LOCAL 802

MUSICIANS HEALTH PLAN

Summary Plan Description

2013 Edition

Local 802 Musicians Health Fund
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About This Booklet

This booklet is the Summary Plan Description ("SPD") for the Local 802 Musicians Health Plan. It replaces and supersedes any previous SPD that you received. The primary purpose of this booklet is to help you understand how the Plan works and provide you with a non-technical, summary explanation of the most important features of the Plan. We urge you to read it carefully so that you will understand the Plan as it applies to you and to your family. We also suggest that you share this booklet with your family, and that you keep it in a safe place for future reference. If you lose your copy, please feel free to ask the Local 802 Musicians Health Fund Office for another copy.

This booklet does not change or otherwise interpret other official Plan documents, including the Trust Agreement and collective bargaining agreements establishing the Plan as well as any applicable Certificates of Insurance issued by insurers. Your complete rights are determined by referring to this booklet and all of the other official Plan documents (which are available for your inspection at the Local 802 Musicians Health Fund Office).

Please note that no individuals other than the Board of Trustees of the Plan (and its designees) have any authority to interpret the Plan (including this Summary Plan Description and other official Plan documents), or to make any promises to you about it. In addition, the Plan's Board of Trustees reserves the right, in its sole and absolute discretion, to amend or end this Plan, in whole or in part, at any time and for any reason, subject to the terms of the applicable collective bargaining agreements. No benefits described in this booklet are guaranteed.

<u>Notice of "Grandfathered Status" Under the Affordable Care Act</u>

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

LOCAL 802 MUSICIANS HEALTH FUND

January 2013

Dear Musician:

We are pleased to provide you with this new Summary Plan Description (“SPD”) that describes the benefits available to you and your eligible Dependents under the Local 802 Musicians Health Fund (the "Fund" or "Plan”). The benefits described in this booklet are the result of the continuous efforts of the Board of Trustees (the “Trustees”) to furnish you with a program of benefits that will help meet your needs.

Don’t forget that coverage is financed primarily through Employer contributions made on your behalf under the terms of collective bargaining agreements negotiated by Local 802. Because many musicians work for multiple employers in a year, we ask that you be sure that contributions are being made on your behalf at all your jobs. (See page 10 for more details on eligibility and participation.)

We urge you to read this booklet carefully to familiarize yourself with benefits provided under the Plan. Share it with your family and keep it in a convenient location for future reference.

The Trustees work diligently to maintain high quality benefits; however, it must be recognized that general economic conditions, cessation of employer contributions and other factors beyond the Trustees’ control could affect the financial condition, capabilities and viability of the Fund. Please note that all benefits are subject to the terms of the Trust Agreement and the other official plan documents that establish and govern the Fund’s operations.

Sincerely,

Board of Trustees
Local 802 Musicians Health Fund

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YOUR BENEFITS AT A GLANCE

The Local 802 Musicians Health Fund offers four benefit options, with different Employer contribution requirements, for you and your eligible Dependents. These include:

- Plan A+ With Hospitalization
- Plan A+ (Without Hospitalization)
- Plan A
- Plan B

The level of Employer contributions made to the Fund on your behalf will determine your level of benefits (See page 7). Please note that Plan A+ (Without Hospitalization), Plan A and Plan B only provide major medical coverage -- they do *not* include hospitalization coverage. The major medical coverage is provided on a self-insured basis through the MagnaCare PPO. However, if you are eligible for any of those coverage options, you may "buy into" the Empire BlueCross BlueShield Direct HMO, which is a comprehensive HMO that includes hospitalization coverage, on a self-pay basis.

The benefits available under the Empire BlueCross BlueShield Direct HMO are described in the Certificate of Coverage that you may obtain from the Fund Office. The Certificate also describes coordination of benefits provisions, specific claims filing procedures and appeals rights that pertain to the coverage. Note: If you buy into the HMO, you will not be covered for any medical benefits under the Fund's self-insured medical coverage provided through MagnaCare. However, you will be eligible for the Fund's self-insured vision and prescription drug benefits. Please note that the prescription drug benefits are not available under Plan B.

As noted, the Plan's medical benefits are provided on a self-insured basis through the MagnaCare PPO, as described on pages 36 through 47. Hospitalization coverage is provided on an insured basis by Empire. Vision, earplug and prescription drug coverage is provided on a self-insured basis for participants in Plans A+ and A. Participants in Plan B are not eligible for prescription drug benefits, but are eligible for the fund's self-insured vision benefit and earplug benefit.

BENEFITS AT A GLANCE

	Plan A+ With Hospitalization	Plan A+	Plan A	Plan B
Contribution Requirements and Self-Pay Amounts				
Required 6-month Employer Contribution	$4,300	$3,200	$1,400	$500
Individual/Family Major Medical Only Participant Premium	$0/$300 quarterly	$0/$600 quarterly	$75/$405 quarterly	N/A
Individual/Family Major Medical *and* Hospitalization Participant Premium	$0/$600 quarterly	N/A	N/A	N/A
Individual HMO Buy-up	$50 month	$100 month	Contact Fund Office	Contact Fund Office
Family HMO Buy-up	$200 month	$400 month	Contact Fund Office	Contact Fund Office
Major Medical Benefits (MagnaCare)				
Annual Maximum benefit	$2,000,000	$2,000,000	$50,000	$5,000
In-Network (MagnaCare)	$20 Co-pay			
Out-of-Network (subject to deductible)	*Deductible*: $500 Individual $1,000 Family Benefits payable at 70% of R&C thereafter	*Deductible*: $500 Individual $1,000 Family Benefits payable at 70% of R&C thereafter	*Deductible*: $1,000 Individual $2,000 Family Benefits payable at 50% of R&C thereafter	*Deductible*: $1,000 Individual $2,000 Family Benefits payable at 50% of R&C thereafter
Out-of-Pocket Maximum	$1,500	$1,500	$5,000	N/A
Hospitalization Benefits (Empire)				
Hospitalization	Empire BlueCross BlueShield Hospitalization These benefits are described in the Certificate issued by Empire BlueCross BlueShield.	No hospitalization coverage	No hospitalization coverage	No hospitalization coverage
Prescription Drugs (Administered by Express Scripts)				
Retail Generic	$0 Co-pay		Mandatory Generic Greater of $10 or 25% of total cost	N/A

	Plan A+ With Hospitalization	Plan A+	Plan A	Plan B
Retail Preferred Brand-Name	$15 Co-pay		Greater of $20 or 25% of total cost	N/A
Retail Non-preferred Brand-Name	20% coinsurance; $30 minimum/$60 maximum		Greater of $40 or 25% of total cost	N/A
Mail Order Generic	$5 Co-pay		Greater of $20 or 25% of total cost	N/A
Mail Order Preferred Brand-name	$30		Greater of $40 or 25% of total cost	N/A
Mail Order Non-preferred Brand-name	$60 Co-pay		Greater of $80 or 25% of total cost	N/A
VISION (Fund-Administered)				
Routine Eye Exam (one per Calendar Year)	$15 maximum allowance			
Frames (limited selection)	$11 maximum allowance			
Lenses				
Single Vision	$13 maximum allowance			
Bi-Focal	$19 maximum allowance			
Tri-Focal	$24 maximum allowance			

Schedule of Major Medical Benefits		
Benefit	**MagnaCare In-Network**	**MagnaCare Out-of-Network**
Home/Office Visit	$20 Co-pay	Subject to deductible and % of Reasonable & Customary Charges thereafter.
Annual Physical Exam	**Not Covered**	
Acupuncture	Not covered	Subject to deductible and % of Reasonable & Customary Charges thereafter.
Chiropractic	$20 Co-pay	Subject to deductible and % of Reasonable & Customary Charges thereafter.
Emergency Room	100%	
Nursing Care	Subject to deductible and % of Reasonable & Customary Charges thereafter.	
Occupational Therapies (Speech, Language and Vision)*	$20 Co-pay	Subject to deductible and % of Reasonable & Customary Charges thereafter.
Physical Therapy*	$20 Co-pay	Subject to deductible and % of Reasonable & Customary Charges thereafter.
Well-Child Care	100%	100%
Well-Woman Care	100%	100%
Mental Health Inpatient (A+ w/hospital only)	Covered through Empire Blue Cross Hospitalization or Direct HMO	Covered through Empire Blue Cross Hospitalization or Direct HMO
Mental Health Outpatient	$20 Co-pay	Subject to deductible and % of Reasonable & Customary Charges thereafter.

