-payment was incurred and the name of the self-injectable prescription drug;
6. You or your covered dependent may not apply for the out-of-pocket reimbursement more than once a month and the Fund will not issue a reimbursement of more than $85.00 per filled prescription. A $15.00 co-payment will be required; therefore your reimbursement will be less the $15.00 co-payment.

The reimbursement policy is effective retroactive to January 1, 2004. Please submit your pharmacy receipt showing your co-payment, the date the co-payment was incurred and the name of the self-injectable prescription drug purchased. The Fund's administrator will then verify that your information meets the Fund's requirement and that the self-injectable prescription drug is covered under the applicable Health Net plan formulary. The Trustees reserve the right to amend, modify, terminate or suspend the injectable drug reimbursement policy.

Life and Accidental Death and Dismemberment Insurance

The Prudential Insurance Company of America
All Eligible Participants are enrolled in the Prudential Life and Accidental Death and Dismemberment plan. Dependents are not eligible for this benefit. Your Certificate of Group Insurance details the benefits provided.

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

IMPORTANT NOTE FOR NON-CALIFORNIA RESIDENTS:
Any given plan may not be available in all geographic areas. Please refer to your Evidence of Coverage, for each provider, or call the Trust Administrator's Office to determine if out of California coverage is provided.
Vision, Dental and Chiropractic benefits are not offered to out of California Participants and/or Dependents.

IMPORTANT NOTE

The Evidence of Coverage booklet for each plan contains the insuring provisions, including applicable limitations and exclusions for each program. If you have any questions regarding your Plan coverage, please contact the Trust Administrator's Office before incurring any expenses.

OPEN ENROLLMENT PERIOD

(APPLICABLE TO BOTH CALIFORNIA RESIDENT PLAN
AND NON-CALIFORNIA RESIDENT PLAN)

The Plan's Open Enrollment Period is November 20th through December 20th. At that time you may make changes to your coverage (i.e. medical, dental, vision). All such changes must be received by the Trust Administrator's office no later than December 31.

IMPORTANT NOTE:
You must advise the Trust Administrator's office immediately (in writing) of any changes that affect your coverage or your dependents' status. Examples are:
1) Changes in marital status, i.e. Marriage or Dissolution of Marriage.
2) Changes in dependent status.

MEDICARE PART D NOTIFICATION

(The Following Section Applies Only To Those Fund Participants And/Or Covered Dependents Who Are Eligible For Or Actually Enrolled In Medicare Coverage)

Under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the MMA), a new prescription drug benefit was added to the federal Medicare program. The Fund has determined, based on present Federal regulations that interpret and apply the MMA, that the prescription drug benefits it currently sponsors equate to creditable coverage under the MMA. This means that the anticipated financial value of the prescription drug benefits sponsored through the Fund would at least equal or exceed the amount of paid claims under the standard Medicare Part D prescription benefit as required by the MMA.

Also, this means that if you are Medicare eligible, or soon to become Medicare eligible, you may maintain your enrollment in the Fund's benefit plans and not be required to pay an extra enrollment fee when you later enroll for both Medicare and Medicare Part D.

Participants may enroll in a Medicare Part D prescription drug plan upon reaching eligibility for Medicare coverage. Generally, enrollment for Medicare Part D plans occurs November 15th through December 31st annually, and participants in union/employer medical plans such as the Fund may also be eligible for a special Medicare Part D enrollment period when they attain Medicare eligibility.

However, if a participant drops his/her prescription drug coverage though the Fund and opts, instead, for a Medicare Part D plan, the participant's dependents, to the extent they are enrolled in and covered by the Fund, may lose their prescription drug coverage and may not be able to reinstate this coverage with the Fund.

Also, if a participant or covered dependent who is/are Medicare eligible drops or loses coverage with the Fund, and that participant and/or dependent does not enroll with a Medicare Part D plan until after coverage from the Fund ceases, that participant and/or dependent will pay a penalty before being allowed to enroll in a Medicare Part D prescription drug plan. Under the MMA, if a participant or covered dependent loses his/her coverage with the Fund and then goes 63 days or longer without prescription drug coverage that's at least as good as the average Medicare Part D prescription drug plan, that participant's and/or dependent's monthly premium will rise 1% for every month that person does not have the required coverage. Additionally, if a participant and/or covered dependent fails to timely enroll in an approved Medicare Part D prescription drug plan after dropping or losing coverage with the Fund, he/she may also have to wait until the following November 15th through December 31st window to enroll.

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

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

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

COORDINATION OF BENEFIT RULES
(APPLICABLE TO ALL BENEFIT COMPONENTS)

The Fund provides for coordination of benefits between the Plan and any other plan. Contact the Fund Administrator and/or review your Evidence of Coverage for further coordination of benefits information.

Also, under the Medicare, Medicaid and SCHIP Extension Act of 2007, the Fund coordinates benefits with Medicare for those Participants who are Medicare eligible. Thus, for any Participant, who is Medicare eligible, the Fund is the primary insurer and Medicare is treated as the secondary carrier.

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

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

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

The MHPA also allows covered group plans to require that a participant demonstrate the medical necessity for any claim relating to medical health/substance abuse coverage. In the event a group plan determines that such medical necessity must be established by a participant, it may also provide to the participant, or her/his treating physician, upon request the criteria used by the plan to determine medical necessity. Further, the MHPA requires that covered group plans provide written notice of denial of mental health/substance abuse claim and the reasons for such denial.

The Trustees have determined that the responsibility for compliance with the MHPA rests with the Trust's carriers. Thus, any inquiry regarding MHPA compliance should be directed to the carriers that are providing health and medical coverages to the Trust.

TERMINATION OF PARTICIPANT COVERAGE

Your coverage will terminate on the earliest of the following dates:

1. The last day of a Coverage Period, (i.e. December 31) if eligibility for the following Coverage Period was not established during the applicable earning period; or
2. The date you enter into full-time military service; or
3. The type of coverage for which you are eligible is eliminated from the Plan.
4. Failure to remit any required Participant premium or co-premium as may be established by the Trustees.
5. Failure to comply with any rule, regulation or requirement of the Trust Fund (i.e. failure to timely return a completed enrollment form).

Please see information in the section entitled “The Reinstatement Period” earlier in the document.

DEPENDENT COVERAGE

Once a Participant qualifies for Eligibility (Initial and Continuing Eligibility), eligible Dependents are also entitled to the benefits provided by the Plan under the self-pay premium option (i.e. timely payment of full dependent premium) for dependent coverage as set forth herein, as long as the Participant remains eligible and enrolled for coverage through the Plan. Eligible Dependents, if paid for, will be covered under the same medical, dental and vision program selected by the Eligible Participant.

Eligible Dependents are: 1) your wife or husband; (2) Domestic Partner, (3) the Participant’s children, including adopted children, and stepchildren, children under age 26, provided the covered child is not eligible for their own employer sponsored health coverage.

An unmarried dependent child over age 26, who is incapable of supporting him/herself because of mental or physical handicap which began prior to age 26, will continue to qualify as an eligible dependent as long as the child remains disabled, unmarried, and is dependent on the Participant for support and maintenance. Satisfactory proof of such incapacity and dependency, as determined by the Trustees, must be furnished to the Fund and/or provider(s) upon request. Disabilities that occur after your child is no longer eligible are not covered.

Proof of Dependent status will be required for claims administration or services by the Trust or the Providers (e.g., marriage certificate, affidavit of domestic partner, birth certificates, and dependent certification form).

There shall be no coverage exclusion in connection with pre-existing medical conditions for dependents under the age of 19.

NOTE: A Dependent will be eligible for coverage only if his full name, date of birth, Social Security Number and relationship to the Participant has been registered with the Trust Administrator's Office by filing an enrollment application and timely remittance of the applicable premium payment.

Medical Leave of Absence from School

A covered dependent child who has reached the age limit shown above who remains eligible due to enrollment as a full-time student according to the eligibility criteria stated above, who takes a medical leave of absence from school, will continue to be eligible for coverage under the Plan as follows:

1. If the nature of the child's injury, illness, or condition would make the child incapable of self-sustaining employment and if the child is chiefly dependent upon the Participant for support and maintenance, then coverage may continue under the terms described under the "Disabled Child" heading, shown below.

2. If the nature of the child's injury, illness, or condition does not meet the eligibility conditions required to continue coverage as a disabled child, as shown below, the child's eligibility for coverage will not terminate for a period of up to 12 months, or until the date on which coverage is scheduled to terminate under the Plan, whichever comes first.

Documentation or certification of the medical necessity for a leave of absence from school must be submitted to the Fund at least 30 days prior to the medical leave of absence from school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the start date of the medical leave of absence from school.

Disabled Child

Children who reach age 26 are eligible to continue coverage if all of the following conditions apply:

- The child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and
- The child is chiefly dependent upon the Subscriber for support and maintenance.

If you are enrolling a disabled child for new coverage, you must provide the Fund Administrative Office with proof of incapacity and dependency within 30 days of the date you request enrollment in the Plan. The child must have been continuously covered as a dependent of the Participant or spouse under a previous group health plan at the time the child reached the age limit.

The Fund Administrative Office will provide you notice at least 90 days prior to the date your enrolled child reaches the age limit at which the dependent child's coverage will terminate. You must provide the Fund Administrative Office with proof of your child's incapacity and dependency within 30 days of the date you receive such notice from the Fund Administrative Office in order to continue coverage for a disabled child past the age

limit.

You must provide the proof of incapacity and dependency at no cost to the Fund.

A disabled child may remain covered by this Plan for as long as he or she remains incapacitated and continues to meet the eligibility criteria described above.

The Carrier may approve or deny enrollment based upon the proof of incapacity and dependency you provide.

HIPAA Dependent Special Enrollment Information

Under certain circumstances the Health Insurance Portability and Accountability Act allows for late enrollment. The Health Insurance Portability and Accountability Act section of this SPD has information on HIPAA enrollment requirements.

Premiums Required for Dependent Coverage

For active Participants, the cost of covering your eligible dependents is 100% of the current premium for that particular coverage, plus an administration fee. During the Fund's Open Enrollment period you will receive written notification of the applicable Dependent premium. If you have any questions on this topic, please contact the Administrator's office to obtain information on the current premium and administrative fee.

Premiums must be paid on a monthly basis on or before the 1st of the month prior to the month of coverage desired.

Required premiums are due on the 1st of the month prior to the month of coverage and are deemed delinquent if not received by the 20th of the month prior to the month of coverage may result in a loss of coverage for your Dependents. You may also pre-pay your Dependent coverage premiums for up 12 months in advance. In the event you do not pre-pay your Dependent premium for the entire coverage year, you are required to remit the premium for any unpaid months on or before the 20th of the preceding month.

Important Note: The Fund will ***not*** send you a reminder or other form of courtesy notice from the Fund other than your initial Dependent premium billing. It is your responsibility to remit your Dependent premium in a timely manner and the Fund will not provide you with any written or other notice that you are about to lose Dependent coverage due to the failure to timely remit a required premium. The only other notice you will receive from the Fund other than the initial notice of Dependent premium will be a notification that, in the event the Dependent premium is not timely remitted, your dependent coverage has been terminated in accordance with the Fund's rules and regulations.

EXAMPLE: Participant receives written reminder notice on June 1st that Dependent premium is due for July coverage. The June 1st reminder is the only notice Participant will receive and the Dependent premium must be received by the Fund no later than June 20th.

In the event a Participant loses coverage and becomes entitled to elect continuation of

coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), his/her Dependent's cost of coverage will be governed by the provisions set forth in the section entitled **Continuation of Coverage under Federal Law (COBRA)**. (See the section under COBRA)

Termination of Dependent Eligibility

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

1. When the Participant ceases to be eligible; or
2. the date the Dependent no longer qualifies as an eligible Dependent; or
3. the date the Dependent enters into full-time military, naval, or air service; or
4. the date the Trustees terminate coverage for dependents; or
5. the date the premium for Dependent Coverage is not timely paid.
6. Failure by the Participant or Dependent to comply with any rule, regulation or requirement of the Trust.
7. A covered Participant fails to timely enroll his/her Dependents with the Plan.

IMPORTANT NOTE
Termination of Dependent coverage due to non-payment of premium or withdrawal from coverage for reasons other than a change in eligibility status will result in the Dependent having to wait a minimum of 12 months from the date of termination before reenrolling in benefits. Enrollment may then occur only at the Fund's annual open enrollment period. **REMEMBER: Dependents may only enroll if the Participant is eligible and enrolled.**

Example: An enrolled Participant owes premiums for his/her Dependent. The premium is due March 1, 2010; the Participant pays the premium April 1, 2010. Dependent coverage will be terminated and the Dependent will be unable to enroll until January 1, 2011`.

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

If you are eligible for health coverage through the Professional Musicians, Local 47 and Employers Health and Welfare Fund (the "Fund"), but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, the Fund is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

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

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

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

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER

Under the Omnibus Budget Reconciliation Act of 1993, the Fund must recognize any Qualified Medical Child Support Order and enroll, as directed by the Order, any child of a Participant specified by the Order. A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a settlement agreement) issued by a court or an administrative agency authorized to issue child support orders under State law that provides the child of a Plan Participant with child support or health benefits under the Plan; or enforces State law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the Participant parent does not enroll the child, the non-Participant parent or State agency may enroll the child.

To be qualified, a Medical Child Support Order must clearly specify:

1. the name and last known mailing address of the Participant and the name and mailing address of each child covered by the Order;
2. a reasonable description of the type of coverage to be provided by the Plan to each such child, or the manner in which such type of coverage is to be determined; and
3. the period to which each order applies.

Further, a Medical Child Support Order will not qualify if it would require the Fund to provide any type or form of benefit or any option not otherwise provided under the Plan, except to

the extent necessary to comply with Section 1908 of the Social Security Act.

Upon receipt of a Medical Child Support Order, the Trust Administrator's Office will notify the Participant and each child of the receipt of the Order and the Fund's procedures for determining whether the Medical Child Support Order is qualified. Each child will also be notified of his or her right to designate a representative to receive copies of all notices sent to the child with respect to a Medical Child Support Order.

Upon receipt of a Medical Child Support Order, the Trust Administrator's Office will review the Order to verify that it meets the standards set forth above. The Trust Administrator's Office will make such a determination within a reasonable period, and notify the Participant and each child of the determination. If the Order is a qualified Order, the child will be enrolled in the Plan.

Payment for benefits made under the Plan and pursuant to a Qualified Medical Child Support Order to reimburse expenses advanced by an alternate recipient, or his/her custodial parent or legal guardian, shall be made to the alternative recipient, or his/her custodial parent or legal guardian.

FAMILY MEDICAL LEAVE ACT (FMLA)

The Trust Fund will accept contributions from an Employer on behalf of an Employee who has taken leave for family or medical reasons pursuant to the FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA), as amended by The National Defense Authorization Act. However, in order to obtain or maintain coverage the Participant must satisfy the following requirements:

1. Employer contributions must be at a level to meet the minimum contribution necessary for eligibility.
2. If already enrolled for benefits with the Trust, the Employee must remit the co-premium and if applicable the dependent premium in a timely manner and as required by the Fund's rules and regulations.
3. The Participant must comply with all rules and regulations set forth by the Trustees.

Continued active participation in the Trust while on FMLA leave will be at your option. Premiums will continue to be paid on your behalf while you are on FMLA leave. If you elect not to continue your benefits during the FMLA leave, your coverage will be reinstated without regard to any pre-existing condition limitation on your return to active working status on or before the end of the FMLA leave.

***IMPORTANT NOTE*: You must contact your Employer to determine your eligibility for FMLA leave. It is not the role of the Trustees or the Trust Administration Office to make this determination.**

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

CONTINUATION OF COVERAGE UNDER FEDERAL LAW

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called COBRA continuation coverage) at group rates in certain instances where coverage under the plan would otherwise end. Individuals entitled to COBRA continuation coverage are referred to as qualified beneficiaries. COBRA continuation coverage applies to employer-sponsored group or individual medical, dental, vision, prescription drug plans, certain health flexible spending accounts, and other arrangements that provide similar benefits. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provision of the law. (Both you and your spouse should take time to read this notice carefully.)

Eligibility for COBRA Coverage

If Eligibility under the Trust terminates due to one of the following Qualifying Events, Participants and Dependents who were covered by the health care plans on the day before the Qualifying Event have the right to continue health coverage (Medical, Vision and Dental benefits), under a federal law known as "COBRA."