Schedule of Major Medical Benefits		
Benefit	**MagnaCare In-Network**	**MagnaCare Out-of-Network**
Alcohol/Substance Abuse Treatment Inpatient (A+ w/hospital only)	Covered through Empire Blue Cross Hospitalization or Direct HMO	Covered through Empire Blue Cross Hospitalization or Direct HMO
Alcohol/Substance Abuse Treatment Outpatient	$20 Co-pay	Subject to deductible and % of Reasonable & Customary Charges thereafter.

This Schedule of Benefits contains only a brief summary of the coverage available under the Plan.

ELIGIBILITY, ENROLLMENT AND WHEN COVERAGE ENDS

PARTICIPANT'S INITIAL ELIGIBILITY

Employers are required to make contributions to the Fund on your behalf if you work for an employer who is a signatory to a Local 802 AFM collective bargaining agreement (CBA) requiring such contributions. The CBA sets the contribution level for the work you perform for a participating Employer.

If a certain amount of employer contributions are made on your behalf during a six-month Contribution Period, you will be eligible for health coverage from the Fund during the corresponding six-month Coverage Period. Since you may work for several employers in a single Contribution Period, the Fund looks at all of the employer contributions made on your behalf during that period in order to determine whether you are eligible for coverage.

In order to be eligible, you must have the following minimum contributions made on your behalf during a six-month Contribution Period (January 1- June 30th or July 1st to December 31st). You will be eligible for one of the Fund's four benefit options based on the amount of contributions that are received on your behalf in accordance with the following:

Minimum Contribution Requirements	
Plan A+ With Hospitalization	$4,300
Plan A+	$3,200
Plan A	$1,400
Plan B	$500

When you reach the minimum contribution level during a six-month Contribution Period, you and your eligible Dependents are eligible for coverage under one of the above options for the corresponding Coverage Period, subject to payment of the required premium (if applicable) as follows:

For the Contribution Period that runs for the Six-Month Period from:	The Coverage Period will be the Six-Month Period from:
January 1-June 30	October 1-March 31
July 1-December 31	April 1-September 30

Dual Contributions

If you and your spouse or eligible domestic partner are both active employees working for an employer contributing to the Fund on your behalf, but neither of you has earned sufficient employer contributions to establish eligibility, the earned employer contributions may be combined for the purpose of obtaining family coverage.

However, only one member can be considered the covered participant; the other person is considered a dependent. You have the option to designate who will be considered the covered participant. This decision does not have to be based on who has the greater amount of employer contributions.

CONTINUING ELIGIBILITY

Once covered by the Fund, you and your eligible Dependents will continue to be eligible for coverage during subsequent Coverage Periods provided that employer contributions are made on your behalf for the corresponding Contribution Period, as described above.

Excess Contributions (BANK)

This provision applies to all participants other than Plan B participants. If you have contributions over the minimum requirement for coverage for your chosen Plan option (Plan A or Plan A+), the excess amount can be carried forward from the previous two six-month Contribution Periods to maintain continued eligibility. For each Contribution Period, your "account" will be charged with the amount of contributions required for eligibility and the excess, if applicable, will be carried forward and applied to the next Contribution Period. The maximum amount of credit that may be carried forward is equal to the total amount of the contributions required for the previous 12-month period.

PARTICIPANT PREMIUMS

Participants are not required to contribute toward the cost of their own coverage under Plan A+ (with or without hospitalization) or Plan B. However, participants are required to pay a quarterly premium of $75 for their own coverage under Plan A.

For family coverage, participants are required to contribute to the cost of coverage under Plan A+ (with or without hospitalization) and Plan A, as detailed below. Family coverage is available under Plan B at no cost to the participant.

Quarterly Participant Premiums	
Plan A+ With Hospitalization ($4,300 level of employer contributions)	$600 (includes hospitalization) for Family Coverage $300 (major medical only*) for participant and dependent
Plan A+ ($3,200 level of employer contributions)	$600 for Family Coverage
Plan A ($1,400 level of employer contributions)	$75 for Individual-Participant Coverage $405 for Family Coverage
Plan B ($500 level of employer contributions)	Family Coverage is available at no cost

* By choosing this option, you are opting out of hospital coverage for yourself and your family members and you may obtain limited reimbursement for the hospital cost. (See section entitled Reimbursement for Family Coverage on page 59.

If you are required to make a quarterly premium payment , you will receive a quarterly invoice from the Fund. Once you receive your invoice, you have a 30-day grace period to make your payment. The invoice will state when the grace period expires. Payments MUST be postmarked by the last day of the grace period in order to be considered timely.

Plan A participants who do *not* pay the required quarterly premium for individual coverage will default to Plan B coverage and will remain on Plan B until their premium payment is processed. Late premium payments (after the 30-day grace period has expired) will be returned to you.

DEPENDENT ELIGIBILITY

Once you become eligible for coverage, your eligible Dependents are also eligible for health care coverage from the Fund. In general, your eligible Dependents are your:

- Lawful spouse (determined in accordance with applicable State law);
- Domestic Partner (who meets the Plan's eligibility requirements);
- Eligible children up to age 26. Coverage is available for children up to age 26 regardless of whether the child is married or unmarried, and regardless of the child's student status, employment status, financial dependency on you, or any other factor other than the relationship between you and your child.

For the purposes of the Plan, your "children" include:

- Your biological children;
- Your legally adopted children;
- Your domestic partner's children;
- Your step or foster children;
- Children placed with you for adoption or for whom you are responsible under court order or appointed legal guardianship; and
- Children for whom you are responsible to provide medical coverage as a result of a Qualified Medical Child Support Order (QMCSO).

Important Note: The Fund will provide medical coverage to eligible children through the end of the Calendar Year in which the child attains age 26 but BlueCross BlueShield will only provide hospitalization and HMO coverage through the end of the month in which the child attains age 26.

Dependents Who Are Covered Persons

If you are also eligible as a Dependent under this Plan, benefits will be payable to you as a covered participant and as a Dependent consecutively. If you and your spouse are covered as employees under this Plan, benefits will be payable to such individual as a covered participant and as a Dependent consecutively. Each covered person may claim benefits on behalf of his dependent children up to the maximum amounts provided under this Plan. However, in no event will the aggregate of benefits payable exceed 100% of the actual Covered Medical Expenses incurred.

DOMESTIC PARTNERS

The Plan offers coverage for participants' Domestic Partners. For purposes of the Plan, a Domestic Partner is defined as two individuals who:

- are at least 18 years of age or older;
- are of the same or opposite sex;
- are not married to, or legally separated from, another individual, and are not in a domestic partner relationship with any other individual;
- are not related by blood to a degree of closeness that would prohibit marriage in their state of residence;
- have lived together in the same residence for at least six months prior to the application for benefits and presently intend to live together indefinitely; and are financially interdependent, which must be demonstrated by the types of evidence described in the Fund's Policy regarding Domestic Partner Benefits.