1) In the case of a Participant/Covered Employee: you have an independent right to choose COBRA continuation coverage, for up to 18 months, if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

2) In the case of a spouse who is a Dependent of a currently-enrolled Participant covered under the group health plan, he or she has an independent right to choose COBRA continuation coverage for a maximum of 36 months (*See* Applicable Period of COBRA Continuation Coverage, Disability Extension to COBRA Coverage and Second Qualifying Event Extension, all below) if group health coverage is lost due to any of the following five qualifying events and proper notice is given (*See* Notice Requirements, below):

    (A) The death of the Participant;
    (B) A termination of the Participant's employment (for reasons other than gross misconduct on the Participant's part) or reduction in the Participant's hours of employment;
    (C) Divorce or legal separation; or
    (D) The Participant becomes entitled to Medicare. (A Participant is considered entitled to Medicare Part A if he or she is age 65 or over and receives (or has applied for) Social Security or is entitled to

Medicare/Social Security at an earlier age due to a disabling condition).

3) In the case of a dependent child of an employee covered under the group health plan, he or she has an independent right to choose COBRA continuation coverage for a maximum of 36 months (*See* Applicable Period of COBRA Continuation Coverage, Disability Extension to COBRA Coverage and Second Qualifying Event Extension, all below) if group health coverage is lost due to any of the following five qualifying events and proper notice is give (*See* Notice Requirements, below):

   (A) The death of the Participant;
   (B) A termination of the Participant's employment (for reasons other than gross misconduct on the Participant's part) or reduction in the Participant's hours of employment;
   (C) The Participant's divorce or legal separation;
   (D) The Participant becomes entitled to Medicare (A Participant is considered entitled to Medicare Part A if he or she is age 65 or over and receives (or has applied for) Social Security or is entitled to Medicare/Social Security at an earlier age due to a disabling condition); or
   (E) The dependent ceases to be a dependent child, as defined in the group health plan.

(4) A child who is born to or placed for adoption with a covered employee during a period of continuation coverage is deemed a qualified beneficiary for COBRA purposes. The newborn or adopted child must be added to COBRA coverage within the time frame allowed by the plan. The newborn or adopted child's continuation coverage period is measured from the original date that COBRA coverage began.

IMPORTANT NOTE:
You are not eligible for COBRA coverage if you were eligible for, but did not enroll in the benefit Plan offered by the Fund.
Loss of coverage due to failure of Participant to tender co-premium, dependent premium or to follow rules and regulations of the Trustees is not a COBRA qualifying event.
Domestic Partners are not considered to be a Qualified Beneficiaries under COBRA; therefore, they do not have an independent right to continuation of coverage under the above provision.

COBRA and Other Health Care Coverage

You cannot lose your COBRA rights if you have other health care coverage (including Medicare entitlement) prior to electing COBRA continuation coverage. Similar rights may apply to certain retirees, spouses, and dependent children of a retiree if the employer commences a bankruptcy proceeding and these individuals lose coverage within 12 months before or after the date on which the bankruptcy proceeding begins.

Notice Requirements

Under the law, the covered employee or a family member has the responsibility to inform the Fund Administrator of a divorce, legal separation, or a child losing dependent status under the terms of the group health plan within 60 days after the date of the qualifying event or the date on which the qualified beneficiary would lose coverage because of the qualifying event, whichever is later. As soon as you experience a qualifying event, you must contact the Fund Administrator and request a form titled Cobra Qualifying Event-Notice to Fund Administrator. It is your responsibility to complete, sign and return the form to the Trust Administrator within the 60-day period in order to be eligible for COBRA continuation coverage.

The employer has the responsibility to notify the Fund Administrator of the employee's death, termination, reduction in hours of employment, or Medicare entitlement (*See*, Eligibility For COBRA Coverage Section, above, for definition of Medicare entitlement). If there is a loss of coverage in anticipation of a qualifying event, you may still be entitled to continuation coverage. If this applies to you, please notify your employee benefits representative immediately to determine your COBRA rights.

When the Fund Administrator is notified that a qualifying event has occurred, the Fund Administrator will then notify you in writing, at your last known address, that you have the right to continue your coverage. Under the law, you have a 60-day election period during which you must inform the Fund Administrator in writing that you want continuation coverage. This election period begins on the later of: (1) the date you lose coverage due to one of the events described above, or (2) the date you are provided your COBRA election notification. Each qualified beneficiary has independent election rights. However, a covered employee or the spouse of the covered employee may elect continuation coverage for all qualifying family members. If you are or become mentally or physically incapacitated during this election period, an appointed guardian or responsible party may elect and/or pay for COBRA continuation coverage on your behalf. After you make your COBRA election, you will have 45 days to remit the initial premium(s); A 30-day grace period shall apply to all subsequent COBRA premium payments.

> ***Example 1:*** Joe is notified that he has lost eligibility and therefore his health benefits will be terminated effective December 31. He has 60 days from December 31st to elect COBRA. On February 26th Joe decides to submit his completed COBRA election form and enrollment application. Along with Joe's election form and application, he sends his premium check to the Fund's Administrator. Joe's check is for three months of coverage (January, February and March). He must pay his premiums retroactive to the first day that he lost coverage and pay for all months due; in this case, the March payment would be due. Joe is now enrolled in COBRA benefits retroactive to January 1.
>
> ***Example 2:*** Mary was also notified that her eligibility had been lost. She elected COBRA on February 10th. When she mailed her COBRA election form and application, she DID NOT send a check to the Fund's Administrator. (Mary chose to

utilize the 45-day rule: Provided that Mary elected COBRA within the 60-day period, she could wait 45 days from the date of the election to pay the full premium.) Mary submits her premium on March 22nd; to receive coverage she will pay for her January, February, March and April premiums (the April payment is due March 1st).

IMPORTANT NOTE: You will **not** be enrolled in benefits until the Fund's Administrator receives full payment. Although you have the right to elect COBRA within the 60-day window, and pay 45 days after election; you will not be in the insurance company's computer as being covered until the **full** premium is paid.

Under COBRA, you must be offered the opportunity to elect the group health plan coverage that is provided to active employees. Ordinarily, this will be the same coverage you had on the day before the qualifying event. You must also be offered the same rights as active employees during open enrollment and HIPAA special enrollment periods. Your continuation coverage is subject to change if coverage under the plan is modified for active employees.

If you choose continuation coverage, your election (or payment) is considered made on the date you send your election form (or payment) to the plan. If you do not choose and pay for continuation coverage, your group health coverage will end in accordance with the terms of the plan and you will cease to be a qualified beneficiary at the end of the election period.

Cost of COBRA Continuation Coverage

As mentioned above, the coverage required through COBRA is available **only at your own expense.** If you or your Dependents elect to continue coverage, the full cost, plus a 2 percent administrative charge, will be charged. If the benefit cost of coverage were $100, your premium would be $102. **NOTE: There is no charge for any period during which the Trust normally extends coverage beyond the Qualifying Event if such coverage is based upon the Eligibility rules of the Trust.**

Example:

Cost of Coverage	Your COBRA Payment
$100	$102

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

You or your Dependents are also responsible for sending in payments for required monthly

premiums in full and on the premium due date, as established by the Trust Administrator's Office. If any premiums are not received within 30 days of the due date, eligibility for the COBRA Continuation of Coverage will terminate. Such termination of continuation coverage will occur, upon failure to timely remit the required premium(s), without any further written notice that the premium is due. Applicable Period of COBRA Continuation Coverage

The law requires that you be given the opportunity to maintain continuation coverage for three years, unless you lost group health coverage due to employment termination or a reduction in hours of employment. In that case, the required continuation coverage period is 18 months.

Subsidized Cost of COBRA Continuation Coverage

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended on December 19, 2009 by the Department of Defense Appropriations Act, 2010 (2010 DOD Act), provides for premium reductions for health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA. These premium reductions are provided to those persons who qualify as an "assistance eligible individual" ("AEI"), as defined in ARRA.

To qualify, as an AEI, an individual, who was previously qualified to enroll in the Trust's benefit plans, must experience a COBRA qualifying event that is the involuntary termination of a covered employee's employment. Eligible individuals pay only 35 percent of their COBRA premiums and the remaining 65 percent is reimbursed to the Trust by the Secretary of Treasury.

The employer from whom your employment was terminated must have made contributions on your behalf to the Trust Fund. The loss of work must have contributed to your loss of eligibility for benefits through the Fund.

The involuntary termination must occur during the period that began September 1, 2008 and ends on February 28, 2010. The premium reduction applies to periods of health coverage that began on or after February 17, 2009 and lasts for a maximum of 15 months. Any additional period of COBRA coverage – over and above the 15 months of subsidized premiums – for which a participant may be eligible are not subject to the subsidized premium. (Example: COBRA enrollee, when first applying for COBRA benefits, is found to be an AEI and receives 15 months of subsidized premiums; if COBRA enrollee opts to maintain enrollment in COBRA for entire 18 month coverage, the remaining 3 months of COBRA reverts to regular monthly premium payment due from COBRA enrollee).

The ARRA COBRA subsidy is not available to individuals who incur a COBRA qualifying event after May 31, 2010. The subsidy does not apply to COBRA qualifying events that occur after May 31, 2010, because ARRA itself provides that individuals who suffer a COBRA qualifying event that occurs after May 31, 2010, will no longer be eligible for the subsidy. However, any participant or beneficiary who qualified as an AEI and timely submitted an ARRA COBRA subsidy request for a qualifying event that occurred prior to

May 31, 2010, would still be entitled to the 15 months of subsidized COBRA premiums.

Disability Extension to COBRA Coverage

The standard continuation coverage period of 18 months may be extended to a total of 29 months if any qualified beneficiary is determined to have been disabled (under Title II or XVI of the Social Security Act) at any time during the first 60 days of COBRA continuation coverage. In the case of a newborn or adopted child, the 60-day period is measured from the date of the child's birth or placement for adoption. To qualify for this extension, you must contact the Fund Administrator and request a form titled Cobra Qualifying Event-Notice to Fund Administrator. It is your responsibility to complete, sign and return the form to the Fund Administrator and include the Social Security Administration disability determination letter (commonly referred to as a Notice of Award) within 60 days of receipt and before the end of the original 18-month continuation coverage period.

The disabled individual may be any qualified beneficiary (former employee, spouse or dependent). Additionally, the disability extension applies independently to non-disabled family members who are qualified beneficiaries due to the termination or reduction in hours of employment. The Fund Administrator must be notified within 30 days of any final determination that the individual is no longer disabled.

The Fund Administrator must be notified within 30 days of any final determination that the individual is no longer disabled. To provide such notice, you must contact the Fund Administrator and request a form titled Cobra Qualifying Event: Loss Of Social Security Disability Status -Notice to Fund Administrator. You must complete, sign and return the form to the Trust Administrator within 30 days of any final determination of the loss of Social Security disability status.

As mentioned above, the Fund can require 102 percent of the applicable premium for continuation coverage in the Plan. However, if coverage is extended due to a disability and the disabled individual is part of the coverage group, the Fund may charge up to 150 percent of the applicable premium during the disability extension period. If only non-disabled qualified beneficiaries are in the coverage group, 102 percent of the applicable premium would apply.

Second Qualifying Event Extension

A continuation coverage period of 18 or 29 months (in the case of Social Security disability status; *see*, Disability Extension to COBRA Coverage, described above) may be extended to 36 months for eligible dependent qualified beneficiaries if a second qualifying event occurs (such as employee death, divorce, legal separation, employee Medicare entitlement *see*, Eligibility For COBRA Coverage Section, above, for definition of Medicare entitlement or a child losing dependent status) during the 18- or 29- month period. The extension applies only if the Fund Administrator is notified in writing within 60 days of the second qualifying event and within the original 18- or 29- month coverage period. To qualify for this extension, you must contact the Fund Administrator and request a form titled Cobra Second Qualifying Event-Notice to Fund Administrator. It is your responsibility to

complete, sign and return the form to the Fund Administrator within the 60-day period in order to be eligible for the extension. In no event will continuation coverage last beyond three years from the date of the event that originally made a qualified beneficiary eligible to elect coverage. A reduction in hours followed by a termination of employment is not considered a second qualifying event for COBRA purposes. If the qualifying event occurs within 18 months after the employee became entitled to Medicare, the covered spouse or dependent children are entitled to a COBRA coverage period that ends 36 months after the employee became entitled to Medicare.

Coordination Between COBRA and The Health Insurance Portability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follows.

If you become covered under another group health plan, and that group health plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, **the Fund may cancel your COBRA coverage.**

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the plan reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Open Enrollment Under COBRA

If you or your Dependents are covered through the Plan under COBRA, during the Open Enrollment period you may make modifications to those medical, dental, vision and any other benefits the Fund makes available to COBRA Participants and Dependents. The effective date of any change will be the first of the month following the Open Enrollment Period.

Further information concerning the Fund's Open Enrollment Period will be provided during the month preceding the Open Enrollment Period for your group.

Termination of COBRA Continuation Coverage

Eligibility for COBRA Continuation of Coverage will terminate on the first day of the month following the occurrence of any one of the events listed below:

a) Failure to remit the required premium payment whether for Participant and/or Dependent coverage, as is applicable in full and on time (within no later than 45 days following submission of the initial COBRA Election Form; thereafter within no later than 30 days following the due date established by the Fund’s Administrative Office);

b) You or your eligible Dependents receive coverage, as a Participant or as a Dependent, under any other group health plan, unless that plan will not cover you or your Dependents for a pre-existing condition, in which case you may continue COBRA coverage as long as the successor plan's pre-existing condition rules apply (but not beyond the end of the maximum COBRA continuation coverage you and/or your Dependents have qualified for) ;
c) You or your Dependents become entitled to Medicare benefits (*See*, Eligibility For COBRA Coverage Section, above, for definition of Medicare entitlement) after first qualifying for COBRA coverage through the Fund;
d) The date the Professional Musicians, Local 47 and Employers' Health and Welfare Fund ceases to provide group health coverage under this Plan.
e) You or your Dependents have continued coverage for additional months due to a disability, and there has been a final determination by Social Security that you or your Dependents are no longer disabled. In this case, coverage ends on the first of the month that begins more than 30 days after the Social Security Administration makes a final determination that you or your Dependent are no longer disabled or at the end of the applicable 18 or 36 month maximum coverage period described above, whichever occurs last.
f) You or your Dependents reach the end of your maximum COBRA continuation coverage period as described above.
g) You and/or your Dependents request cancellation of COBRA continuation coverage in writing.
h) You and/or your Dependents fail to abide by and follow all applicable rules and regulations of the Fund and this Plan.
i) Your employer stops making contributions to the Fund on behalf of its active employees and provides alternative coverage to those employees under another group health plan.

IMPORTANT NOTE: If you relocate to an area not covered by the Health Net plans sponsored through the Fund, alternative coverage may not be available. In the event the Trust does offer other coverage to Participants that is available in, or can be extended to, your new location, you may elect to receive that coverage (restrictions may apply). However, COBRA continuation coverage will not be provided to you if none of the coverages offered to Participants are available in the area to which you relocate.

Conversion Rights Upon Expiration of COBRA Coverage

Once COBRA Continuation of Coverage terminates, you or your Dependents (if eligible) may have the right to convert health insurance (medical only) to conversion coverage under the Right to Convert Health Insurance provisions provided by Health Net. You must check the Evidence of Coverage Booklet for Conversion to Individual Plan Coverage.

Additional COBRA Information

This notice provides you with a broad overview of a complex federal employer law. Should the contents of this notice differ from continuation coverage provisions as stated in the federal law, the federal law will prevail.

In order to protect your rights you should keep the Trust Administrator informed of a change of marital status, or if a dependent ceases to be a dependent eligible for coverage under the plan, or if you, your spouse or dependent child have a change of address. You must notify the Trust Administrator at the following address:

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

MILITARY LEAVE OF ABSENCE AND CONTINUATION OF COVERAGE

If you are on a military leave of absence from your employment, and the period of military leave is less than thirty-one (31) days, you will continue to be eligible for coverage under this Plan during the thirty-one (31) day leave with no self-payment required, provided you are in an eligible status under this Plan at the time your military leave begins. If, however, you are on a military leave of absence from your employment, and the period of military leave is longer than thirty one (31) days, your rights to continue health coverage are established under two federal laws: COBRA (as discussed above) and the Uniformed Services Employment and Re-employment Rights Act of 1994, which is discussed more fully below.