For purpose of the Fund's Policy, the term Domestic Partner also includes two people of the same gender who are legally married in a state that recognizes such marriages, or are parties to a civil union in a state that recognizes such unions. The parties must submit to the Fund a copy of their marriage certificate or civil union certificate (and need not provide the Fund with evidence of financial interdependence).

Enrollment of Domestic Partners

A participant may enroll a Domestic Partner and his/her eligible dependent children for coverage under the Fund by submitting to the Fund Office a completed and signed Affidavit of Domestic Partnership (which must be notarized) along with the required proof (e.g., marriage certificate, civil union certificate, proof of financial interdependence, birth certificate for child, etc), and a completed enrollment form obtained from the Fund Office. Enrollment of a Domestic Partner (and child) must occur at one of the following times:

(i) when the participant first becomes enrolled in the Fund for him/herself,
(ii) during the Fund's annual enrollment period,
(iii) within 30 days of marriage or entering into a civil union,
(iv) within 30 days of the birth or adoption of a child of the Domestic Partner (provided that the Domestic Partner is enrolled for coverage either before or at that time), or
(v) within 30 days of the individual's loss of other coverage, provided that sufficient proof of loss is provided to the Fund Office.

Coverage will be effective in accordance with the Fund's enrollment rules.

Important Note Regarding Penalties for Providing Incorrect or Incomplete Information: *If the Fund (or its designee) determines that a Fund participant or Domestic Partner has committed fraud or made an intentional misrepresentation of a material fact (including, for example, in the Affidavit or enrollment forms; in a benefit claim or appeal; in response to any request for information by the Fund (or its designee); or by failing to timely notify the Fund of the termination of a Domestic Partnership (including a divorce or dissolution of a civil union) within 30 days of such termination, divorce or dissolution), coverage may be terminated retroactively on thirty (30) days written notice. Coverage may also be terminated retroactively and without notice (unless required by law) if the Fund (or its designee) determines that the Domestic Partner or child is ineligible for coverage under the Plan and such retroactive termination would not be considered a "rescission" under applicable federal law.*

If coverage is terminated retroactively, the participant and Domestic Partner will be required to reimburse the Fund, its insurers and agents for any expenditures made by them for benefit claims, processing fees, administrative charges and all other costs (including interest and any attorneys' fees incurred in order to collect such amounts) on behalf of a Domestic Partner and his or her child. In addition, the participant may be subject to further action (such as termination of coverage).

Domestic Partner Coverage and Important Tax Consequences

Domestic Partners (and their eligible children) are eligible for *self-pay* health coverage on the same basis as spousal (and dependent child) coverage is provided under the Fund.

However, the Internal Revenue Service ("IRS") generally does not recognize domestic partners, civil union partners or same-sex spouses (or their children) as eligible dependents under the Internal Revenue Code's provisions regarding employer-sponsored health plans. Therefore, unless the Domestic Partner (or child) is the participant's "dependent" as defined in Section 105(b) of the Internal Revenue Code, the fair market value of the health coverage provided by the Fund to the Domestic Partner and his or her children will be included in the participant's gross income, subject to Federal income tax withholding and employment taxes, and will be reported by the Fund on an IRS Form W-2. The value of the coverage may also be subject to State and City income tax depending on the applicable state and locality.

A participant who enrolls a Domestic Partner (and his or her child) for coverage under the Fund will receive an IRS Form W-2 reflecting the value of the coverage provided by the Fund (as determined in the Fund's discretion, and as may be changed from time to time without prior notice). The Fund generally calculates the fair market value of Domestic Partner coverage using the applicable COBRA rate (not including the 2% administrative fee).

If a participant believes that his or her Domestic Partner or his/her child qualifies as the participant's dependent under the Internal Revenue Code, the participant must submit a notarized certification to the Fund Office. In general, in order to qualify as the participant's dependent for this purpose, the individual: (i) must be a member of the participant's household during the entire taxable year, and (ii) must receive more than half of his or her support from the participant. Participants are strongly encouraged to consult with a tax advisor regarding all of the requirements for dependent status before completing such a certification.

Termination of Domestic Partner Coverage

Coverage extended to a Domestic Partner and his/her eligible children will end on the earliest to occur of the following:

- on the date that the participant's coverage under the Fund ends for any reason (including the participant's death);
- when the child loses eligibility under the terms of the Fund;
- when the participant fails to timely pay the required contributions for such coverage in accordance with the Fund's rules;
- when the participant voluntarily dis-enrolls the Domestic Partner and child from coverage at any time, by providing written notice to the Fund Office; or
- when the partners no longer satisfy the requirements of a Domestic Partnership as described in the Fund's Policy and the Declaration (or, in the case of a marriage or civil union, when the parties have divorced or dissolved their civil union), in which case coverage will end on the last day

of the month in which the parties no longer satisfy the requirements for a Domestic Partnership, or on the date of the divorce or dissolution of their civil union. *You must notify the Fund Office in writing within 30 days of the date that the parties no longer satisfy the requirements of a Domestic Partnership (or within 30 days of a divorce or dissolution of a civil union, in those cases). In cases of divorce or dissolution of a civil union, the participant must provide the Fund Office with a copy of divorce decree or dissolution certificate within 30 days of the divorce or dissolution.*

Important Note: Upon termination of coverage, a Domestic Partner and his/her children will only be entitled to federal COBRA continuation coverage *if the participant is eligible for and receiving COBRA coverage for him/herself.* However, New York State continuation coverage may be available to a same-sex spouse (and his or her child) under certain circumstances upon a loss of the *insured hospitalization coverage* provided by the Fund.

A participant may not enroll a *new* Domestic Partner for coverage under the Fund within twelve (12) months of the termination of another Domestic Partner's coverage, except in cases of a new marriage or civil union.

ENROLLMENT RULES

Participant Coverage: There is no action required in order to enroll for coverage under the Fund unless you want to enroll in the HMO option or hospitalization coverage (if eligible). The Fund Office determines participant eligibility based on employer contributions remitted during the applicable eligibility period.

HMO and Hospitalization: You must enroll before the start of the applicable coverage period and pay the applicable premium.

Dependent Coverage:

In order to enroll your dependents, you must complete the required enrollment form that you obtain from the Fund Office and return it to the Fund Office with the appropriate

supporting documentation (e.g., marriage certificate and/or birth certificate) no later than 30 days after the start of the coverage period, and timely pay the applicable participant contribution.

IMPORTANT: AS NOTED, IN ORDER FOR YOUR DEPENDENTS TO BE COVERED UNDER THE PLAN, YOU NEED TO ENROLL THEM AND PAY THE APPLICABLE PARTICIPANT CONTRIBUTION IN A TIMELY MANNER.

Special Enrollment Rights Under HIPAA and CHIPRA

If you are declining enrollment for yourself or your Dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in the Fund if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment in the Fund within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage), and you must provide the Fund with a certification from the other plan showing the date that the other coverage ended.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents for coverage under the Fund at that time. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you request enrollment in writing (and submit the required forms) within that 31-day period, the coverage will be effective as of the date of marriage, birth, adoption or placement for adoption. If you do <u>not</u> request enrollment in writing within that 31-day period, the coverage will not be effective until the date that the Fund Office receives your written request for enrollment (including all appropriate documentation).

In addition, *effective April 1, 2009*, if either of the following two events occur, you will have *60 days* from the date of the event to request enrollment in the Fund:

- TERMINATION OF MEDICAID OR CHIP COVERAGE – If you or your dependent is covered under a Medicaid plan or under a State children's health insurance program (SCHIP) and coverage under such a plan is terminated as a result of a loss of eligibility for such coverage.

- ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP – If you or your dependent becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relations to such a plan. In general, this is a program where the state assists employed individuals with premium payment assistance for a group health plan rather than provide direct enrollment in a state Medicaid program.

If enrollment is permitted in accordance with the above, coverage under the Fund will be effective beginning on the first day of the first calendar month following the month in which a completed request for enrollment is received by the Fund Office. You are required to pay any additional premium required by the Fund.

To request special enrollment or obtain more information, contact the Fund Office.

Late Enrollment: If your enrollment is received after 31 days (or 60 days if eligible for a Medicaid/CHIP enrollment right), coverage will begin as of the next coverage period.

If you are enrolled in the Empire BlueCross BlueShield Hospital or Direct HMO benefits, there may be some variations in how new dependents are covered due to state insurance laws. Please see the eligibility and enrollment sections in the applicable Certificate of Insurance for information on how these provisions are applied.

WHEN COVERAGE ENDS

Your coverage under the Plan ends on the earliest of any of the following events:

- The end of the Coverage Period following the Contribution Period in which there are insufficient contributions credited on your behalf to qualify for any benefit option provided by the Fund.
- The date the Plan terminates;
- The last day of the period for which you have last timely paid the required premium/self-pay amounts, if any;

- The date you die.

When your coverage ends, you may have the right to continue coverage under the Fund for a temporary period of time on a self-pay basis pursuant to COBRA and/or State law, depending on the reason for which coverage ends. See pages 25 through 34 for information regarding continuation coverage.

When Dependent Coverage Ends

Under this Plan, Dependent coverage will end upon the earliest of the following dates:

- The date that your (the participant's) coverage ends;
- The date the Dependent no longer meets the Plan's definition of Dependent, except as otherwise provided in the Plan;
- The date the Plan is amended to terminate coverage for the class to which the Dependent belongs; or
- The date this Plan terminates.

When a Dependent's coverage ends, he/she may have the right to continue coverage under the Fund for a temporary period of time on a self-pay basis pursuant to COBRA and/or State law, depending on the reason for which coverage ends. See pages 25 through 34 for information regarding continuation coverage.

Certificate of Creditable Coverage

Under a federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Fund is required to provide, without charge, certificates of creditable coverage to participants or dependents that were covered under the Fund upon the occurrence of certain events, or upon request. The certificate will state the period of time that the participant and/or dependent was covered under the Fund (including COBRA coverage), as well as certain other information required by law. The purpose of these certificates is to provide evidence of an individual's coverage under the Fund in order to reduce a preexisting condition exclusion period under another plan, to help the individual get the right to enroll in another plan, or to obtain certain types of individual health coverage if the person has health problems.

The Certificate of Creditable Coverage will be provided to a participant or dependent:

- upon request at any time while he or she is covered under the Fund and up to 24 months after coverage ends;

- when his or her coverage under the Fund ends and he or she is entitled to elect COBRA continuation coverage;

- when his or her coverage ends, even if he or she is not entitled to COBRA; and

- when his or her COBRA coverage ends.

You should retain these Certificates of Creditable Coverage as proof of prior coverage in the event you become covered by a new health plan.

Who may request a certificate of creditable coverage? Any individual who is covered under the Fund, or whose coverage has ceased within the previous 24 months, may request a certificate. Additionally, a certificate may be requested by a person or entity designated to make such a request on the individual's behalf; for instance, by a subsequent plan seeking to verify the individual's coverage.

When will a certificate be provided after a request is made? Certificates will be provided by the Fund Office as soon as administratively practicable following the request.

To whom should requests for Certificates be made? All requests for certificates of creditable coverage should be made in writing and should be directed to the Fund Administrator. However, to request a Certificate for benefits that are insured through Empire, send your request to:

Empire BlueCross Blue Shield

P.O. Box 1407

Church Street Station

New York, NY 10008-1407

Other HIPAA Information

Preexisting Condition Exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as

"preexisting condition exclusions." A preexisting condition exclusion generally can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior Creditable Coverage. Most health coverage is Creditable Coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high risk pools and the Peace Corps. Not all forms of Creditable Coverage are required to provide Certificates of Creditable Coverage. If you do not receive a certificate of past coverage, talk to the Fund Administrator. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break. Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break.

If you become eligible for coverage under a group health plan that excludes coverage for your condition, you may need to provide a Certificate of Creditable Coverage (see above) if advice, diagnosis, care or treatment is recommended or received for your condition within the six-month period before you enroll in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for conditions that are present before you enroll.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late

enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.) Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;

- Your most recent coverage was under a group health plan (which can be shown by a Certificate of Creditable Coverage);

- Your group coverage was not terminated because of fraud or nonpayment of premiums;

- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and

- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job. Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. The foregoing describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state. Therefore, if you are covered through the fully insured HMO or the Hospitalization Coverage offered through Blue Cross/Blue Shield by this Fund, you may be offered additional protection.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa, the DOL's interactive web pages - Health *E*laws

CONTINUATION OF COVERAGE -- FEDERAL AND STATE LAW

FEDERAL COBRA CONTINUATION COVERAGE

Under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), you and/or your eligible Dependents have the right to continue health care coverage under the Fund for a temporary period of time, on a self-pay basis, when you lose coverage under the Fund due to certain events (called "Qualifying Events"). COBRA coverage is identical to the health care coverage provided to active participants.

Under the law, only "Qualified Beneficiaries" are entitled to elect COBRA coverage. Depending on the type of Qualifying Event, a Qualified Beneficiary can include you (the employee) or eligible Dependents that are covered by the Plan when a Qualifying Event occurs. A child who becomes an eligible Dependent by birth, adoption, or placement for adoption with you (the employee) during a period of COBRA coverage is also a Qualified Beneficiary. (Note: Domestic Partners and their children are only eligible for COBRA continuation coverage if the participant is receiving such coverage; they are not Qualified Beneficiaries under the federal COBRA law.)

- If you timely elect COBRA coverage, you and your eligible Dependents may continue the same group health coverage that you had prior to the Qualifying Event. COBRA applies only to group health benefits; it does not apply to sick pay and other benefits.

QUALIFYING EVENTS AND MAXIMUM PERIOD OF COBRA COVERAGE

The chart below shows when you and your eligible Dependents may qualify for continued coverage under COBRA, and how long your coverage may continue.

Qualifying Event	Who May Elect COBRA Continuation Coverage	Maximum Period of Continued Coverage
Termination of employment (other than for gross misconduct)	You, your spouse and/or eligible dependent children	18 months*
Reduction in hours of employment/required contributions	You, your spouse and/or eligible dependent children	18 months*

Your death	Your spouse and/or eligible dependent children	36 months
You and your dependent spouse legally separate or divorce	Your spouse and/or eligible dependent children	36 months
Your child(ren) lose(s) dependent status under the Plan	Eligible dependent child(ren)	36 months

Note: See page 33 regarding state continuation rights applicable to the insured hospitalization and HMO coverage provided by the Fund.

Coverage Continues for 29 Months (Extended Disability Coverage). Your and your Dependent's continuation coverage may be extended from 18 months to a total of 29 months (an additional 11 months) if the Social Security Administration (SSA) determines that you or your Dependent are disabled during the first 60 days of continuation coverage. This extended continuation period is only available if you notify the Fund Office (and provide a copy of the SSA award) within 60 days of the *latest of: (i) the date of the SSA disability determination, (ii) the date of the Qualifying Event, or (iii) the date on which the Qualified Beneficiary loses coverage as a result of the Qualifying Event, and within the initial 18-month period of COBRA coverage.* . Each Qualified Beneficiary within a family who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the Qualified Beneficiary is determined by SSA to no longer be disabled, you must notify the Fund Office of that fact within 30 days after SSA's determination. This extended period of continuation coverage will end the earliest of:

- The last day of the month that begins more than 30 days after Social Security determines that you or your Dependent is no longer disabled. You or your Dependent must notify the Fund Office within 30 days of the date of such a Social Security determination;
- The date continued coverage would end for any reason other than the end of the 18-month continuation period (such as failure to timely pay the required premiums); or
- The end of the 29 month period.

Notice of Qualifying Events

The Fund will offer COBRA coverage to Qualified Beneficiaries only after the Fund Office has been notified that a Qualifying Event has occurred. Your contributing employer is responsible for notifying the Fund Office of termination of employment, reduction in hours of employment/contributions, and death of the employee. However, you or your

family should also notify the Fund Office promptly if any such Qualifying Event occurs in order to avoid confusion over the status of your health coverage in the event there is a delay or oversight in providing that notice.

You Must Give Notice of Some Qualifying Events and All Second Qualifying Events

You and/or a family member are responsible for providing the Fund Office with written notice of the following Qualifying Events no later than 60 days after the later of: (1) the date of the relevant Qualifying Event; or (2) the date when coverage would be lost under the Plan as a result of the Qualifying Event:

(1) The divorce of a covered employee from his or her spouse.

(2) A beneficiary ceasing meet the requirements under the Plan as a Dependent child.

(3) The occurrence of a second Qualifying Event after a qualified beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second Qualifying Event could include an employee's death, divorce or child losing Dependent status. See the Section "Multiple Qualifying Events while Covered Under COBRA" for information on second Qualifying Events.

In addition, you and/or a family member must also provide the Fund Office with notice within the timeframes described on the prior page with regard to a Social Security Disability Determination (for the 11-month extension) or a determination by the Social Security Administration that a Qualified Beneficiary is no longer disabled.

All of the above notices must be in writing and must contain the following information:

- your name,
- which Qualifying Event occurred,
- the date of the Qualifying Event,
- attachments of the necessary supporting documentation (e.g., copy of divorce decree, copy of dependent's birth certificate, Medicare Card, death certificate, SSA Award, etc.).

Notices must be sent to the Fund Office and may be provided by the covered employee or any other Qualified Beneficiary with respect to the qualifying event, or any representative

acting on behalf of the covered employee or Qualified Beneficiary. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same Qualifying Event.

If the notice has not been received by the Fund Office by the end of the applicable period described in this Section, you and/or your spouse and/or your Dependent(s) will not be entitled to choose/extend COBRA Continuation Coverage.

ELECTING COBRA COVERAGE

When the Fund is notified that a Qualifying Event has occurred, the affected Qualified Beneficiaries will be provided with notice and information regarding COBRA coverage and an election form. Under the law, Qualified Beneficiaries have 60 days from the later of the date of the loss of coverage or the date of the notice, to elect COBRA coverage.

IF YOU AND/OR ANY OF YOUR ELIGIBLE DEPENDENTS DO NOT ELECT COBRA COVERAGE WITHIN THIS 60-DAY PERIOD, YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN AFTER COVERAGE ENDS.

Each Qualified Beneficiary has an independent (separate) right to elect COBRA coverage. Coverage may be elected for some members of the family and not others. In addition, one or more eligible Dependents may elect COBRA even if the participant does not elect it. However, in order to elect COBRA coverage, the family members must have been covered by the Plan on the date of the Qualifying Event or became an eligible Dependent by birth, adoption, or placement for adoption during the period of COBRA coverage. A participant may elect COBRA coverage on behalf of his or her spouse and a parent may elect or reject COBRA coverage on behalf of Dependent children.

PAYING FOR COBRA COVERAGE

Each Qualified Beneficiary will be required to pay the entire cost of continuation coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the Plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

The amount charged for continuation coverage may be adjusted due to changes in coverage. In addition, even in the absence of any changes in coverage, amounts charged for continuation coverage may change on a yearly basis or as otherwise permitted by applicable law.

The monthly premium rates for COBRA continuation coverage will be included in the election package that the Fund sends upon receiving notice of a Qualifying Event. If you elect COBRA coverage, you do not have to send any payment along with your election form. However, the first COBRA payment must be provided to the Fund Office not later than 45 days after the date of your election, and subsequent payments are due on a monthly basis, with a 30-day grace period (as described below). If you do not timely pay for COBRA coverage, you will lose all continuation coverage rights under the Plan. Additional information about elections and payment terms will be included in the election package.

Important Note: You may be able to reduce your COBRA premiums by contributions made to the Fund on your behalf in the last Contribution Period before your coverage ended. Contact the Fund Office for additional information,

Grace Period for Payments

Although COBRA payments are due on the first day of each month of coverage, you will be given a grace period of 30 days after the first day of the month to make each payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. If you fail to make your payment before the end of the grace period for that month, you will lose all rights to COBRA continuation coverage under the Plan. Premium payments are considered "made" based on the postmark date.

DURATION OF COBRA COVERAGE/SECOND QUALIFYING EVENTS

COBRA continuation coverage will run from the date of loss of coverage and not the date of the qualifying event. See the chart on page 25 for the maximum period of COBRA coverage for each event.

Multiple Qualifying Events While Covered Under COBRA

If, during an 18-month period of COBRA coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, become entitled to Medicare (Part A or B or both), or if an eligible Dependent child ceases to be an eligible Dependent under the Plan, the maximum COBRA continuation period for the affected spouse and/or child(ren) is extended to 36 months.

In no case are you (the participant) entitled to COBRA coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional 11 months of COBRA coverage on account of Social Security disability). As a result, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second qualifying event and COBRA coverage may not be extended beyond 18 months.

If your family experiences a second Qualifying Event during an 18-month period of continuation coverage, you or your family member must notify the Fund Office of the second Qualifying Event within 60 days of the event according to the procedures described in the Section "You Must Give Notice of Some Qualifying Events and All Second Qualifying Events."

In no event is anyone else entitled to COBRA coverage for more than a total of 36 months.

Termination/Reduction in Hours That Follows Medicare Entitlement

If you become entitled to Medicare and you later have a termination of employment or reduction in hours, your eligible Dependents who are qualified beneficiaries would be entitled to COBRA coverage for a period of: (a) 18 months (29 months if the 11-month Social Security disability extension applies); or (b) 36 months from the date you became entitled to Medicare, whichever is longer.

HIPAA Special Enrollment Rights

If, while you are enrolled for COBRA coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that eligible Dependent for coverage for the balance of the period of COBRA coverage available to you by doing so within 31 days after the marriage, birth, adoption, or placement for adoption.

In addition, if, while you are enrolled for COBRA coverage, any of your eligible Dependents lose coverage under another group health plan, you may enroll that Dependent for coverage for the

balance of the period of COBRA coverage available to you by doing so within 31 days after the termination of the other coverage. In order to be eligible for this special enrollment right, the Dependent must have been eligible for coverage under the terms of the Plan when COBRA was initially offered, and the Dependent must have been covered under another group health plan or had other health insurance coverage at that time.

Adding a Dependent may cause an increase in the amount you must pay for COBRA coverage. Please contact the Fund Office for additional information.

WHEN CONTINUATION COVERAGE ENDS

Coverage will be continued on a month-to-month basis until the earliest of:

- The end of the maximum continuation period applicable to the Qualifying Event;
- The date, after the date of election, that you or your Dependent becomes entitled to Part A and/or Part B of Medicare;
- The last day of the month for which premiums were last timely paid;
- The date you or your Dependent first become, after the date of election, covered under any other group health plan (as an employee or otherwise) which does not exclude or limit any pre-existing condition of you or your Dependent; or
- The date this Plan terminates.