RIGHTS UNDER USERRA

This section provides information about your rights under the Uniformed Services Employment and Re-employment Act ("USERRA").

Congress enacted USERRA to provide protections to individuals who serve in the "uniformed services". "Uniformed services" is defined as the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Services, and any other category of persons designated by the President in time of war or national emergency. Service in the uniformed services includes, for example, active duty, active and inactive duty for training and National Guard duty. One of the protections provided by USERRA is that employees covered under a group health plan must be given an opportunity to elect to continue coverage for themselves and/or their dependents (other than a domestic partner who does not qualify as a dependent under

Internal Revenue Code Section 152) if they take leave to serve in the uniformed services (hereinafter "military leave").

The maximum period of continuation coverage for health care under USERRA is the lesser of: (1) 24 months (beginning from the date you leave work due to your military leave) or (2) the day after the date you fail to timely apply for or return to a position of employment with an Employer participating in the Trust.

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

Generally, your right to continuation coverage is governed by COBRA, as described above. However, in the event you choose continuation of coverage, you have the same additional rights under USERRA. The first additional right, which is described in the preceding paragraph, applies if your military leave of absence from employment is less than 31-days. Second, if you become covered by another group health plan or entitled to Medicare during the USERRA maximum coverage period described above, the continuation coverage elected by you and your Dependents will not be terminated.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The Health Insurance a Portability and Accountability Act of 1996 ("HIPAA") provides that Participants (and, in certain circumstances, their Dependents) in a group health plan are protected against pre-existing condition exclusions, for otherwise covered health or medical conditions, if certain prerequisites are met. Generally, a provider may exclude coverage of a pre-existing medical or health condition, except relating to pregnancy, only if either (I) within the six (6) months prior to enrollment in the Plan, the Participant and/or Dependent received treatment for the medical or health condition - or - (ii) prior to enrolling in the Plan the Participant and/or Dependent suffered a significant break in coverage; i.e.. the Participant and/or Dependent was not covered by any plan of health/medical insurance during the 62 days immediately preceding enrollment in the Plan.

If a provider is allowed to apply a pre-existing exclusion to a medical or health condition, such exclusion will be effective for (I) 12 months from the date of enrollment of the Participant and/or Dependent, or (ii) in the case of a Participant’s or Dependent’s late enrollment only, 18 months from the date of any Participant's or Dependent's late enrollment into the Plan.

In the event a Provider determines that a pre-existing exclusion applies to a medical or health condition, it must give written notice of that decision to the affected Participant and/or Dependent. The written notice must (I) state the medical or health condition excluded; (ii) the basis for the exclusion; (iii) the duration of the exclusion, and; (iv) any appeal rights the Participant and/or Dependent may possess with regard to the exclusion.

HIPAA also requires the Fund to provide a Participant and/or Dependent with written certification of their coverage under the Plan when a "qualifying event" occurs. Generally, a "qualifying event" for purposes of HIPAA is the same as a qualifying event under COBRA (Refer to the Consolidated Omnibus Budget Reconciliation Act of 1985 as described earlier in this SPD for further information on COBRA qualifying events).

When a qualifying event occurs - e.g. loss of coverage due to lack of employer contributions -- the Participant and/or Dependent will be automatically issued a certification of coverage card to their last known address. Participants and/or Dependents may also request, up to 24 months after loss of coverage due to a qualifying event, a certificate of coverage card by contacting the Fund Administrator's Office at:

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

The Fund Administrator will provide you with a certificate of coverage at the earliest time that it, acting in a reasonable and prompt fashion, can provide the certificate.

WAIVER OF COVERAGE

Additionally HIPAA regulates matters involving what is known as ***waiver of coverage***.

The most common reason Participants voluntarily waive coverage is that they or their spouse or domestic partner have coverage through another health plan. Since you may be covered by more than one health plan, the law allows you to choose coverage from another health plan and, at the same time, retain your right to enroll at a later date in the Plan.

In order to preserve your right to enroll in the Plan, either for yourself or your Dependents, you must have completed and filed with the Fund Administrator a Waiver of Coverage form. If you lose coverage from your other health plan and you have filed a completed Waiver of Coverage form with the Fund Administrator, you may enroll for benefits if the following criteria are met:

- You are no longer eligible for health benefits through the other source,
- You are currently eligible under the Plan, (you have the required employer contributions for the coverage period), and
- The required HIPAA paperwork is submitted within thirty (30) days of your loss of coverage from the other plan. Along with your HIPAA certificate of coverage, you must submit a copy of your original Waiver of Coverage form, the appropriate enrollment applications and premiums required by the Fund.

You will be enrolled in benefits effective the first day you lost benefits with the other plan if you satisfy the above criteria.

Even if you choose to enroll, but decide not to enroll your dependents because they are covered in another plan, you should still complete the Waiver of Coverage form on their behalf. This protects your family by allowing them to enroll for Musicians Local 47 Health and Welfare benefits if their coverage is canceled. Without the completed Waiver of Coverage form you will not be able to enroll your dependents if they later lose their coverage from another employer provided medical plan.

IMPORTANT NOTE:
Always retain a copy of the Waiver of Coverage form you have filed with the Fund. This will help you avoid potential delays in, or even denials of, coverage in the event the Fund cannot locate your Waiver of Coverage form when you incur a qualifying event and you seek to add you dependents to your coverage through the Fund.

HIPAA also has special rules for persons who become a Dependent of a Participant through marriage, birth, adoption or placement of adoption, provided that the Health & Welfare Plan is notified within thirty (30) days of the event.

A special enrollment period is provided when a Participant: (1) has voluntarily declined coverage; (2) completes and submits a Waiver of Coverage form with the Fund Administrator; (3) then marries and/or adds a child through birth or adoption during the coverage period. Remember, spouses, newborns and adopted Dependents are ***not*** able to enroll ***unless*** the Participant has previously enrolled.

All eligibility rules apply for Participants who enroll late under the HIPAA guidelines. Participants and Dependents may be subject to the twelve (12) or eighteen (18) month pre-existing condition exclusion.

REQUIRED HIPAA DISCLOSURE ABOUT THE FUND'S PROTECTED HEALTH INFORMATION

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

General Information About Health Information Confidentiality

The Fund is committed to maintaining the confidentiality of your private medical information. This part of the SPD describes our efforts to safeguard your health information from improper or unnecessary use or disclosure and only applies to health-related information created or received by or on behalf of the Fund. We are providing this information to you because privacy regulations issued under federal law, the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164 (“HIPAA”), require us to provide you with a summary of the Plan’s privacy practices and related legal duties, and your rights in

connection with the use and disclosure of your Plan information.

In this portion of the SPD, the terms "Plan," "we," "us," and "our" refer to the Fund, the Plan and third parties to the extent they perform administrative services for the Plan. When third party service providers perform administrative functions for the Plan, we require them to appropriately safeguard the privacy of your information.

Please note:

> ***If you are enrolled in an HMO you will also receive a separate notice from your HMO provider that describes the HMO provider's specific use and disclosure of your health information. Your rights with respect to their use and disclosure of your health information are set forth in that separate notice.***

Contact Information

If you have any questions regarding this Notice, please contact:

Privacy Officer
Professional Musicians, Local 47 and Employers' Health & Welfare Fund
1000 North Central Avenue, Suite 400, Glendale, California 91202-3627

What is Protected?

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

your physical or mental health condition,

the provision of health care to you, or

payment for your health care.

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

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Uses and Disclosures of Your PHI

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

To determine proper payment of your Health Plan benefit claims. The Plan uses and discloses your PHI to reimburse you or your doctors or health care providers for covered treatments and services. For example, your diagnosis information may be used to determine whether a specific procedure is medically necessary or to reimburse your doctor for your medical care.

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

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

To a health care provider if needed for your treatment.

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

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

To a family member, friend, or other person involved in your health care if you are present and you do not object to the sharing of your PHI, or it can reasonably be inferred that you do not object, or in the event of an emergency.

For Plan design activities or to collect Plan contributions. The Plan may use summary or de-identified health information for Plan design activities. In addition, Plan employees may use information about your enrollment or disenrollment in a Plan in order to collect contributions that pay for your Plan participation.

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

To Business Associates. The Plan may disclose PHI to other people or businesses that provide services to the Plan and which need the PHI to perform those services. These people or businesses are called business associates, and the Plan will have a written agreement with each of them requiring each of them to protect the privacy

of your PHI. For example, the Plan may have hired a consultant to evaluate claims or suggest changes to the Plan, for which he needs to see PHI.

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

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

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

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

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

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

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

To a law enforcement official for a law enforcement purpose.

For purposes of public safety or national security.

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

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

For cadaveric organ, eye or tissue donation. The Plan may use and disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

For research. The Plan may use and disclose protected health information to assist in research activities, regardless of the source of the funding for the research, where a privacy board or an Institutional Review Board has approved an alteration to or

waived entirely the authorization requirements of the law and the Plan receives certain specific representations and documentation.

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

Incident to a permitted use or disclosure. The Plan may use and disclose protected health information incident to any use or disclosure permitted or authorized by law.

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

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

Absent your written permission, Plan employees will only use or disclose your PHI as described in this SPD. Fund employees will not access your PHI for reasons unrelated to Plan administration without your express written authorization.

If an applicable state law provides greater health information privacy protections than the federal law, we will comply with the stricter state law.

Other Uses and Disclosures of Your PHI

Before we use or disclose your PHI for any purpose other than those listed above, we must obtain your written authorization. You may revoke your authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI except as described above (or as permitted by any other authorizations that have not been revoked). However, please understand that we cannot retrieve any PHI disclosed to a third party in reliance on your prior authorization.

In no event will the Plan use or disclose your PHI that is “genetic information” for “underwriting” purposes, as such terms are defined by the Genetic Information Nondiscrimination Act of 2008.

Your Rights

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

Right to request restrictions: You have the right to request a restriction or limitation on the Plan's use or disclosure of your PHI. For example, you may ask us to limit the scope of your PHI disclosures to a case manager who is assigned to you for monitoring a chronic condition. Because we use your PHI to the extent necessary to pay Plan benefits, to administer the Plan, and to comply with the law, it may not be possible to agree to your request. Except in the limited circumstances described below, the law does not require the Plan to agree to your request for restriction. Except as otherwise required by law (and excluding disclosures for treatment purposes), the Plan is obligated, upon your request, to refrain from sharing your PHI with another health plan for purposes of payment or carrying out health care operations if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. The Plan will not agree to any restriction, which will cause it to violate or be noncompliant with any legal requirement. If we do agree to your requested restriction or limitation, we will honor the restriction until you agree to terminate the restriction or until we notify you that we are terminating the restriction with respect to PHI created or received by the Plan in the future.

You may make a request for restriction on the use and disclosure of your PHI by completing the appropriate request form available from the Plan.

Right to receive confidential communications: You have the right to request that the Plan communicate with you about your PHI at an alternative address or by alternative means if you believe that communication through normal business practices could endanger you. For example, you may request that the Plan contact you only at work and not at home.

You may request confidential communication of your PHI by completing an appropriate form available from the Plan. We will accommodate all reasonable requests if you clearly state that you are requesting the confidential communication because you feel that disclosure in another way could endanger your safety.

Right to inspect and obtain a copy of your PHI: You have the right to inspect and obtain a copy of your PHI that is contained in records that the Plan maintains for enrollment, payment, claims determination, or case or medical management activities. If the Plan uses or maintains an electronic health record with respect to your PHI, you may request such PHI in an electronic format, and direct that such PHI be sent to another person or entity.

However, this right does not extend to (1) psychotherapy notes, (2) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (3) any information, including PHI, as to which the law does not permit

access. We will also deny your request to inspect and obtain a copy of your PHI if a licensed health care professional hired by the Plan has determined that giving you the requested access is reasonably likely to endanger the life or physical safety of you or another individual or to cause substantial harm to you or another individual, or that the record makes references to another person (other than a health care provider), and that the requested access would likely cause substantial harm to the other person.

In the event that your request to inspect or obtain a copy of your PHI is denied, you may have that decision reviewed. A different licensed health care professional chosen by the Plan will review the request and denial, and we will comply with the health care professional's decision.

You may make a request to inspect or obtain a copy of your PHI by completing the appropriate form available from the Plan. We may charge you a fee to cover the costs of copying, mailing or other supplies directly associated with your request. You will be notified of any costs before you incur any expenses.

Right to amend your PHI: You have the right to request an amendment of your PHI if you believe the information the Plan has about you is incorrect or incomplete. You have this right as long as your PHI is maintained by the Plan in a designated record set. We will correct any mistakes if we created the PHI or if the person or entity that originally created the PHI is no longer available to make the amendment. However, we cannot amend PHI that we believe to be accurate and complete.

You may request amendments of your PHI by completing the appropriate form available from the Plan.

Right to receive an accounting of disclosures of PHI: You have the right to request a list of certain disclosures of your PHI by the Plan. The accounting will not include disclosures (1) to carry out treatment, payment and health care operations, (2) to you, (3) incident to a use or disclosure permitted or required by law, (4) pursuant to an authorization provided by you, (5) for directories or to people involved in your care or other notification purposes as permitted by law, (6) for national security or intelligence purposes, (7) to correctional institutions or law enforcement officials, (8) that are part of a limited data set, (9) that occurred prior to April 14, 2003, or more than six years before your request. Your first request for an accounting within a 12-month period will be free. We may charge you for costs associated with providing you additional accountings. We will notify you in advance of any costs, and you may choose to withdraw or modify your request before you incur any expenses.

You may make a request for an accounting by completing the appropriate request form available from the Plan.

Right to Receive Notice: If your "Unsecured" PHI is accessed, acquired, used or disclosed in a manner that is impermissible under the HIPAA privacy rules and that poses a significant risk of financial, reputational or other harm to you, the Plan must notify you within

60 days of discovery of such "Breach" (as such terms are defined in the HIPAA privacy rules)..

Right to file a complaint: If you believe your rights have been violated, you should let us know immediately. We will take steps to remedy any violations of the Plan's privacy policy or of this Notice.

You may file a formal complaint with our Privacy Officer and/or with the United States Department of Health and Human Services at the addresses below. You should attach any evidence or documents that support your belief that your privacy rights have been violated. We take your complaints very seriously. **The Plan prohibits retaliation against any person for filing such a complaint.**

Complaints should be sent to:

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

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

Additional Data About Your Personal Health Information

Changes to the Fund's Privacy Practices : We reserve the right to change the Fund's privacy practices as described in this Notice. Any change may affect the use and disclosure of your PHI already maintained by the Fund, as well as any of your PHI that the Plan may receive or create in the future. If there is a material change to the terms of this Notice, you will receive a revised Notice.

How to obtain a copy of the Fund's Privacy Practices: You can obtain a copy of the current Privacy Practices by contacting the Privacy Officer at the address listed on the front of this Notice.

No change to Plan benefits: This section of the SPD explains your privacy rights as a current or former participant in the Fund. The Fund is bound by the terms of this section of the SPD as they relate to the privacy of your protected health information. However, this section of the SPD does not change any other rights or obligations you may have under the Plan. You should refer to the Plan documents for additional information regarding your Plan benefits.

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

In accordance with the HIPAA Electronic Data Interchange ("EDI") regulations, the Fund certifies that is compliant with the standards governing the transmission of claims, payment and processing information in HIPAA acceptable EDI formats. The Fund has also verified that the insurers who provide the benefits sponsored by the Fund are compliant with the standards governing the transmission of claims, payment and processing information in HIPAA acceptable EDI formats.

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

Group health plans and health insurance issuers 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 vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable.). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 requires that if your health plan provides medical and surgical benefits for a mastectomy, and if a Participant or Dependent should actually undergo a mastectomy, the following benefits must also be provided:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery/reconstruction on the other breast to produce a symmetrical appearance
- Prostheses and/or physical complications that may arise, including lymphedemas.

SUBROGATION OF CLAIMS AGAINST THIRD PARTIES

Covered medical expenses may be incurred due to the negligence or intentional acts of third parties. This would typically include injuries that are caused due to automobile accidents, slip and fall incidents, dangerous property conditions, etc.

In the event you or your covered dependents incur an injury and receive medical care through one of more of the policies of insurance that provide the benefits offered by the Fund, you may be required to sign what is known as a Subrogation Agreement with the carrier. This means that the carrier may require that you sign a written agreement which acknowledges that the carrier can be reimbursed, from the proceeds of any lawsuit or claim

you bring against one or more third parties who may be legally responsible for the injuries that necessitated the medical care, for the cost of the benefits that were provided to you and/or your covered dependants. Each carrier the Fund contracts has different rules concerning the issue of subrogation, and you are advised to review the specific and applicable evidence of coverage to determine what, if any, subrogation rules may apply to your circumstances. In the event you are requested by a carrier to execute a Subrogation Agreement, and you have questions about what the document means and whether you or your covered dependents can be required to sign such a contract, please contact the Fund's Administrative Office.

AUDITS OF EMPLOYERS, PAYROLL AGENTS AND PARTICIPANTS

The Fund reserves the right, in its sole and exclusive discretion, to audit with cause or on a random basis any participating Employer, any payroll agent of any Employer(s), any Participant or any Employee. In the event the Fund determines that it will audit an Employer, Participant or Employee, payroll agent for any Employer(s), the Employer or Participant or Employee is required by law and the Trust Agreement to provide full cooperation to the Fund and its auditors and to disclose to the Fund and its auditors all documents, records, computer files and other items necessary to concluding the audit process. In the event the audited Employer, payroll agent for any Employer(s), Participant or Employee fails and refuses to cooperate, during the audit process, with the Fund and/or its auditors, the Fund reserves the right take all appropriate legal action to compel cooperation with the audit process. Should an audit reveal that an Employer or payroll agent of any Employer(s) failed to remit all contributions required by the governing contract and/or Trust Agreement or in any other manner violated the rules and regulations of the Fund (including, but not limited to the Fund's Trust Agreement) and/or applicable law as pertains to employer contributions to the Fund, the Fund reserves the right to institute the appropriate legal action to collect those delinquent contributions and/or seek such other relief as may be appropriate. Further, and in the event an Employer or a payroll agent for any Employer(s) is found to have failed to remit all required contributions to the Fund, including any liquidated damages or interest payments due in connection with such delinquent contributions, the Fund, through its Board of Trustees, reserves the right to terminate or suspend the contributory status of such Employer and/or payroll agent for any such Employer(s). Also, in the event an audit determines that a Participant obtained eligibility through improperly or fraudulently remitted contributions, the Fund reserves the right to take all or any of the following actions:(i) revoke his/her eligibility during the applicable coverage year; (ii) in the case of potential fraud, refer the matter to the proper governmental authorities for investigation and potential prosecution, (iii) if an employer or payroll agent for such Employer is found responsible for such improper or fraudulent eligibility, the Fund, through its Board of Trustees, reserves the right to terminate or suspend the contributory status of such Employer and/or payroll agent for any such Employer(s), (iv) deduct from the affected Participant(s) eligibility bank(s) all contributions relating or connected to the improper or fraudulent contributions, and; (v) institute legal action to recover all Fund expenses (including any and all premium payments to the Fund's

providers made on account of a Participant who fraudulently obtained coverage and costs of the audit, including auditor's and attorneys' fees) incurred on account of any Participant who has obtained coverage through fraudulent means.

APPEAL AND REVIEW PROCEDURES

Appeal To Benefit Provider If Your Claim Is Denied

If a claim for any benefit provided by any of the Plan's benefit providers is denied in whole or in part, you will receive a written notice of the denial from the benefit provider advising you of the specific reason for the denial and a description of any additional information necessary for you to complete the claims procedure.

If you wish to file a claim or appeal the denial of a claim or the partial denial of a claim or a carrier's decision to rescind your coverage, you must file the claim or appeal, in writing to the appropriate provider (listed below) who is the fiduciary under the Plan and is required to review all claims and appeals you may file:

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

Filing of Claims and/or Appeals with a Provider

The time in which you have to file a claim and/or appeal with any of the above insures will be different based upon the type of claim and/or appeal involved. Generally, the processing of claims and appeals, by the Fund's insurers, shall be governed by the following time frames:

Pre-Authorization Claims: A pre-authorization claim is defined as any claim involving a benefit where advance approval for the medical care is required. The participant must be advised of the approval/denial of the claim within a reasonable period of time, not to exceed 15 days from the insurer's receipt of the claim. If the insurer deems that additional time is necessary to review the claim, it may extend the review period by an additional 30 days, provided the participant is advised, in writing, of the extension during the initial 15 day review time frame. In the event the extension is due to the participant's failure to provide necessary information, the participant must be given written notice and an opportunity, of not less than 45 days, in which to provide the necessary information. The insurer's time for rendering its decision on the claim shall be suspended while it is awaiting more information from the participant.

Appeal from Denial of Pre-Authorization Claim: A participant shall have up to 180 days after receipt of the denial of pre-authorization claim in which to file an appeal with the applicable carrier. The carrier will have up to 30 days from the date of the appeal in which to issue its written approval or denial of the appeal.

Post-Service Claim: A post-service claim is defined as any claim submitted after the medical treatment is received by the participant. The participant must be advised of the approval/denial of the claim within a reasonable period of time, not to exceed 30 days from the insurer's receipt of the claim. If the insurer deems that additional time is necessary to review the claim, it may extend the review period by an additional period of time, but not exceeding 45 days from its original receipt of the claim and provided the participant is advised, in writing, of the extension during the initial 30 day review time frame. In the event the extension is due to the participant's failure to provide necessary information, the participant must be given written notice and an opportunity, of not less than 45 days, in which to provide the necessary information. The insurer's time for rendering its decision on the claim shall be suspended while it is awaiting more information from the participant.

Appeal from Denial of Post-Service Claim: A participant shall have up to 180 days after receipt of the denial of post-service claim in which to file an appeal with the applicable carrier. The carrier will have up to 60 days from the date of the appeal in which to issue its written approval or denial of the appeal.

Claims Involving Urgent Care: An urgent care (or emergency) claim is defined as any claim submitted that, if not decided quickly, could seriously jeopardize the life or health of the claimant, or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without such care or treatment. If the participant fails to follow the proper procedures for filing a pre-authorization claim, he/she must be notified by the carrier within 24 hours of such failure. Said notice must also include a description of the proper pre-service procedure the participant needs to follow. The participant must be advised of the approval/denial of the claim as soon as possible, taking into account the participant's medical condition, but no later than 24 hours from the

insurer's receipt of the claim. If the insurer deems that additional information is necessary to review the claim, it must notify the participant of the specific required information, as soon as possible, but in no event shall such notice be given 24 hours after the insurer's receipt of the claim. The participant must be given at least 48 hours to provide the required information. The insurer will have up to 48 hours after the receipt of the required information in which to advise the participant, in writing, whether the claim is approved or denied. In the event of a request to extend coverage for an existing urgent care claim also known as a "concurrent care claim" the insurer must notify the participant of the approval or denial of the concurrent care claim within 24 hours after receipt of the claim.

Appeal from Denial of Pre-Service Claim: A participant shall have up to 180 days after receipt of the denial of an urgent care claim in which to file an appeal with the applicable carrier. The carrier will have up to 72 hours from the date of the appeal in which to issue its written approval or denial of the appeal.

Content of Notice of Initial Benefit Decision: When rendering an determination on an initial claim, the insurer must set forth its decision whether granting or denying the claim in writing. The written notice must: (I) state the specific reason for the action taken; (ii) refer to the specific plan provision on which it is based; (iii) describe any additional information necessary for the granting of the claim and why such information is necessary; (iv) contain a description of the applicable appeal procedures, the time limits governing the appeal and the participant's right to bring an action, under Section 502(a) of ERISA, seeking the providing of the contested benefits following a adverse decision on appeal; (v) if applicable, include a copy of the internal rule that was relied on in denying the claim or a statement that such a rule was relied on and that, upon request, a copy will be provided at no cost to the participant; (vi) state, if the determination was based upon a conclusion that the procedure was not medically necessary, an explanation of the scientific or clinical judgment relied on or a statement that a copy of the scientific or clinical judgment relied on will be provided, upon request, to the participant at no cost, and; (vii) set forth a description of the expedited review process applicable to urgent care claims.

Content of Appeal Determination Notice: When rendering an determination on an appeal from an initial claim denial, the insurer must set forth its decision whether granting or denying the claim in writing. The written notice must: (I) state the specific reason for the action taken; (ii) refer to the specific plan provision on which it is based; (iii) contain a statement that the participant is entitled to receive, upon request and free of charge, access to all written materials, reports and records which were relied on in the appeal process, which were submitted to or considered during the appeal process and which demonstrate that the appeal was decided in a manner that is consistent with the governing documents of the applicable plan; (iv) set forth a description of any further voluntary appeal procedures available to the participant (e.g. arbitration, mediation, etc.), the participant's right to obtain information about such voluntary appeal procedures and the participant's right to bring an action, under Section 502(a) of ERISA, seeking the providing of the contested benefits following a adverse decision on appeal; (v) if applicable, include a copy of the internal rule that was relied on in denying the claim or a statement that such a rule was relied on and

that, upon request, a copy will be provided at no cost to the participant; (vi) state, if the determination was based upon a conclusion that the procedure was not medically necessary, an explanation of the scientific or clinical judgment relied on or a statement that a copy of the scientific or clinical judgment relied on will be provided, upon request, to the participant at no cost, and; (vii) include the following statement: "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Authorized Representative of the Claimant: The participant may authorize a personal representative to act on his/her behalf throughout the claims/appeals process. If the claim involves urgent care, the participant's treating physician is permitted to act as his/her authorized representative.

Right of Participant to Submit or Obtain Information During Claims/Appeal Procedures: The insurer must provide the participant with the right to submit any materials or information relevant to the determination of the claim/appeal. The insurer must also provide the participant with the right to review all records and information that are in the possession of the insurer and are relevant to the determination of the claim/appeal (with the exception of privileged communications). In the event the participant submits materials or information he/she believes is relevant to the determination of the claim/appeal, such materials and information must be considered by the insurer when rendering its decision.

Claims/Appeals Involving Medical Judgment: If a claim or appeal depends upon a determination that a procedure is or is not medically necessary, the insurer must consult with a health care professional who has the appropriate training and experience in the field of medicine at issue. The insurer must identify to the participant, upon request, the health care professionals with whom it has consulted.

Special Rules Governing Appeals from Claims Denials: The review of the insurer on appeal must not defer to the initial adverse benefit decision and may not be conducted by the individual who made the initial adverse determination nor a subordinate of such individual. The claims review procedure will be designed and carried out in a manner the insures the independents and impartiality of the individual or committee making the claims appeal determination.

Continued Coverage Pending Outcome of an Appeal: While an appeal is pending the law requires that coverage to the affected Participant and/or beneficiary be continued. Also, in the event of an appeal concerning a continuing course of treatment , that ongoing course of treatment cannot be reduced or terminated without prior written notice and an opportunity for advanced review of any determination to deny the ongoing course of treatment.

Benefit Provider’s Discretion to Interpret and Apply Plan of Insurance: In any appeal concerning the denial of a claim and/or benefits, the Benefit Provider shall have, and does possess, the full and complete discretion to interpret and apply the terms of any plan of

insurance sponsored by that Benefit Provider.

Appeal to the Trustees If Your Eligibility Is Denied

A participant, or their duly authorized representative, has a right to appeal denial of eligibility and/or revocation of eligibility (i.e. decision to rescind participatory status by the Fund.) to the Trustees. A denial or revocation of eligibility includes the Funds denial of a participant's or his/her Dependent's request for late enrollment. The appeal MUST BE MADE IN WRITING. The participant (or their representative) may review pertinent documents and may submit comments in writing.

Any appeal from a denial or revocation of eligibility must be filed, in writing, with the Fund Administrator's Office no later than 60 days from the date on which the participant received notice from the Fund that he/she is not eligible for benefits from the Fund or that her/his eligibility has been revoked. The Trustees shall decide the appeal at their next regularly scheduled quarterly meeting. Provided, however, that if appeal is received less than 30 days prior to the next meeting, the appeal may be decided at the following quarterly Trustees' meeting. The Trustees shall promptly advise the participant, or his/her representative, of their decision. In no event, however, shall the Trustees' decision be sent to the participant, or his/her representative, more than 30 days after the Trustees met and ruled upon an appeal from the Fund's denial of eligibility and/or revocation of eligibility.

The Trustees shall provide the participant with a written explanation of their decision. In the event the Trustees deny the appeal, the notice shall: (I) state the specific reason for the action taken; (ii) refer to the specific plan provision on which it is based; (iii) contain a statement that the participant is entitled to receive, upon request and free of charge, access to all written materials, reports and records which were relied on in the appeal process, which were submitted to or considered during the appeal process and which demonstrate that the appeal was decided in a manner that is consistent with the governing documents of the applicable plan; (iv) set forth a description of any further voluntary appeal procedures available to the participant (e.g. arbitration, mediation, etc.), the participant's right to obtain information about such voluntary appeal procedures and the participant's right to bring an action, under Section 502(a) of ERISA, seeking the providing of the contested benefits following a adverse decision on appeal.

Administrator’s Discretion to Interpret and Apply Plan Provisions

The Fund Administrator, including the Plan’s providers, when determining the scope of the Plan’s insured benefits coverage shall have the right and responsibility to interpret the provisions of the Plan, to decide all questions issues and questions arising under and concerning the scope and application of the Plan and to establish reasonable rules and procedures, not otherwise inconsistent with the express terms of the Plan, governing enrollment in the Plan, the filing of claims with the Plan and/or its Providers and the processing of appeals through the Plan and/or its Providers. With regard to those policies of insurance that provide the benefits offered and sponsored by the Plan, the Trustees assign the full discretion and responsibility to interpret, apply and decide all questions arising under such policies of insurance to the Provider(s) who have issued such policies of

insurance to the Plan.

INFORMATION REQUIRED BY (ERISA)
THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

PLAN SPONSOR:

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

NAME AND ADDRESS OF FUND ADMINISTRATOR:

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

TYPE OF ADMINISTRATION:

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

Benefits are provided through group insurance policies and pre-paid service plans, or organizations that have agreements with the Trust Fund. The benefits provided through these policies and agreements are governed by the terms of those contracts. Copies of these documents are available for inspection at the Trust Administrator's Office. Benefits provided by the Plan are subject to the terms of and contributions received pursuant to collective bargaining agreements as well as the availability of funds to the Trust Fund.

NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS:

Mr. Michael L. Cox
c/o PacFed Benefit Administrators, Inc.
1000 North Central Ave., Suite 400
Glendale, CA 91202

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

INTERNAL REVENUE SERVICE PLAN IDENTIFICATION NUMBER: 95-2645284

PLAN NUMBER: 501

PLAN FISCAL YEAR ENDS: March 31

APPLICABLE COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained in accordance with various collective bargaining agreements between Employers and Professional Musicians, Local 47. The agreements require contributions from the participating Employers to provide the benefits described in this booklet. The bases for contribution by the Employer and the types of benefits to be provided are listed in the agreements. Copies of the agreements are available for inspection at the Trust Administrator's Office during regular business hours, and upon written request, will be furnished by mail. You will be charged for the cost of furnishing such a copy. You may also request information as to whether a particular employer is a sponsor of the Professional Musicians, Local 47 and Employers' Health and Welfare Fund.

SOURCE OF FINANCING OF THE PLAN:

The Plan is funded by employer contributions.

PLAN TERMINATION:

The Board of Trustees may terminate the Plan pursuant to its authority under the Trust Agreement. In no event will the termination of the Plan or Trust result in a reversion of any assets to a participating Employer.

Termination will not result in reversion of Trust Fund assets to the Union, Participants, Employers or Dependents. In the event of Plan Termination the Funds assets will be paid out in the form of benefits to its Participants and covered Dependents.