If You Have Questions

Questions concerning the Plan or your COBRA coverage rights should be addressed to the Fund Office. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you may have pre-existing condition exclusions applied to you by

other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA continuation coverage may help you avoid such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not elect COBRA continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law.

You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if you elect COBRA continuation coverage for the maximum time available to you.

Conversion and State Continuation Rights

When your coverage initially ends as well as at the end of the continuation period, you or your Dependent may be entitled to conversion rights as well as State Continuation of Coverage under the Empire Hospitalization or HMO coverage. (See discussion of State Continuation Rights below.) Please refer to the Certificate of Insurance for details on these rights.

CONTINUED COVERAGE DURING MILITARY LEAVE

If you are on a military leave of absence as a result of entering the uniformed services of any country (active duty or inactive duty training), your group health coverage under the Fund may be continued on a self-pay basis for a period of up to 24 months in accordance with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). This period runs concurrently (not consecutively) with COBRA continuation coverage. The COBRA rules for notices, elections and premium payments apply to USERRA continuation coverage.

For leaves of up to 31 days, employees are required to pay only the same amount for continuation coverage as they were paying for active coverage.

In addition to USERRA or COBRA coverage, an employee's eligible Dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care

program for uniformed service members and their families). The Plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice.

ADDITIONAL STATE CONTINUATION RIGHTS WITH REGARD TO INSURED BENEFITS OFFERED THROUGH BLUE CROSS/BLUE SHIELD

New York Mini-COBRA. As previously explained, under the Federal COBRA law, covered employees and their family members generally are entitled to 18 months of continued coverage under the Fund, on a self-pay basis, when coverage is lost due to termination of employment or reduced hours of employment. The New York State Insurance law extends that period (for insured benefits) to 36 months under certain circumstances. Accordingly, a 36-month period of continuation coverage may be available with respect to the insured benefits provided by the Fund through Blue Cross/Blue Shield. The self-insured benefits of the Fund are not subject to this rule. Contact the Fund Office for more information.

Age-29 Option. New York State has also enacted legislation that allows certain unmarried dependents to remain covered under insured group health plans through age 29 if they satisfy certain eligibility requirements. This applies to the insured benefits provided by the Fund through Blue Cross/Blue Shield. The self-insured portion of the Fund is not subject to this rule. If you are interested in obtaining this coverage, please contact Blue Cross/Blue Shield at the contact number or address that appears in this booklet.

YOUR HOSPITAL AND MEDICAL BENEFITS

The Local 802 Musicians' Health Benefit Plan provides four options that are available to participants based on their eligibility (as described on pages 7 through 9): Plan A+ with Hospitalization, Plan A+ (without Hospitalization), Plan A, or Plan B. Once you become eligible for any plan, you have the option of buying into the Empire BlueCross BlueShield Direct HMO.

Empire BlueCross BlueShield Direct HMO

If you are eligible for any of the Plan's benefit options, you also have the option of enrolling in the Empire BlueCross BlueShield Direct HMO**.** You will be responsible for paying the monthly participant premium in addition to the current HMO monthly buy-up premium that is determined each year. The benefits available under the Empire BlueCross BlueShield Direct HMO are described in the Certificate or Evidence of Coverage booklet that can be obtained from the Fund Office. This booklet describes the specific covered services and exclusions applicable to the HMO coverage. The Certificate also describes coordination of benefits provisions, specific claims filing procedures and appeals rights that pertain to the coverage. You will be provided with a copy of the Certificate directly from Empire when you enroll in the HMO. If you need another copy of the Certificate, please contact Empire directly or the Fund Office.

> **Remember:** If you enroll in the Empire BlueCross BlueShield Direct HMO, you are no longer covered by the Fund's benefit options (Plan A+, Plan A or Plan B) and you may **not** use the MagnaCare PPO Provider Network.

Plan A+ Empire BlueCross - Hospital Benefits

If you are eligible for Plan A+, you are eligible for Hospital benefits which are provided under a contract with Empire BlueCross. The benefits available under the Empire BlueCross Hospitalization contract are described in the Certificate or Evidence of Coverage that is provided by Empire. The Certificate describes the specific covered services and exclusions applicable to the hospitalization coverage. The Certificate also describes coordination of benefits provisions, specific claims filing procedures and appeals rights that pertain to the coverage. You will be provided with a copy of the

Certificate directly from Empire when you first become eligible for coverage. If you need another copy of the Certificate, please contact Empire BlueCross BlueShield directly or the Plan Office.

MagnaCare PPO Network – Major Medical Benefits

If you are eligible for **Plan A+, Plan A, or Plan B**, Major Medical coverage is provided under the MagnaCare PPO Network.

Although you and your Dependents are not required to use an In-Network provider, your our-of-pocket expense will be lower if you stay within the MagnaCare PPO Network.

If you use providers outside the MagnaCare PPO Network, the Fund covers Physicians' fees and diagnostic and other medical expenses according to the rate of reimbursement for your eligibility level. With the exception of a routine mammograms, annual gynecological visits, Pap smears, and well-child care, the Plan does not cover routine adult check-ups that do not have a related medical diagnosis, even if you use a MagnaCare provider.

Important: If you receive care in a Network Hospital from a Network Physician, but the pathologist, radiologist, or anesthesiologist is Out-of-Network, your claim for these charges will be treated as Out-of-Network charges according to the terms of the Plan**.** However, if this occurs, you may appeal the claim in accordance with the Plan's appeal procedures. (See the Claims and Appeals Section for details.) If it is determined by the Fund, in accordance with this procedure that the services of the out-of-network pathologist, radiologist or anesthesiologist were provided to you without your knowledge or consent the Fund may waive the out-of-network deductible and co-insurance, and the claim will be re-processed and payment will be limited to the applicable Usual, Reasonable and Customary charge. Note that this rule does **not** apply if you receive care in an Out-of-Network Hospital or from an Out-of-Network Physician.

IMPORTANT: Looking for an In-Network participating MagnaCare PPO provider? You can log onto their website at www.magnacare.com. Or, you can call (800) 352-6465.

Annual Deductible and Out-of-Pocket Maximum

If you use Out-of Network providers under any of the Plan options, you will be responsible for satisfying a Deductible before the Plan will begin to pay benefits. If you choose an In-Network Provider, you only have to pay the designated Co-payment. All medical claims (In- and Out-of-Network) must be submitted to MagnaCare for processing.

At A Glance				
	Plan A+ With Hospitalization	**Plan A +**	**Plan A**	**Plan B**
Required 6-month Employer Contribution	$4,300	$3,200	$1,400	$500
Annual Maximum Benefit	$2,000,000	$2,000,000	$50,000	$5,000
In-Network*	$20 Co-pay	$20 Co-pay	$20 Co-pay	$20 Co-pay
Out-of-Network (subject to deductible)**	Deductible $500 Individual; $1,000 Family Co-insurance: 70% of Reasonable & Customary thereafter	$500 Individual; $1,000 Family 70% of Reasonable & Customary thereafter	$1,000 Individual; $2,000 Family 50% of Reasonable & Customary thereafter	$1,000 Individual/ $2,000 Family 50% of Reasonable & Customary thereafter
Out-of-Pocket Maximum	$1,500	$1,500	$5,000	N/A

*There is no Deductible for In-Network services
**Applicable to Out-of-Network Physicians for office visits
Note: Co-payments do not apply toward the Deductible

Three Month Carry-Over

Covered Medical Expenses incurred during the last three (3) months of a Calendar Year, which are applied to that year's Deductible, will also be applied to the next year's Deductible.

Common Accident

If two or more covered members of a family are injured in the same accident, a maximum amount of one single Deductible amount will be applied to all Covered Medical Expenses incurred by the family as a result of the accident:

- during the Calendar Year in which the accident occurred; or
- the next following Calendar Year.