NAMES AND ADDRESSES OF TRUSTEES

Mike DeMartini LA Philharmonic Association 151 South Grand Avenue Los Angeles, CA 90012	Vince Trombetta Professional Musicians, Local 47 817 Vine Street Hollywood, California 90038
Hal Espinosa Professional Musicians, Local 47 817 Vine Street Hollywood, California 90038	DeeDee Daniel Entertainment Partners 2835 N. Naomi Street Burbank, CA 91504
Robert W. Johnson The Walt Disney Company 500 South Buena Vista Burbank, California 91521	Jay Rosen Professional Musicians, Local 47 817 Vine Street Hollywood, California 90038

INSURERS AND PROVIDERS OF SERVICE TO THE TRUST

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS The Prudential Insurance Company of America Prudential Group Life Claim Division P.O. Box 8517 Philadelphia, Pennsylvania 19176 1-800-524-0542	HOSPITAL, MEDICAL, SURGICAL AND PRESCRIPTION DRUG BENEFITS HEALTH NET CORPORATE P.O. BOX 9103 VAN NUYS, CA 91409-9103
DENTAL BENEFITS DELTA DENTAL PLANS OF CALIFORNIA 12898 TOWNE CENTER DRIVE CERRITOS, CALIFORNIA 90703	HEALTH NET CLAIMS P.O. BOX 14702 LEXINGTON, KY 40512
DELTA DENTAL CLAIMS DELTA DENTAL PLANS OF CALIFORNIA CLAIMS OFFICE P.O. BOX 7736 SAN FRANCISCO, CALIFORNIA 94120	DENTAL BENEFITS DELTACARE USA 12898 TOWNE CENTER DRIVE CERRITOS, CALIFORNIA 90703
VISION BENEFITS GERBER LIFE ADMINISTERED BY MES VISION P.O. BOX 25209 SANTA ANA, CALIFORNIA 92799	CHIROPRACTIC/ACUPUNCTURE BENEFITS LANDMARK HEALTHPLAN, INC. 1750 HOWE AVENUE, SUITE 30 SACRAMENTO, CALIFORNIA 95825

STATEMENT OF ERISA RIGHTS

As a Participant covered under this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA provides that all Plan Participants shall be entitled to:

- Examine, without charge, at the Trust Administrator's Office and at the Union's office all Plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary financial report.

- File suit in a federal court if any materials requested are not received within 30 days of the Participant's request, unless the materials were not sent because of matters beyond the control of the Administrator. The court may require the Plan Administrator to pay up to $110 for each day's delay until the materials are received.

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

You may not be discriminated against to prevent you from obtaining benefits under the Plan or exercising your rights under ERISA.

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

If you have any questions about this statement or your rights under ERISA, you should contact the Plan Administrator or the nearest Office of Pension-Welfare Benefit Programs, or the U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

IMPORTANT PHONE NUMBERS

Health Net Member Service	(800) 522-0088
Landmark Healthplan	(800) 638-4557
Delta Dental Plans (PPO)	(888) 335-8227
DeltaCare USA (Pre-Paid Plan)	(800) 422-4234
MES Vision	(800) 877-6372
The Prudential Insurance Company of America	(800) 524-0542
PacFed Benefit Administrators Member Service	(800) 759-3132

SCHEDULES OF BENEFITS - APPENDIX A

CALIFORNIA PLANS

Schedule 1 – Health Net HMO Medical and Prescription Drug Benefit Summary

Schedule 2 – Health Net PPO Medical and Prescription Drug Benefit Summary

Schedule 3 – Landmark Chiropractic and Acupuncture Benefit Summary

Schedule 4 – DeltaCare USA Benefit Summary (DHMO)

Schedule 5 – Delta Dental Preferred Summary (PPO)

Schedule 6 – MES Vision Benefit Summary

Schedule 7 – Prudential Life and AD&D Benefit Summary

OUT-OF-STATE PLAN

(Non-California Plan)

Schedule 2 – Health Net PPO Out-of-State Benefit Summary

Schedule 7 – Prudential Life and AD&D Benefit Summary

This Summary Plan Description (SPD) has been prepared to give you basic information concerning the benefit plans (collectively the Plan) available to you through the Professional Musicians, Local 47 and Employers' Health and Welfare Fund (The Fund).

A complete Evidence or Certificate of Coverage may be found on the Fund's website www.pacfed.com/musicians/

PLAN DISCLAIMER

BENEFIT SCHEDULE 1

This Schedule of Benefits is a brief list of benefits, with applicable copayments, coinsurance and deductibles information for your health plan. It does not list the exclusions and limitations or other important terms applicable to your plan.

The Evidence of Coverage (EOC) for your plan contains the complete terms and conditions of your Health Net coverage. It is important for you to thoroughly review the EOC for your plan.

Health Net HMO Plan Chart (NG) Plan 4SK	4SK 1/1/2011
PROFESSIONAL SERVICES	
Visit to a physician, physician assistant or nurse practitioner at a PPG.	$10
Periodic health evaluations. Includes annual preventive physical examinations, preventive vision/hearing screenings, well-woman exam and preventive laboratory tests and x-rays.	$0
Vision examinations for refractive eye exams.	$10
Hearing examinations for hearing loss.	$10
Specialist consultations. Includes OB/GYN self-referral for non-preventive services. For preventive services, refer to periodic health evaluations above.	$10
Physician visit to member's home (at discretion of physician).	$20
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	$0
Other immunizations (except foreign travel/occupational - see below).	$0
Immunizations for foreign travel/occupational purposes.	20%
Allergy testing.	$0
Allergy serum.	$0
Allergy injection services (serum not included).	$0
Injections related to infertility services.	50%
All other injections.	$0
Surgeon/assistant surgeon in hospital or PPG.	$0
Administration of anesthetics.	$0
X-ray and laboratory procedures. Preventive x-ray/lab, refer to periodic health evaluations above.	$0
Rehabilitation therapy (outpatient physical, speech, occupational and respiratory therapy). Provided as long as significant improvement is expected. See *PPG Operations Manual.*	$10
Dental services (when medically necessary to properly monitor, control or treat a severe medical condition when excluded dental services are being performed. See *PPG Operations Manual).*	$0
CARE FOR CONDITIONS OF PREGNANCY (professional services only)	
Prenatal and postnatal office visit.	$10
Normal delivery, Cesarean section. Includes newborn inpatient care provided by a member physician.	$0
Complications of pregnancy including medically necessary abortions.	$0
Elective abortions.	$150
Genetic testing of fetus.	$0
Circumcision of newborn.	$0
FAMILY PLANNING (professional services only)	
Contraceptive devices - intrauterine device (IUD).	$20
Infertility services (including professional services, inpatient and outpatient care, treatment by injection and prescription drugs, if applicable. See *PPG Operations Manual).*	50%
Sterilization of females.	$125
Sterilization of males.	$50
Reversal of sterilization.	Not covered
ALCOHOL/DRUG REHABILITATION and CARE FOR MENTAL DISORDERS	
ADMINISTERED BY MANAGED HEALTH NETWORK (MHN) **Refer members to the MHN telephone number on the back of their Health Net ID card**	

❖❖Refer to the Introduction pages for an explanation of the benefit plan charts. ❖❖

Health Net HMO Plan Chart (NG) Plan 4SK	4SK
OTHER SERVICES	
Medical social services.	$0
Patient education.	$0
Ground ambulance.	$0
Air ambulance.	$0
Durable medical equipment.	50%
Orthotics (braces and supports).	$0
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).	Not covered
Diabetic supplies (except footwear, see below). Refer to the Introduction section for additional information.	20%
Diabetic footwear.	$0
Hearing aids.	Not covered
Prosthesis (replacing body parts).	$0
Blood and blood products.	$0
Nuclear medicine (professional services only).	$0
Organ and bone marrow transplants (non-experimental and noninvestigative. Professional services only).	$0
Chemotherapy or radiation therapy (professional services only).	$0
Renal dialysis (professional services only).	$0
Home health visit. The copayment starts the 31st calendar day after the first visit.	$10
Hospice care.	$0
HOSPITAL AND SKILLED NURSING FACILITY SERVICES	
Unlimited days of hospital care in a semi-private room or ICU with ancillary services. Excluding care for mental disorders.	$0
Confinement for infertility services.	50%
Confinement in a skilled nursing facility (limited to 100 days each calendar year).	$0
Maternity care. Includes routine nursery charges.	$0
Outpatient services.	$0
EMERGENCY CARE/URGENTLY NEEDED CARE - Within or outside the PPG service area - (Refer to the Introduction pages for more information)	
NOTE: Non-emergency care (including urgently needed care) received **within** the PPG service area must be performed or authorized by the member's PPG in order for services to be covered. When urgently needed care is provided **outside** the PPG service area, authorization is not mandatory in order for services to be covered. When services are provided that meet the criteria for emergency care, whether **within or outside** the PPG service area, the services are covered, even if the member never contacted the PPG. See the Introduction pages for more information.	
Use of emergency room (facility and professional services). ❊	$50
Use of urgent care center (facility and professional services). ❊	$50
OUT-OF-POCKET MAXIMUM	
For each member.	$1,500
For two-party.	$3,000
For each family (3 or more members).	$4,500

❊ The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room or urgent care center. See the Introduction pages for more information regarding emergency services/urgently needed care.

Health Net
A BETTER DECISION

HEALTH NET
PHARMACY BENEFITS

The following is a brief description of your Health Net Pharmacy benefits.

RETAIL COPAYMENT

drug type	description	copayment
Level I – Generic drugs	Drugs listed on the Health Net Recommended Drug List (primarily generic)	$10
Level II – Brand, preferred	Drugs and diabetic supplies (including insulin) listed on the Health Net Recommended Drug List (primarily brand name)	$15
Level III	Drugs not on the Health Net Recommended Drug List	$35

PRESCRIPTIONS BY MAIL

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period of time), you have the option of filling it through our convenient and cost-saving Prescriptions By Mail Drug Program. Under this program, your copayments for up to a 90-day supply are: **$20 level I / $30 level II / $70 level III**. For complete information, log on as a Health Net member at www.healthnet.com > *View prescription coverage* > *Get prescriptions by mail* or call Member Services at **1-800-676-6976**.

GENERIC SUBSTITUTIONS

Generic drugs will be dispensed when a generic drug equivalent is commercially available. If you request a brand name drug when a generic equivalent is commercially available, you must pay the difference between the generic equivalent and the brand name drug in addition to the listed copayments or coinsurance. However, if the prescription drug order states "dispense as written," "do not substitute" or words of similar meaning in the physician's handwriting, only the listed drug copayment will be applicable.

This is a brief description of your Health Net Pharmacy benefits. Please refer to your Evidence of Coverage to determine the specific benefits, limitations, exclusions and all other terms and conditions of coverage.

PLAN DISCLAIMER

BENEFIT SCHEDULE 2

This Schedule of Benefits is a brief list of benefits, with applicable copayments, coinsurance and deductibles information for your health insurance plan. It does not list the exclusions and limitations or other important terms applicable to your insurance plan.

The Certificate of Insurance (COI) for your insurance plan contains the complete terms and conditions of your Health Net Life Insurance Company coverage. It is important for you to thoroughly review the COI for your insurance plan.

Health Net Large Group PPO (NG) Plan 4MD - Effective 1/1/2011	**PPO**	**OON** Member pays coinsurance and any charges exceeding RBRVS.
Note: All services are subject to the deductible, unless otherwise noted. The member must satisfy the calendar-year deductible before benefit payment begins.		
PROFESSIONAL SERVICES		
Visit to a physician, physician assistant or nurse practitioner.	$10 ded waived	30%
Preventive care		
Child (through age 16). Includes annual preventive physical examinations, preventive vision/hearing screenings and preventive laboratory tests and x-rays.	$0 ded waived	Not covered
Adult (age 17 and older). Includes annual preventive physical examinations, preventive vision/hearing screenings, well-woman exam and preventive laboratory tests and x-rays. Refer to Introduction pages for list of covered services.	$0 ded waived	Not covered
Annual routine physical examinations provided for employment, school, camp or sports. Limited to a maximum of $250 each calendar year.	$10	Not covered
Vision examinations for refractive eye exams. Children through age 16.	$10 ded waived	Not covered
Adult (age 17 and older).	Not covered	Not covered
Hearing examinations for hearing loss. Children through age 16.	$10 ded waived	Not covered
Adult (age 17 and older).	Not covered	Not covered
Specialist consultations (includes second surgical opinions). For preventive services, refer to preventive care above.	$10 ded waived	30%
Physician visit to member's home (at discretion of physician).	10%	30%
Immunizations (**except** foreign travel/occupational purposes, refer below).	$0 ded waived	Not covered
Immunizations for foreign travel/occupational purposes.	Not covered	Not covered
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	10%	30%
Allergy testing.	$10 ded waived	30%
Allergy serum.	10%	30%
Allergy injection services (serum not included).	$10 ded waived	30%
Injections for treatment of infertility. Deductible required.	10% ◆	30% ◆
All other injections. Only self-injectables require certification by Health Net Pharmacy. Refer to the Introduction pages and the ⌘ for additional information.	$10 ded waived	30%
Surgeon/ assistant surgeon. Only specified procedures require certification. Refer to the Introduction pages and the ⌘ for additional information.	10%	30%
Administration of anesthetics.	10%	30%
X-ray and laboratory procedures. Only specified procedures require certification. Refer to the Introduction pages and the ⌘ for additional information. Preventive x-ray/lab, refer to preventive care above.	10%	30%
Physical, speech, occupational and respiratory therapy. Only specified procedures require certification. Refer to the Introduction pages and the ⌘ for additional information. Visit maximum combined for all therapies.	10%	30% Combined limit of 20 visits (PPO/OON) ✞
Dental services (when medically necessary to properly monitor, control or treat a severe medical condition when excluded dental services are being performed).	10%	30%
CARE FOR CONDITIONS OF PREGNANCY		
Prenatal and postnatal office visit.	GLOBAL FEES REQUIRED	
Normal delivery, Cesarean section. Includes newborn inpatient professional care. ⌘	10%	30%
Complications of pregnancy including medically necessary abortions. ⌘	10%	30%
Elective abortions.	10%	30%
Genetic testing of fetus.	10%	30%
Circumcision of newborn.	10%	30%
FAMILY PLANNING (professional services only)		
Contraceptive devices - intrauterine device (IUD).	10%	30%
Infertility services (including professional services, inpatient and outpatient care, and treatment by injection). **Excludes** coverage of artificial insemination. Deductible required.	10% ◆	30%◆
Sterilization of females.	10%	30%
Sterilization of males.	10%	30%
Reversal of sterilization.	Not covered	Not covered

Health Net Large Group PPO - (NG) Plan 4MD	PPO	OON Member pays coinsurance and any charges exceeding RBRVS.
Note: All services are subject to the deductible, unless otherwise noted. The member must satisfy the calendar-year deductible before benefit payment begins.		
CARE FOR MENTAL DISORDERS		
Severe Mental Illnesses Severe mental illnesses include the following conditions: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder (autism), anorexia nervosa, bulimia nervosa, and serious emotional disturbances in children (under age 18).		
Outpatient mental visit for severe mental illness. Includes intensive outpatient care or partial hospitalization / day treatment.	$10 ded waived	30%
Inpatient care in a hospital or residential treatment facility for severe mental illness. Through OON, limited to a maximum allowable amount of $600 each day. ⌘	10%	30%
Physician visit to hospital or residential treatment facility for severe mental illness.	10%	30%
Other Mental Illnesses (Non-severe mental illnesses)		
Outpatient mental visit for non-severe mental illness. Includes intensive outpatient care or partial hospitalization / day treatment.	$10 ded waived	30%
Inpatient care in a hospital or residential treatment facility for non-severe mental illness. Through OON, the maximum amount allowable is $600 each day. ⌘	10%	30%
Physician visit to hospital or residential treatment facility for non-severe mental illness.	10%	30%
CHEMICAL DEPENDENCY REHABILITATION		
Outpatient consultation (therapy, counseling and/or psychological testing) in an outpatient chemical dependency rehabilitation facility. Includes intensive outpatient care or partial hospitalization / day treatment.	$10 ded waived	30%
Detoxification (acute care for substance abuse). Through OON, the maximum amount allowable is $600 each day. ⌘	10%	30%
Inpatient rehabilitation for chemical dependency in a hospital or residential chemical dependency facility. Through OON, the maximum amount allowable is $600 each day. ⌘	10%	30%
OTHER SERVICES		
Medical social services.	10%	30%
Patient education for diabetics only.	10%	30%
Air ambulance. ⌘	10%	30%
Ground ambulance.	10%	30%
Durable medical equipment. ⌘	10%	30% Combined limit of $2,000 (PPO/OON)
Orthotics (braces and supports).	10%	30%
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).	10%	30%
Diabetic supplies (refer to the Introduction section for additional information).	10%	30%
Hearing aids.	Not covered	Not covered
Prosthesis (replacing body parts). ⌘	10%	30%
Acupuncture. Through PPO/OON, the maximum amount payable for each visit is $25.	$10 ded waived	30% Combined limit of 20 visits (PPO/OON)

⌘	These services require prior certification before being provided or received. If prior certification is not acquired, benefits are reduced to 50%. In addition, for **uncertified outpatient services**, a $50 deductible is required for each visit; for **uncertified inpatient admissions**, a $250 deductible is required for each inpatient admission. Refer to the Certification lists located in the Introduction section to determine the appropriate list to utilize and for additional information. **NOTE:** Routine care for conditions of pregnancy and renal dialysis do not require prior certification. However, notification is requested.
◆	Infertility services, supplies, injections and medications, are subject to a lifetime deductible of $500 and limited to a lifetime maximum benefit of $2,000. This maximum is combined through PPO and OON. **Note**: artificial insemination is not a covered benefit.
✞	Additional visits are payable if precertified as medically necessary following neurological and orthopedic surgery, cerebral cardiovascular accident, third degree burns, head trauma or spinal cord injuries.