In no event will any covered participant's Deductible be more than what would have applied in the absence of this provision.

Emergency Treatment

If you or your Dependent goes to an Out-of-Network provider because you need Emergency Treatment, benefits will be paid on the same basis as if you or your Dependent had used a Network provider.

Cancer Second Opinion

You or your Dependent have the option of seeking a second medical opinion. In this case, benefits will be subject to all the terms and conditions of this Plan.

Earplug Benefit

The Fund provides earplugs through several preferred earplug providers. Participants who obtain earplugs through a preferred provider will be reimbursed up to a maximum of $105 for a set. This benefit is available once every two years. Contact the Fund Office for additional information regarding the preferred providers.

WHAT'S COVERED—MEDICAL BENEFITS

Covered Medical Expenses are the Medically Necessary charges incurred by you or your Dependent, except as limited under What's Not Covered or excluded under General Exclusions. A charge is incurred on the date treatment is provided.

Covered Medical Expenses include charges made by or in relation to:

- A Physician for medical care;
- Physical therapy by a licensed or certified physical therapist. Physical therapy furnished in connection with surgical care will be a Covered Medical Expense only for charges incurred within the first 6 months from the date of discharge from a Hospital; or the date surgical care was rendered for a minimum of 365 days from the date of discharge from a Hospital or to the date surgical care was rendered;
- Speech or hearing therapy. The speech or hearing disorder must be a result of an Injury or Illness. The therapy must be rendered by a licensed speech therapist; speech

pathologist; or audiologist. The therapy must be considered progressive therapy and not maintenance therapy;

- A registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.);
- Transportation of you or your Dependent for Emergency Care which requires the attendance of a licensed medical professional during transport, if such transport:
  - is to the nearest facility equipped to provide the required treatment; and
  - is provided by a licensed professional ambulance service; and
  - is land transportation, except where land transport is too dangerous or not available.
- Diagnostic X-ray and laboratory services. These include charges for Magnetic Resonance Imaging (MRI);
- Radiation treatment. This is limited to:
  - X-ray therapy;
  - radium therapy;
  - radioactive isotope therapy; and
  - charges for cancer chemotherapy.
- The administration or dialysis of blood or blood components;
- The cost of whole blood or blood components, if the blood is not replaced;
- Anesthesia and its administration by a licensed anesthesiologist;
- Contraceptives;
- Prescription drugs when purchased under the direction of a Physician. Such charges also include injectable insulin, syringes and needles. Such charges do not include expenses incurred for the administration of any self-administered drug unless received by you or your Dependent:
  - from a Physician during an office visit; or
  - from a Home Health Care Agency.

  However, if drugs are covered under any Prescription Drug benefit provided by the Fund (under this Plan or as a separate plan), then such drug is not covered under this medical benefit.
- Oxygen and the rental of equipment for its administration;
- Rental of durable medical equipment, but not to exceed the purchase price. At the Board of Trustee's option, and on a basis determined by the Board of Trustees, purchase may be made.
- Pre-admission Testing. This is limited to Outpatient diagnostic, X-ray, and laboratory examinations made prior to the scheduled Outpatient surgery. There are no Deductibles or Co-payment requirements for pre-admission testing if the following requirements are met:

- the scheduled Outpatient surgery, is confirmed in writing by the attending Physician before the test occurs;
- the tests must be performed within seven (7) days before the Outpatient surgery;
- the tests must be ordered by the attending Physician;
- the tests must be performed in a facility accepted by the Hospital; and must be in place of the same tests that would normally be done while Hospital confined;
- the tests are not duplicated in the Hospital;
- the Outpatient surgery is performed, except if a Hospital bed is unavailable, or because there is change in your or your Dependent's health condition, which would preclude the procedure.

If the above requirements are not met, the Deductible and coinsurance for medical expenses will apply to the charges for the pre-admission test.

- A Second Surgical Opinion on the need for surgery. It must be given by a state Board Certified Physician specialist:
  - whose specialty is appropriate to the surgical procedure being evaluated:
  - who has personally examined you or your Dependent; and
  - who does not perform the surgery.

  The Second Surgical Opinion:
  - must be given no later than six (6) months after the initial surgical opinion indicating the need for the same surgery;
  - must be given in writing; and
  - does not include repetition of any diagnostic tests.
- Dressings, casts, splints, trusses, braces, or crutches;
- Initial non-dental prosthetic devices such as artificial limbs or eyes. Replacement of such devices will be covered only if required by a change in your or your Dependent's physical structure;
- Supportive devices for the feet, including charges for adjustments to the shoe or the device, but not including the cost of the shoe;
- Outpatient expenses for the treatment of cleft lip and cleft palate of a Dependent child. Such expenses include:
  - orthodontics;
  - oral surgery;
  - otologic;
  - audiological; and
  - speech/language treatment.

- Treatment of infertility. The benefit payable is limited to reimbursement of Reasonable and Customary charges for:
  - diagnostic testing;
  - medical counseling; and
  - treatment of correctable medical conditions that result in infertility.
- Treatment of:
  - temporomandibular joint dysfunction syndrome (TMJ); or
  - any other treatment of the face, neck, or head is covered on the same basis as any other treatment of the skeletal system. The procedure must be Medically Necessary to treat a condition caused by congenital deformity, Injury, or Illness. However, charges for intraoral prosthetic devices are excluded.
- Manual manipulation of the spine;
- Reconstructive breast surgery following a mastectomy, including reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications at all stages of the mastectomy, including lymphedemas;
- Outpatient visits for diagnosis and treatment of chemical abuse or dependence. Coverage will include services rendered in a certified or an accredited:
  - Outpatient clinic; or
  - medically supervised ambulatory substance abuse program.

  Benefits will be paid for Outpatient visits, of which 20 visits may be used for family members, per Calendar Year;
- Diagnostic screening for prostate cancer when such service is prescribed by a Physician. Standard diagnostic testing includes, but is not limited to, a digital rectal exam and a prostate-specific antigen test:
  - at any age for males with a prior history of prostate cancer;
  - annually for males 50 and over who are asymptomatic; and
  - annually for males age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.
- Annual gynecological examinations (Pap smears and pelvic examination) for a female covered individual age 18 or older. The requirements that the charges incurred must be a result of an Injury or Illness or deemed Medically Necessary do not apply to these charges;
- Mammography screening for a woman who does not have symptoms of cancer. The requirements that the charges incurred must be a result of an Injury or Illness or deemed Medically Necessary do not apply to these charges. Benefits will be paid for:
  - a mammogram at any age for a woman who has a prior history of breast cancer or whose mother or sister has a prior history of breast cancer, if recommended by a Physician;
  - a single baseline mammogram for a woman who is at least age 35, but less than 40;

- a mammogram every two (2) years, or more frequently if recommended by a Physician for a woman who is at least age 40, but less than 50;
- a mammogram once a year for a woman who is age 50 or older.

- Home health care for you or your Dependent if:
  - you or your Dependent would otherwise require inpatient treatment in a Covered Facility, and
  - a home health care treatment plan is established and approved in writing by the attending Physician. The Board of Trustees (or its designee) has the right to review the proposed plan of treatment on a regular basis to determine the Medical Necessity of continued care.

  Such care must be provided by a certified Home Health Agency and must consist of one or more of the following:

  - part-time or intermittent home:
    - nursing care by or under the supervision of a professional registered nurse (R.N.); or
    - health aide services which consist primarily of caring for the patient.
  - physical, occupational or speech therapy if provided by the Home Health Agency or service;
  - medical supplies, drugs and medications prescribed by a Physician and laboratory services by or on behalf of a certified Home Health Agency to the extent such items would have been covered under this Plan if you or your Dependent was confined in a Covered Facility.