Health Net Large Group PPO - (GF) Plan 4MD	PPO	OON Member pays coinsurance and any charges exceeding RBRVS.
Note: All services are subject to the deductible, unless otherwise noted. The member must satisfy the calendar-year deductible before benefit payment begins.		
OTHER SERVICES (continued)		
Chiropractic care. Through PPO/OON, the maximum amount payable for each visit is $25.	$10 ded waived	30% Combined limit of 20 visits (PPO/OON)
Blood and blood products.	10%	10%
Nuclear medicine (professional services only).	10%	30%
Organ and bone marrow transplants (non-experimental and noninvestigative. Professional services only.) ⌘	10%	Not covered
Chemotherapy or radiation therapy (professional services only).	10%	30%
Renal dialysis (professional services only). ⌘	10%	30%
Home health visit. Each day of care is limited to a maximum payment of $110 (PPO & OON). ⌘	10%	30%
Infusion therapy (home or physician's office). Through OON, limited to a maximum allowable amount of $500 each day. ⌘	10%	30%
Hospice care (elected by member). ⌘	10%	30%
HOSPITAL AND SKILLED NURSING FACILITY		
Unlimited days of hospital care in a semi-private room or ICU with ancillary services. Excludes care for mental disorders. Through OON, this benefit is limited to a maximum allowable amount of $600 a day. ⌘	10%	30%
Confinement for infertility services. Through OON, this benefit is limited to a maximum allowable amount of $600 a day. Deductible required. ⌘	10% ◆	30% ◆
Confinement in a skilled nursing facility. Through OON, this benefit is limited to a maximum allowable amount of $250 a day. ⌘	10%	30% Unlimited days
Maternity care. Includes routine nursery charges. Through OON, this benefit is limited to a maximum allowable amount of $600 a day. ⌘	10%	30%
Outpatient services. Only specified procedures require certification. Refer to the Introduction pages and the ⌘ for additional information.		
Outpatient services other than surgery. Through OON, the maximum allowable amount is 50% of billed charges.	10%	30%
Outpatient surgery at hospital or ambulatory surgical center. Through OON, the maximum allowable amount is 50% of billed charges.	10%	30%
EMERGENCY ROOM / URGENT CARE CENTER		
Note: For all services which meet the criteria for emergency care, the coinsurance will be the percentage shown for PPO, even if the services were received from an OON provider. The member must request certification for inpatient hospital or outpatient emergency room or urgent care center services within 48 hours, or as soon as reasonably possible. Health Net Life will determine whether services meet the criteria for emergency care.		
Use of emergency room (facility and professional services).	10% ❄	30% ❄
Use of urgent care center (facility and professional services).	10% ❄	30% ❄

⌘	These services require prior certification before being provided or received. If prior certification is not acquired, benefits are reduced to 50%. In addition, for **uncertified outpatient services**, a $50 deductible is required for each visit; for **uncertified inpatient admissions**, a $250 deductible is required for each inpatient admission. Refer to the Certification lists located in the Introduction section to determine the appropriate list to utilize and for additional information. **NOTE:** Routine care for conditions of pregnancy and renal dialysis do not require prior certification. However, notification is requested.
❄	An additional $100 emergency room or urgent care deductible is required if the member is not admitted as an inpatient. The deductible is waived if admitted.
◆	Infertility services, supplies, injections and medications, are subject to a lifetime deductible of $500 and limited to a lifetime maximum benefit of $2,000. This maximum is combined through PPO and OON. **Note**: artificial insemination is not a covered benefit.

CALENDAR YEAR DEDUCTIBLES	CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOPM)	LIFETIME BENEFIT MAXIMUM
$250 per member (PPO) $500 per member (OON) Three family members must satisfy their individual deductibles to satisfy the family deductible.	$2,000 for each member (PPO) $6,000 for each member (OON) **Note:** Mental health services (severe, non-severe & chemical dependency rehabilitation) apply to OOPM.	Unlimited Maximum medical and mental health/ substance abuse payments.

HEALTH NET PPO PHARMACY BENEFITS

The following is a brief description of your Health Net Pharmacy benefits.

RETAIL COPAYMENTS

drug type	description	Participating pharmacy copayment	non-participating pharmacy copayment
Level I – Generic drugs	Drugs listed on the Health Net Recommended Drug List (primarily generic)	$10	$10 + 50% AWP
Level II – Brand, preferred	Drugs and diabetic supplies (including insulin) listed on the Health Net Recommended Drug List (primarily brand name)	$15	$15 + 50% AWP
Level III	Drugs not on the Health Net Recommended Drug List	$35	$35 + 50% AWP

PRESCRIPTIONS BY MAIL

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period of time), you have the option of filling it through our convenient and cost-saving Prescriptions By Mail Drug Program. Under this program, your copayments for up to a 90-day supply are: **$20 level I / $30 level II / $70 level III**. For complete information, log on as a Health Net member at www.healthnet.com > *View prescription coverage > Get prescriptions by mail* or call Member Services at **1-800-676-6976**.

GENERIC SUBSTITUTIONS

Generic drugs will be dispensed when a generic drug equivalent is commercially available. If you request a brand name drug when a generic equivalent is commercially available, you must pay the difference between the generic equivalent and the brand name drug in addition to the listed copayments or coinsurance. However, if the prescription drug order states "dispense as written," "do not substitute" or words of similar meaning in the physician's handwriting, only the listed drug copayment will be applicable.

This is a brief description of your Health Net Pharmacy benefits. Please refer to your Certificate of Insurance to determine the specific benefits, limitations, exclusions and all other terms and conditions of coverage.

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BENEFIT SCHEDULE 3

SCHEDULE OF BENEFITS

Chiropractic/Acupuncture Standard Benefit

Your Employer Group has contracted with Landmark Healthplan of California, Inc. (Landmark) to provide you with a combined chiropractic and acupuncture benefit that requires the use of Participating Chiropractors and Acupuncturists. You can obtain a directory of Participating Chiropractors and Acupuncturists through your employer, plan administrator, or Landmark. You may also call Landmark's Customer Service Department at **1-800-638-4557** for referrals to Participating Practitioners in your area.

FREE LANGUAGE ASSISTANCE IS AVAILABLE

If you need help in understanding your Landmark chiropractic or acupuncture benefits or need help to handle an issue about your benefits, please contact Landmark's Customer Service Department at 1-800-638-4557 between 5:30 AM and 5 PM, Monday through Friday, for free help. We can also help you in languages other than English.

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

Landmark Healthplan of California, Inc.
Attn: QM Dept. - SURVEY
1750 Howe Avenue, Suite 300
Sacramento, CA 95825

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

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

A. Covered Services

1. Chiropractic Treatment of Injury or Illness

Covered Chiropractic Services are those within the scope of chiropractic care that are supportive or necessary to help Members achieve the physical state enjoyed before an injury or illness, and that are determined by Landmark to be Medically Necessary, are pre-authorized by Landmark, and are generally furnished for the diagnosis and/or treatment of a neuromusculoskeletal condition associated with an injury or illness, including the following:

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

2. Acupuncture Treatment of Injury or Illness

Covered Acupuncture Services are those within the scope of acupuncture care that are pre-authorized by Landmark, and are supportive and Medically Necessary for the treatment of neuromusculoskeletal pain resulting from an injury or illness, or for the treatment of uncomplicated asthma (that which is not effected by another condition or disease), allergies, post-operative or chemotherapy nausea and vomiting, nausea of pregnancy, post-operative (including dental) pain, fi-

bromyalgia, headaches and low-back pain. Services include the following:

- Acupuncture
- Electro-acupuncture
- Moxibustion
- Cupping
- Acupressure, only when acupuncture is contraindicated

3. Durable Medical Equipment (DME)

DME is covered up to the annual maximum benefit amount when it is Medically Necessary, is prescribed by a Participating Chiropractor, is pre-authorized by Landmark, and is not prescribed solely for the comfort or convenience of the patient.

Covered DME includes: crutches or canes; cervical collar (hard and soft); cervical pillow; cervical traction unit; hot/cold packs; electric hot pads (dry and moist); exercise tubing and gym balls; lumbar roll or cushion; lumbar supports and belts; orthotics, wedges or lifts (full sole and heel); rib belts; supports, splints, slings and braces for wrists, elbows, shoulders, ankles, knees, hips, fingers and thumbs; and trochanter belts.

4. Acupuncture Herbal Therapies

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

5. Initial Visit

Pre-authorization is not required for a Member's initial visit, which consists of an examination by the Participating Practitioner and may be followed by treatment. However, any subsequent treatments and/or services require pre-authorization from Landmark to be obtained by the Participating Practitioner.

6. Emergency Services

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

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

B. Second Opinions and Referrals

1. Second opinions

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

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

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

C. Limitations and Exclusions[1]

Circumstances Causing Services to be Excluded or Limited

1. Services provided by a Non-Participating Practitioner, except for emergencies, or as authorized by Landmark
2. Services provided outside of Landmark's Service Area, except for emergencies
3. Services that are not pre-authorized, except for initial visits or emergencies

[1]If your employer has purchased a Supplemental Rider, certain of the exclusions and limitations listed here may not apply to the additional services covered under the Supplemental Rider.

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

Specific Services that are Excluded or Limited

1. Services for preventive, maintenance, or wellness care
2. Experimental or investigational services
3. Services not Medically Necessary as determined by Landmark
4. Vocational, stroke, or long-term rehabilitation
5. Hypnotherapy, behavior training, sleep therapy, or biofeedback
6. Rental or purchase of Durable Medical Equipment (DME), except as specified in the Schedule of Benefits
7. Treatment primarily for purposes of weight control
8. Lab services
9. Thermography, hair analysis, heavy metal screening, or mineral studies
10. Transportation costs, including ambulance charges
11. Inpatient services
12. Massage or soft-tissue techniques
13. Advanced diagnostic services, such as MRI, CT, EMG, SEMG, and NCV

Chiropractic Only Limitations/Exclusions

1. Drugs, vitamins, nutritional supplements, or herbs
2. Manipulation under anesthesia
3. Services related to diagnosis and treatment of jaw joint or TMJ disorders
4. Treatment of non-neuromusculoskeletal disorders
5. X-rays not considered Medically Necessary or performed on equipment not certified, registered or licensed by the State of California

Acupuncture Only Limitations/Exclusions

1. Drugs, vitamins, nutritional supplements, or herbs, except as specified in the Schedule of Benefits
2. X-rays of any kind
3. Services related to menstrual cramps
4. Services related to addiction, including smoking cessation

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deltadentalins.com

Welcome to DeltaCare USA - quality, convenience, predictable costs

DeltaCare USA (administered by Delta Dental Insurance Company) provides you and your family with quality dental benefits at an affordable cost. The DeltaCare USA program is designed to encourage you and your family to visit the dentist regularly to maintain your dental health.

When you enroll, you select a contract dentist to provide services. The DeltaCare USA network consists of private practice dental facilities that have been carefully screened for quality.

Enroll in DeltaCare USA and you'll enjoy these features:

Quality

- Extensive benefits for you and your family
- No restrictions on pre-existing conditions covered, except for work in progress
- Large, stable network of dentists, so you can enjoy a long-term relationship with your dentist

Convenience

- No claim forms to complete
- Easy access to specialty care
- Expanded business hours for toll-free customer service, from 5 a.m. to 6 p.m., Pacific time

Predictable costs

- No deductibles
- Out-of-pocket costs are clearly defined
- Out-of-area dental emergency coverage up to $100 per emergency
- No annual or lifetime dollar maximums except for accidental injury

DELTA DENTAL

Administered by Delta Dental Insurance Company

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What if I have questions about my DeltaCare USA Program?

Eligibility for you and your family

If you meet your group's eligibility requirements for dental coverage, you can enroll in the DeltaCare USA program. You may also enroll eligible dependents. Contact your benefits administrator if you have any questions.

Easy enrollment

Simply complete the enrollment process as directed by your benefits administrator. Be sure to indicate a dentist (from the list of contract dental facilities) for both yourself and your eligible dependents. Include the name of your group.

How your DeltaCare USA program works

Your selected contract dentist will take care of your dental care needs. If you require treatment from a specialist, your contract dentist will handle the referral for you.

After you have enrolled, you will receive a Delta Dental membership packet that includes an identification card and an Evidence of Coverage booklet that fully describes the benefits of your dental program. Also included in this packet are the name, address and phone number of your contract dentist. Simply call the dental facility to make an appointment.

Under the DeltaCare USA program, many services are covered at no cost, while others have copayments (amount you pay your contract dentist) for certain benefits. See the "Description of Benefits and Copayments" for a list of your benefits.

Please note: Dental services that are not performed by your selected contract dentist, or are not covered under provisions for emergency care below, must be preauthorized by Delta Dental to be covered by your DeltaCare USA program.

Provisions for emergency care

Under your DeltaCare USA program, you and your eligible dependents are covered for out-of-network dental emergencies. Your program pays up to $100 for out-of-network emergency dental expenses per emergency for each enrollee.

My dentist is a Delta Dental dentist but is not on the list of DeltaCare USA dentists. Can I still receive treatment from this dentist?

You must receive treatment from your selected DeltaCare USA contract dentist. Please note that Delta Dental dentists are not necessarily DeltaCare USA dentists. With more than 3,800 general and specialist dentists, the DeltaCare USA network is one of the largest dental networks in California.

Do my family members receive treatment from the same DeltaCare USA contract dentist?

You and your eligible dependents may receive care from the same contract dentist, or if you prefer, you may collectively select up to a maximum of three individual contract dental facilities.

Can I change my contract dentist?

You may change contract dentists by notifying us either by phone or in writing, or by visiting our website (deltadentalins.com). If you contact us by the 21st of the month, the change will become effective the first of the following month.

How long does it take to get an appointment with a DeltaCare USA dentist?

Two to four weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time, you may have to wait longer. Most DeltaCare USA dentists are in private group practices, which means greater appointment availability and extended office hours.

Are pre-existing dental conditions and work in progress covered?

Treatment for pre-existing conditions, such as extracted teeth, is covered under the DeltaCare USA program. However, benefits are not provided for any dental treatment started before joining the program (that is, work in progress, such as preparations for crowns, root canals and impressions for dentures). Orthodontic treatment in progress may be covered for new DeltaCare USA enrollees. See the "Limitations and Exclusions of Benefits."

How does the DeltaCare USA program encourage preventive care?

Your DeltaCare USA program is designed to encourage regular visits to the dentist by having no copayments (fees you pay to the contract dentist) on most diagnostic and preventive benefits. See the enclosed "Description of Benefits and Copayments."

Does my DeltaCare USA program cover specialists' services?

Your contract dentist will coordinate your specialty care needs for oral surgery, endodontics, periodontics or pediatric dentistry with an approved contract specialist. If there is no contract specialist within your service area, a referral to an out-of-network specialist will be authorized at no extra cost, other than the applicable copayment. If you or your dependent is assigned to a dental school clinic for specialty services, those services may be provided by a dentist, a dental student, a clinician or a dental instructor.

What if I have questions about my DeltaCare USA program?

Call Delta Dental Customer Service at 800-422-4234. We have multilingual representatives available from 5 a.m. to 6 p.m. Pacific time, Monday through Friday. Our Customer Service representatives have worked in dental facilities and can answer benefits questions, as well as arrange facility transfers and urgent care referrals.

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SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as CDT-2011 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0210	Intraoral *radiographs* - complete series (including bitewings) - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
D0270	Bitewing *radiograph* - single film	No Cost
D0272	Bitewings *radiographs* - two films	No Cost
D0273	Bitewings *radiographs* - three films	No Cost
D0274	Bitewings *radiographs* - four films - *limited to 1 series every 6 months*	No Cost
D0330	Panoramic film	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost
D1000-D1999	**II. PREVENTIVE**	
D1110	Prophylaxis *cleaning* - adult - *1 per 6 month period*	No Cost
D1120	Prophylaxis *cleaning* - child - *1 per 6 month period*	No Cost
D1203	Topical application of fluoride - child - *to age 19; 1 per 6 month period*	No Cost
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients - *child to age 19; 1 per 6 month period*	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1510	Space maintainer - fixed - unilateral	$15.00
D1515	Space maintainer - fixed - bilateral	$15.00
D1520	Space maintainer - removable - unilateral	$15.00
D1525	Space maintainer - removable - bilateral	$15.00
D1550	Re-cementation of space maintainer	No Cost
D1555	Removal of fixed space maintainer	No Cost
D2000-D2999	**III. RESTORATIVE**	
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.		
D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost

D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior [1, 2]	Optional
D2392	Resin-based composite - two surfaces, posterior [1, 2]	Optional
D2393	Resin-based composite - three surfaces, posterior [1, 2]	Optional
D2394	Resin-based composite - four or more surfaces, posterior [1, 2]	Optional
D2510	Inlay - metallic - one surface [3, 4]	No Cost
D2520	Inlay - metallic - two surfaces [3, 4]	No Cost
D2530	Inlay - metallic - three or more surfaces [3, 4]	No Cost
D2542	Onlay - metallic - two surfaces [3, 4]	No Cost
D2543	Onlay - metallic - three surfaces [3, 4]	No Cost
D2544	Onlay - metallic - four or more surfaces [3, 4]	No Cost
D2610	Inlay - porcelain/ceramic - one surface [2, 4]	Optional
D2620	Inlay - porcelain/ceramic - two surfaces [2, 4]	Optional
D2630	Inlay - porcelain/ceramic - three or more surfaces [2, 4]	Optional
D2642	Onlay - porcelain/ceramic - two surfaces [2, 4]	Optional
D2643	Onlay - porcelain/ceramic - three surfaces [2, 4]	Optional
D2644	Onlay - porcelain/ceramic - four or more surfaces [2, 4]	Optional
D2650	Inlay - resin-based composite - one surface [2, 4]	Optional
D2651	Inlay - resin-based composite - two surfaces [2, 4]	Optional
D2652	Inlay - resin-based composite - three or more surfaces [2, 4]	Optional
D2662	Onlay - resin-based composite - two surfaces [2, 4]	Optional
D2663	Onlay - resin-based composite - three surfaces [2, 4]	Optional
D2664	Onlay - resin-based composite - four or more surfaces [2, 4]	Optional
D2710	Crown - resin-based composite (indirect) [4, 5]	$45.00
D2712	Crown - ¾ resin-based composite (indirect) [4, 5]	$45.00
D2720	Crown - resin with high noble metal [3, 4, 5]	$75.00
D2721	Crown - resin with predominantly base metal [4, 5]	$75.00
D2722	Crown - resin with noble metal [4, 5]	$75.00
D2740	Crown - porcelain/ceramic substrate [4, 5]	$75.00
D2750	Crown - porcelain fused to high noble metal [3, 4, 5]	$75.00
D2751	Crown - porcelain fused to predominantly base metal [4, 5]	$75.00
D2752	Crown - porcelain fused to noble metal [4, 5]	$75.00
D2780	Crown - ¾ cast high noble metal [3, 4]	$75.00
D2781	Crown - ¾ cast predominantly base metal [4]	$75.00
D2782	Crown - ¾ cast noble metal [4]	$75.00
D2790	Crown - full cast high noble metal [3, 4]	$75.00
D2791	Crown - full cast predominantly base metal [4]	$75.00
D2792	Crown - full cast noble metal [4]	$75.00
D2794	Crown - titanium [3, 4]	$75.00
D2910	Recement inlay, onlay or partial coverage restoration	No Cost
D2915	Recement cast or prefabricated post and core	No Cost
D2920	Recement crown	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - *anterior primary tooth*	$10.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$10.00
D2940	Protective restoration	$10.00
D2950	Core buildup, including any pins	$10.00
D2951	Pin retention - per tooth, in addition to restoration	$10.00

D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation* [3]	$10.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation* [3]	$10.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$10.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$10.00
D2970	Temporary crown (fractured tooth) - *palliative treatment only*	$5.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$15.00
D2980	Crown repair, by report	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	$7.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$7.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$7.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration) [6]	$40.00
D3320	*Root canal* - endodontic therapy, bicuspid tooth (excluding final restoration) [6]	$80.00
D3330	*Root canal* - endodontic therapy, molar (excluding final restoration) [6]	$120.00
D3346	Retreatment of previous root canal therapy - anterior [6]	$55.00
D3347	Retreatment of previous root canal therapy - bicuspid [6]	$95.00
D3348	Retreatment of previous root canal therapy - molar [6]	$135.00
D3410	Apicoectomy/periradicular surgery - anterior [6]	$50.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root) [6]	$50.00
D3425	Apicoectomy/periradicular surgery - molar (first root) [6]	$50.00
D3426	Apicoectomy/periradicular surgery (each additional root) [6]	No Cost
D3430	Retrograde filling - per root [6]	$50.00
D3450	Root amputation, per root - *not covered in conjunction with a hemisection* [6]	No Cost

D4000-D4999 V. PERIODONTICS

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$100.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$20.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$100.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$100.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$200.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$200.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$10.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$10.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months*	$10.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$8.00

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110	Complete denture - maxillary [7, 8]	$95.00
D5120	Complete denture - mandibular [7, 8]	$95.00
D5130	Immediate denture - maxillary [7, 8]	$110.00
D5140	Immediate denture - mandibular [7, 8]	$110.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) [7, 8]	$105.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) [7, 8]	$105.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [7, 8]	$110.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [7, 8]	$110.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) [7, 8]	$160.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth) [7, 8]	$160.00
D5410	Adjust complete denture - maxillary [7]	$5.00
D5411	Adjust complete denture - mandibular [7]	$5.00
D5421	Adjust partial denture - maxillary [7]	$5.00
D5422	Adjust partial denture - mandibular [7]	$5.00
D5510	Repair broken complete denture base	$15.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$10.00
D5610	Repair resin denture base	$15.00
D5620	Repair cast framework	$15.00
D5630	Repair or replace broken clasp	$15.00
D5640	Replace broken teeth - per tooth	$10.00
D5650	Add tooth to existing partial denture	$10.00
D5660	Add clasp to existing partial denture	$10.00
D5710	Rebase complete maxillary denture [9]	$40.00
D5711	Rebase complete mandibular denture [9]	$40.00
D5720	Rebase maxillary partial denture [9]	$40.00
D5721	Rebase mandibular partial denture [9]	$40.00
D5730	Reline complete maxillary denture (chairside) [9]	$20.00
D5731	Reline complete mandibular denture (chairside) [9]	$20.00
D5740	Reline maxillary partial denture (chairside) [9]	$20.00
D5741	Reline mandibular partial denture (chairside) [9]	$20.00
D5750	Reline complete maxillary denture (laboratory) [9]	$40.00
D5751	Reline complete mandibular denture (laboratory) [9]	$40.00
D5760	Reline maxillary partial denture (laboratory) [9]	$40.00
D5761	Reline mandibular partial denture (laboratory) [9]	$40.00
D5820	Interim partial denture (maxillary) - *limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing* [7]	No Cost
D5821	Interim partial denture (mandibular) - *limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing* [7]	No Cost
D5850	Tissue conditioning, maxillary [7, 9]	No Cost
D5851	Tissue conditioning, mandibular [7, 9]	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

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

D6210	Pontic - cast high noble metal [3, 10]	$75.00
D6211	Pontic - cast predominantly base metal [10]	$75.00
D6212	Pontic - cast noble metal [10]	$75.00
D6240	Pontic - porcelain fused to high noble metal [3, 5, 10]	$75.00
D6241	Pontic - porcelain fused to predominantly base metal [5, 10]	$75.00
D6242	Pontic - porcelain fused to noble metal [5, 10]	$75.00
D6245	Pontic - porcelain/ceramic [2, 10]	Optional
D6250	Pontic - resin with high noble metal [3, 5, 10]	$75.00
D6251	Pontic - resin with predominantly base metal [5, 10]	$75.00
D6252	Pontic - resin with noble metal [5, 10]	$75.00
D6600	Inlay - porcelain/ceramic, two surfaces [2, 10]	Optional
D6601	Inlay - porcelain/ceramic, three or more surfaces [2, 10]	Optional
D6602	Inlay - cast high noble metal, two surfaces [3, 10]	No Cost
D6603	Inlay - cast high noble metal, three or more surfaces [3, 10]	No Cost

D6604	Inlay - cast predominantly base metal, two surfaces [10]	No Cost
D6605	Inlay - cast predominantly base metal, three or more surfaces [10]	No Cost
D6606	Inlay - cast noble metal, two surfaces [10]	No Cost
D6607	Inlay - cast noble metal, three or more surfaces [10]	No Cost
D6608	Onlay - porcelain/ceramic, two surfaces [2, 10]	Optional
D6609	Onlay - porcelain/ceramic, three or more surfaces [2, 10]	Optional
D6610	Onlay - cast high noble metal, two surfaces [3, 10]	No Cost
D6611	Onlay - cast high noble metal, three or more surfaces [3, 10]	No Cost
D6612	Onlay - cast predominantly base metal, two surfaces [10]	No Cost
D6613	Onlay - cast predominantly base metal, three or more surfaces [10]	No Cost
D6614	Onlay - cast noble metal, two surfaces [10]	No Cost
D6615	Onlay - cast noble metal, three or more surfaces [10]	No Cost
D6720	Crown - resin with high noble metal [3, 5, 10]	$75.00
D6721	Crown - resin with predominantly base metal [5, 10]	$75.00
D6722	Crown - resin with noble metal [5, 10]	$75.00
D6740	Crown - porcelain/ceramic [2, 10]	Optional
D6750	Crown - porcelain fused to high noble metal [3, 5, 10]	$75.00
D6751	Crown - porcelain fused to predominantly base metal [5, 10]	$75.00
D6752	Crown - porcelain fused to noble metal [5, 10]	$75.00
D6780	Crown - ¾ cast high noble metal [3, 10]	$75.00
D6781	Crown - ¾ cast predominantly base metal [10]	$75.00
D6782	Crown - ¾ cast noble metal [10]	$75.00
D6790	Crown - full cast high noble metal [3, 10]	$75.00
D6791	Crown - full cast predominantly base metal [10]	$75.00
D6792	Crown - full cast noble metal [10]	$75.00
D6930	Recement fixed partial denture	No Cost
D6940	Stress breaker [10]	No Cost
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated - *includes canal preparation* [3]	$10.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer - *base metal post; includes canal preparation* [3]	$10.00
D6973	Core buildup for retainer, including any pins	$10.00
D6976	Each additional indirectly fabricated post - same tooth - *includes canal preparation* [3]	$10.00
D6977	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$10.00
D6980	Fixed partial denture repair, by report	$15.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - deciduous tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No Cost
D7220	Removal of impacted tooth - soft tissue	No Cost
D7230	Removal of impacted tooth - partially bony	$45.00
D7240	Removal of impacted tooth - completely bony	$65.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$65.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	$65.00
D7286	Biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$35.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$35.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost

D8000-D8999 XI. ORTHODONTICS

D8070 Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* [11] $1,600.00
D8080 Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* [11] $1,600.00
D8090 Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* [11] $1,800.00
D8660 Pre-orthodontic treatment visit - *not to be charged with any other consultation procedure(s)* [12] ..... No Cost
D8680 Orthodontic retention (removal of appliances, construction and placement of retainers) [13] ..... No Cost
D8999 Unspecified orthodontic procedure, by report - *includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding* $350.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110 Palliative (emergency) treatment of dental pain - minor procedure $5.00
D9211 Regional block anesthesia ..... No Cost
D9212 Trigeminal division block anesthesia ..... No Cost
D9215 Local anesthesia in conjunction with operative or surgical procedures ..... No Cost
D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician ..... No Cost
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed $5.00
D9440 Office visit - after regularly scheduled hours $20.00
D9450 Case presentation, detailed and extensive treatment planning ..... No Cost
D9999 Unspecified adjunctive procedure, by report - *includes failed appointment without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00* $10.00

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees."

"Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to Delta Dental's Customer Service department at 800-422-4234.

FOOTNOTES

1 *An amalgam is the benefit.*

2 *Optional is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the "filed fee" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits. "Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding the DeltaCare USA program should be directed to Delta Dental's Customer Service department at 800-422-4234.*

3 *Base or noble metal is the benefit. If a crown, pontic, inlay, onlay or indirectly fabricated post and core is made of high noble metal, an additional fee up to $100.00 per tooth will be charged for the upgrade. This charge also applies to a titanium crown.*

4 *Replacement is subject to a limitation requiring the existing restoration to be 5+ years old.*

5 *Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of $150.00.*

6 *A benefit for permanent teeth only.*

7 *Includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement, if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.*

8 *Replacement is subject to a limitation requiring the existing denture to be 5+ years old.*

9 *Limited to 1 per denture during any 12 consecutive months.*

10 *Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.*

11 *Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 (Start-up fee). Beyond 24 months of active treatment, an additional monthly fee of $75.00 applies.*

12 *In the event comprehensive orthodontic treatment is not required or is declined by the Enrollee, a fee of $25.00 will apply. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.*

13 *Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of $75.00 applies.*

SCHEDULE B

Limitations of Benefits

1. Full mouth x-rays are limited to one set every 24 consecutive months and include any combination of periapicals, bitewings and/or panoramic film.
2. Bitewing x-rays are limited to not more than one series of four films in any six month period.
3. Diagnostic casts are limited to aid in diagnosis by the Contract Dentist for covered benefits.
4. If a biopsy is preauthorized by Delta Dental for an oral surgeon, then examination of the resulting biopsy specimen is covered under codes D0472, D0473 or D0474 and available at no additional cost.
5. Prophylaxis or periodontal maintenance is limited to one procedure each six month period.
6. Benefits for sealants include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars through age nine and second molars through age 15. Benefits for sealants do not include the repair or replacement of a sealant on any tooth within three years of its application.
7. A filling is a benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
8. A crown is a benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five year limitation (Limitation #12).
9. A covered metallic inlay, onlay, crown or fixed partial denture (bridge) using base or noble metal is available for listed Copayment(s). If the Enrollee elects to have high noble metal used instead, the maximum additional cost of this material upgrade is $100.00 per tooth or pontic. For an indirectly fabricated post and core, the benefit is for base or noble metal. If the Enrollee elects to have a high noble metal indirectly fabricated post and core instead, the maximum additional cost of this material upgrade is $100.00 per tooth.
10. For molars, a covered inlay, onlay, crown, or unit of a fixed partial denture (bridge) is metallic without porcelain or other tooth-colored material. If the Enrollee elects to have porcelain, porcelain-fused-to-metal, resin or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is $150.00 per molar.
11. If a porcelain margin is also chosen by the Enrollee for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is $75.00.
12. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:
    a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**
    b. Either of the following:
        - The existing non-functional restoration/bridge/denture was placed five or more years prior to its replacement, **or**
        - If an existing partial denture is less than five years old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
13. A direct or indirect pulp cap is a benefit only on a vital permanent tooth with an open apex or a vital primary tooth.
14. With the exception of pulp caps and pulpotomies, endodontic procedures (e.g. root canal therapy, apicoectomy, retrofill, etc.) are only a benefit on a permanent tooth.
15. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.
16. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
17. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.
18. Coverage for the placement of a fixed partial denture (bridge) or removable partial denture:
    a. Fixed partial denture (bridge):
        - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, **or**
        - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics (see Limitation #12) **or**
        - Each abutment tooth to be crowned meets Limitation #8.
    b. Removable partial denture:
        - Cast metal (D5213, D5214), one or more teeth are missing in an arch.
        - Resin based (D5211, D5212), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease (see Limitation #12).

19. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.
20. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to:
    - The replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture **or**
    - The replacement of permanent tooth/teeth for children under 16 years of age.
21. Retained primary teeth shall be covered as primary teeth.
22. Excision of the frenum is a benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.
23. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
24. In cases of accidental injury, benefits available are described in *Schedule B, Accident Injury Benefit.* Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function, exclusive attrition and normal wear, will be covered as described in *Schedules A, Description of Benefits and Copayments; and B, Limitations and Exclusions of Benefits.*
25. Soft tissue management programs include, but are not limited to, periodontal pocket charting, root planing, scaling, curettage, oral hygiene instruction, periodontal maintenance and/or prophylaxis. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter the benefit for covered services.
26. A new removable partial, complete or immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.
27. An Optional procedure is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the "filed fee" for the covered procedure, plus any applicable Copayment for the covered procedure.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments.*
2. Dental conditions arising out of and due to Enrollee's employment for which Workers' Compensation is paid. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.
3. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Dental expenses incurred in connection with any dental procedure started after termination of eligibility for coverage.
6. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, orthodontics, unless qualified for the orthodontic treatment in progress provision.
7. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.), except for the treatment of newborn children with congenital defects or birth abnormalities.
8. Dispensing of drugs not normally supplied in a dental facility.
9. Any procedure that in the professional opinion of the Contract Dentist:
    a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
    b. is inconsistent with generally accepted standards for dentistry.
10. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized in writing by Delta Dental or as cited under *Emergency Services.* To obtain written authorization, the Enrollee should call Delta Dental's Customer Service department at 800-422-4234.
11. Consultations for non-covered benefits.

12. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.

13. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.

14. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

15. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ).

16. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction under the DeltaCare USA program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not eliminate the benefit for other covered services.

17. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.

18. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions.

19. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.

Orthodontic Limitations

The DeltaCare USA program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The start-up fees and the cost to the Enrollee for the treatment plan are listed in *Schedule A, Description of Benefits and Copayments* and subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist.

2. Benefits cover 24 months of active comprehensive orthodontic treatment. Included is the initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustment to retainers and office visits for a maximum of two years.

3. Treatment plans extending beyond 24 months of active treatment, or 24 months of the retention phase of treatment will be subject to a monthly office visit fee to the Enrollee not to exceed $75.00 per month.

4. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not Delta Dental will be responsible for payment of any balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on a maximum of $2,800.00 for covered dependent children to age 19 and $3,000.00 for covered adults and dependent children to age 23. The amount will be prorated over the number of months to completion of the treatment and, will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Contract Orthodontist.

5. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation has been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of $25.00 in addition to diagnostic record fees.

6. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are benefits. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the Contract Orthodontist's "filed fees."

7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the Enrollee's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Contract Orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same Copayment amounts as for fixed appliances.

8. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records which include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances.
3. Retreatment of orthodontic cases.
4. Changes in treatment necessitated by accident of any kind.
5. Initial or continuing orthodontic treatment when such treatment would be inconsistent with generally accepted professional standards.
6. Surgical procedures incidental to orthodontic treatment.
7. Myofunctional therapy.
8. Surgical procedures related to cleft palate, micrognathia or macrognathia.
9. Treatment related to temporomandibular joint disturbances.
10. Supplemental appliances not routinely used in typical comprehensive orthodontics.
11. Restorative work caused by orthodontic treatment.
12. Phase I orthodontics, as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.
13. Extractions solely for the purpose of orthodontics.
14. Treatment in progress at inception of eligibility, unless qualified for the orthodontic treatment in progress provision.
15. Composite bands, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

Accident Injury Benefit

An accidental injury is damage to the hard and soft tissue of the mouth caused directly and independently of all other causes by external forces. Damage to the hard and soft tissue of the mouth from normal chewing function is covered under *Schedule A, Description of Benefits and Copayments*.

Delta Dental will pay up to 100 percent of the Contract Dentist's "filed fees," for expenses an Enrollee incurs for an accident injury, less any applicable Copayment(s), up to a Maximum of $1,600.00 in any 12 month period.

Accident injury benefits include the following procedure in addition to those listed in *Schedule A, Description of Benefits and Copayments*.

CODE

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus - includes splinting and/or stabilization.

Payment of accident injury benefits is subject to *Schedule B, Limitations and Exclusions of Benefits*, in addition to the following provisions:

MAXIMUM

Accident injury benefits will be provided for each Enrollee up to a maximum of $1,600.00 in any 12 month period.

LIMITATION

Accident injury benefits are limited to services provided as a result of an accident which occurred (a) while the Enrollee was covered under the DeltaCare USA program, or (b) while the Enrollee was covered under another DeltaCare USA program, and if the benefits for the expenses incurred would have been paid if the Enrollee had remained covered under that program.

EXCLUSIONS

In addition to *Schedule B*, limitations #13, #15, #20, #21 and #24 and exclusions #1-9, #11-15 and #18-20, the following exclusions apply:

1. Prophylaxis.

2. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
3. Replacement of existing restorations due to decay.
4. Orthodontic services (treatment of malalignment of teeth and/or jaws).
5. Replacement of existing restorations, crowns, bridges, dentures and other dental or orthodontic appliances damaged by accident injury.

"Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to Delta Dental's Customer Service department at 800-422-4234.

Free newsletter

Get the latest in oral health with *Dental Wire*, our bi-monthly e-mail newsletter. Sign up at: deltadentalins.com/oral_health.

DeltaCare USA Customer Service

800-422-4234
deltadentalins.com

NOTE: THIS IS ONLY A BRIEF SUMMARY OF THE PLAN.

The Group Dental Service Contract must be consulted to determine the exact terms and conditions of coverage. An Evidence of Coverage will be sent to you upon enrollment. **If you wish to review an Evidence of Coverage prior to enrollment, you may request a copy by calling the Customer Service department at 800-422-4234.**

In California, DeltaCare USA is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company. These companies are financially responsible for their own products.

Customer Service
800-422-4234
Monday through Friday
5 a.m. to 6 p.m., Pacific time

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

Administered by:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023

DELTA DENTAL

Delta Dental PPO℠ – Easy, Friendly, Accessible

We'll do **whatever it takes and then some.**

Greatest potential savings when you visit a Delta Dental PPO dentist

OUT-OF-POCKET COSTS

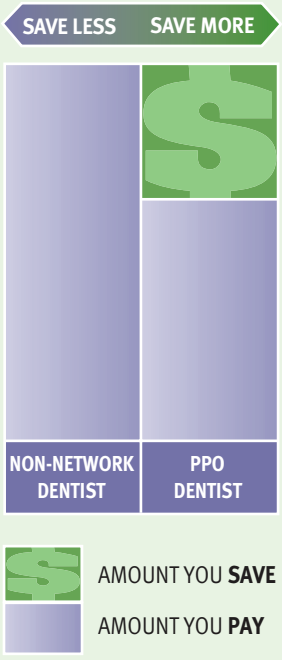

Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and by group contract.

We're pleased to be your partner in maintaining great oral health. The Delta Dental PPO* plan makes it easy for you to find a dentist, and easy to control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

- **Save money with a Delta Dental PPO dentist.** Our PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental dentists won't balance bill you the difference between the contracted amount and their usual fee.
- **Visit the dentist of your choice.** Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest when you see a PPO dentist.
- **Many network dentists to choose from.** Since Delta Dental offers access to some of the largest dentist networks in the U.S., chances are there's a wide choice of network dentists near your home or office. Four out of five dentists nationwide are contracted Delta Dental dentists, giving more enrollees convenient access to more dentists. Visit us at www.deltadentalins.com to search our dentist directory by location or specialty.
- **Easy to use your benefits.** When you visit a Delta Dental dentist, pay only your portion for services. Delta Dental dentists will file claim forms for you and receive payment directly from us. Many non-Delta Dental dentists ask that you pay the entire cost up front and wait for reimbursement.
- **Delta Dental's Online Services make getting information quick and easy.** Access your benefits and eligibility, print ID cards and get information about your claims. And check out Delta Dental's oral health resources too for tips and information that can help keep your smile healthy.

** In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.*

DELTA DENTAL®

WE KEEP YOU SMILING®

HL_PPO_ENG_2col_BWL #60482 (9/10)

Plan Benefit Highlights for: Professional Musicians Local 47 & Employers Health & Welfare Fund

Group No: 1811 **Effective Date:** 1/1/2011

Eligibility	Primary enrollee, spouse(includes different-sex domestic partner only) and eligible dependent children to age 26	
Deductibles	$50 per person / $150 per family each calendar year	
Deductibles waived for D & P?	Yes	
Maximums	$1,500 per person each calendar year	
Waiting Period(s)	Basic Benefits N/A	Major Benefits N/A

Benefits and Covered Services*	**Delta Dental PPO dentists****	**Non-Delta Dental dentists****
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays	100 %	80 %
Basic Services Fillings, simple tooth extractions, sealants	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations, bridges and dentures	50 %	50 %
Implants	50 %	50 %
Implants Maximum	$ 1,500 Lifetime	$ 1,500 Lifetime

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

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

Delta Dental of California
100 First St.
San Francisco, CA 94105

Customer Service
800-765-6003

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

www.deltadentalins.com

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

HLT_PPO_2COL_DDC (Rev. 1 6/10)(Grp#1811 12/13/10 dh)

MES Vision

BENEFIT SCHEDULE 6 SUMMARY OF VISION BENEFITS

PROFESSIONAL MUSICIANS LOCAL 47 & EMPLOYERS HEALTH & WELFARE

Follow these simple steps:

1. **Select a provider.** Select a participating vision care provider by visiting www.MESVision.com. Obtaining services from a Participating Provider will maximize your benefits.
2. **Make an appointment.** Make an appointment with the Participating Provider of your choice and inform them of your vision coverage.
3. **You're done! Your doctor will take care of the rest.** The Participating Provider will contact MESVision to verify your eligible benefits and submit a claim for payment for services covered by your plan.
4. If covered services are received from a non-participating provider, you are responsible for paying the provider in full. You or the provider must submit the itemized bill and a copy of your prescription with the Claim Form to MES*Vision*. Reimbursement will be made to the insured person up to the schedule of allowances shown for non-participating providers.

LIMITATIONS

Contact Lenses and fitting except as specifically provided; Eyewear when there in no prescription change, except when benefits are otherwise available; Non-standard lenses, including, but not limited to; Progressive, Photochromic, hi-index, Polycarbonate, occupational lenses, beveled, faceted, coated or oversize; Tints other than pink or rose #1 or #2, except as specifically provided; Two pair of glasses in lieu of bifocals, unless prescribed; New-patient intermediate examinations: .When an Enrollee selects a different provider to perform the intermediate examination , the Enrollee will be responsible for the difference between the intermediate examination allowance and the comprehensive examination allowance. To maximize benefits, the patient should return to the original provider; Non-precription (Plano) eyewear, except when specifically covered.

EXCLUSIONS

Any eye examination required by the employer as a condition of employment; Any covered services provided by another vision plan; Conditions covered by Workers' Compensation; Contact lens insurance of care kits; Frame cases; Covered Services which began prior to the Enrollee's effective date or after benefits have been terminated; Charges for which the Enrollee is not legally obligated to pay; Covered Services required by any government agency or program federal, state or subdivision thereof; Covered Services performed by a Close Relative or by an individual who ordinarily resides in the Enrollee's home; Covered Services obtained from a Non-Participating Provider; Medical or Surgical treatment of the eyes; Orthoptics, vision training or Subnormal or Low Vision Aids; Services that are Experimental or Investigational in nature; Services for treatment directly related to any totally disabling condition, illness or injury; Lenses or frames which are lost, stolen or broken will not be replaced, except when benefits are otherwise available; In connection with war or any act of war whether declared or undeclared; a condition or accident occurring while on full-time active duty in the armed forces or any country or combination of countries.

This is a brief outline of the plan and is not to be accepted or construed as a substitute for the provisions of the contract.

Benefits:

Co-pay:	$5.00
Comprehensive Vision Exam:	One every 12 months
Lenses* (Standard)	One pair every 12 months
Frame:**	One frame every 12 months
Contact Lenses:***	One pair every 12 months

The Policy provides full coverage for Covered Services when you go to a Participating Provider of the MES*Vision* network. If Covered Services are provided by a Non-Participating Provider, charges will be paid, but not to exceed the following Schedule of Allowances.

*"Standard" lenses (plastic) fit any frame with an eye size less than 61mm.

	Participating Provider	Non-Participating Provider
Opthalmologic Examination	Covered	Up to $ 60.00
Optometric Examination	Covered	Up to $ 50.00
Single Vision Lenses*	Covered	Up to $ 43.00
Bifocal Lenses*	Covered	Up to $ 60.00
Trifocal Lenses*	Covered	Up to $ 75.00
Progressive Lenses	Up to $89.50	Up to $ 75.00
Polycarbonate Lenses****	Up to $85.00	Up to $ 55.00
Aphakic Monofocal	Covered	Up to $ 120.00
Aphakic Multifocal	Covered	Up to $ 200.00
Frame**	Covered	Up to $ 40.00
Contact Lenses ***		
Medically Necessary	Covered	Up to $ 250.00
Cosmetic or Convenience	Up to $105.00	Up to $ 100.00

** Participating Providers allow a selection of frames that retail up to **$75.00** with lenses that fit an eyesize less than 61 millimeters. If a more expensive frame is selected, you are responsible for the additional cost above **$75.00**. If the lenses received are 61 millimeters or above, the charge for the oversize lenses is your responsibility. Retail frame benefits will be converted to wholesale equivalent prices at certain provider locations, see our website or provider directory for further information.

*** This benefit is in addition to the comprehensive vision examination, but in lieu of lenses and frame. If contact lenses are for cosmetic or convenience purposes, the Policy will pay up to **$105.00** toward the contact lens evaluation, fitting costs and materials. Any balance is your responsibility. If contact lenses are medically necessary, they are a fully covered benefit. Approval from MESVision is required. Please refer to your Policy if you require additional information.

****For Dependent Children through age 18

Discounts: A 20% discount is available for cosmetic extras, such as tints, coatings and other add-on charges to standard lenses, after Covered Services are rendered. The discount may be applied to charges for the frame or contact lenses (except disposable or replacement contact lenses) over the stated allowances. The 20% discount also applies to additional pairs of glasses and/or pairs of standard contact lenses. To determine whether a provider offers the 20% discount, an insured individual can review their Participating Provider Directory, call MESVision or visit www.MESVision.com. Discounts are available through TLCVision for conventional and custom LASIK procedures with the TLCVision Advantage Program.

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

Underwritten By:

Gerber Life Insurance Company
A separate subsidiary of Gerber Products
Home Office: White Plains, NY 10605

BENEFIT SCHEDULE 7

Your Group Life Plan at a Glance

PROFESSIONAL MUSICIANS, LOCAL 47 EMPLOYER'S HEALTH & WELFARE FUND

Coverage(s)	Basic Employee Term Life, Accidental Death & Dismemberment (AD&D)
Group Contract/Control Number	#45588
Effective Date	January 1, 2008
Eligibility	Eligible Members who have qualified and are determined to be eligible by the Professional Musicians, Local 47 and Employers' Health and Welfare Board of Trustees
Contributions	Non-contributory
Basic Life/AD&D Coverage	Flat $20,000
Age Reductions	Age 70 reduces to 65% of pre-age 69 amount Age 75 reduces to 50% of pre-age 69 amount
Age Reductions Take Effect	Next policy anniversary date after birth date
Living Benefit Option (LBO)	80% to a max of $16,000
Life Expectancy (LBO)	12 months
Waiver of Premium	Prior to age 60, 6 month waiting period, age 65 duration
Conversion	Yes
☎Life Claims (800) 524-0542 / Fax (800) 778-4797	
☎Conversion Area (877) 889-2070	

Group Basic Term Life, Optional Term Life, Dependent Term Life, Accidental Death & Dismemberment, Optional Accidental Death & Dismemberment, and Business Travel Accident Insurance are underwritten by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. 800-524-0542. (Contract Series 83500 and 99444). This is a summary of benefits. It does not include all plan provisions, exclusions, and limitations. A Group Contract with complete plan information will be provided. If there is a discrepancy between this document and the Group Contract issued by Prudential, the terms of the Group Contract will govern. This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department. IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

Prudential Financial