  Home health care will not include:

  - services or supplies not included in the home health care plan of treatment;
  - services of a person who lives with you or your Dependent or is a member of your, including your spouse's, immediate family. “Immediate Family” will include spouse, child, parent, brother, or sister;
  - transportation services;
  - treatment for Mental Illness, alcoholism, and drug addiction;
  - personal comfort items;
  - housekeeping services;
  - any period during which you or your Dependent is not under the continuing care of a Physician.

  Covered Medical Expenses for Home Health Care:

  - will be limited to 40 visits per Calendar Year except that visit limit will not apply when the visit relates to the treatment of hemophilia; and
  - must be provided by a member of the Home Health Care team, including a home health aide.

A "visit" will consist of up to four (4) consecutive hours of service or any fractional part of four (4) hours within a 24 hour period.

As used above, "Home Health Agency" may include:

- a Hospital that has a valid operating certificate and is certified to provide Home Health Care services; or
- a public or private health service or agency that provides skilled nursing care functions or activities in your or your Dependent's home. It is licensed as such (or if no license is required, approved as such) by a state department or agency having authority over Home Health Care Agencies.

- A cancer second medical opinion from a specialist for the treatment of cancer in the event of:
  - a positive or negative diagnosis of cancer;
  - a recurrence of cancer; or
  - a recommendation of a course of treatment for cancer.
- The following equipment and supplies for the treatment of diabetes, when recommended or prescribed by a Physician or other legally authorized health care provider:
  - blood glucose monitors and blood glucose monitors for the legally blind;
  - data management systems;
  - test strips for glucose monitors and visual reading and urine testing;
  - insulin. unless otherwise payable under the Prescription Drug benefit;
  - injection aids, and syringes;
  - cartridges for the legally blind;
  - insulin pumps and appurtenances;
  - insulin infusion devices; and
  - oral agents for controlling blood sugar.

  Coverage will include diabetic self-management education and education relating to proper diet for the purposes of providing you or your Dependent with proper self-management and treatment of his or her diabetic condition when provided by:
  - a Physician, or other legally authorized health care provider, or the staff of such provider as part of an office visit for diagnosis or treatment of diabetes; or
  - a certified diabetes nurse educator certified nutritionist, certified dietitian or registered dietician, if referred by a Physician or other legally authorized health care provider, in a group setting whenever possible.

  Benefits for self-management education and education relating to diet, including home visits, and except for visits that are primarily for weight loss, will include but be limited to Medically Necessary visits upon the diagnosis of diabetes, when:

- the Physician diagnoses a significant change in your or your Dependent's symptoms or conditions which require changes in your self-management; or
- re-education or refresher education is necessary.

- Ambulatory Care provided in a Hospital Outpatient facility or in a Physician's office that is ordered by a Physician. Such care includes diagnostic services, treatment, mild medications used for non-experimental cancer chemotherapy and cancer hormone therapy, provided such services and medications are Medically Necessary for the treatment or diagnosis of your or your Dependent's Illness or Injury.

  However, payment for physical therapy is limited to physical therapy that commences within six (6) months after discharge from a Hospital or the date surgical care was rendered. No payment will be made for any physical therapy occurring after 365 days from the date of discharge from the Hospital or the date surgical care was rendered that requires such physical therapy.

- Preventive and primary care services rendered by a Physician to a Dependent child from the date of birth to age 19. There are no Deductibles or Co-payment requirements for this benefit. Coverage will consist of the following services that must be provided in accordance with the prevailing clinical standards of a national association of pediatric doctors designated by the Commissioner of Health:
  - an initial Hospital check-up and scheduled well-child care visits, when such services are provided by, or under the supervision of:
    - a Physician in a Physician's office; or
    - a licensed health care practitioner acting within the scope of his or her practice who has the authority to perform the specified services.
  - covered services at each visit will include:
    - medical history;
    - complete physical examination;
    - developmental assessment;
    - anticipatory guidance; and
    - appropriate immunizations and laboratory tests which are ordered at the time of the visit and performed in the practitioner's office, as authorized by law, or in a clinical laboratory; and
  - necessary immunizations as determined by the Superintendent in consultation with the Commissioner of Health consisting of at least adequate dosages of vaccine against:
    - diphtheria; pertussis; tetanus;
    - polio; measles; rubella, mumps;
    - hemophilus influenza type B; and
    - hepatitis B;

which meet the standards approved by the United States Public Health Service for such biological product.

WHAT'S NOT COVERED

GENERAL EXCLUSIONS

Important: Be advised that routine check-ups that are unrelated to a medical diagnosis are not covered for adults under the Plan, even if you use a MagnaCare provider. Exceptions are made for a routine mammogram, annual gynecological visit and Pap smear, and well-child care.

The following charges are not Covered Medical Expenses under this Plan:

- Charges that are not listed as Covered Medical Expenses and charges that are listed as a **General Exclusion, below**;
- Charges due to confinement; services; supplies; or treatment that the Trustees determine is not Medically Necessary. This does not apply to preventive or other health care services specifically covered under this Plan.
- Charges due to any confinement, services, supplies, or treatment:
  - that is not recommended and approved by a Physician; or
  - received while not under the care and treatment of a Physician.
- Charges due to nursing care rendered in a Hospital by a private duty nurse.
- Charges incurred in connection with treatment that is cosmetic. This does not apply to:
  - reconstructive surgery to restore tissue damaged by Injury or Illness: or
  - treatment of a child from birth to correct a congenital disease or anomaly including an oral defect; or
  - reconstructive surgery breast surgery following a mastectomy including reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy including lymphedemas.
- Charges due to the repair or replacement of orthotic devices other than due to growth.
- Any portion of a charge which is in excess of the Reasonable and Customary charge for the treatment.
- Charges incurred for treatments, procedures, or medicines that are not generally accepted by the medical profession, or that are listed as experimental, under investigation or limited to research:
  - by the federal Food and Drug Administration (FDA); the American Medical Association (AMA); Diagnostic and Therapeutic Technology Assessment (DATTA); or the Office of Medical Application of Research of the National Institute of Health Office of Technology Association (OMT); or
  - if a treatment has not been addressed by one of the organizations listed above, the Trustees have the right to determine if a treatment is appropriate based on the advice

of its medical review department and/or an independent medical reviewer and other medical experts.

However, a drug prescribed for the treatment of a certain type of cancer will not be excluded on the basis that such drug has not been approved by the federal Food and Drug Administration (FDA), provided, however, that such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:

- the American Medical Association Drug Evaluations;
- the American Hospital Formulary Service Drug Information;
- the United States Pharmacopeia Drug Information; or
- recommended by review article or editorial comment in a major peer reviewed professional journal.

No coverage will be provided for any experimental or investigational drugs or any drug which the FDA has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed. This exclusion is subject to your or your Dependent's right to external appeal.

- Charges due to the purchase or fitting of eyeglasses or contact lenses. However, charges incurred for contact lenses or eyeglasses and frames required immediately following and because of cataract surgery will be a Covered Medical Expense.
- Charges due to a voluntary surgical sterilization, or its reversal, subject to your or your Dependent's right to external appeal.
- Charges due to non-prescription:
  - drugs or medicines;
  - vitamins;
  - nutrients; and
  - food supplements;

  even if prescribed or administered by a Physician. This does not apply to the extent any of these is the only available source of nutriments.
- Charges incurred directly or indirectly for weight loss, other than surgical treatment of morbid obesity.
- Charges incurred for the purchase or fitting of hearing aids;
- Charges incurred for treatment of the teeth or gums, or alveolar processes, except as specifically listed as a Covered Medical Expense. However, charges incurred for the repair or replacement of sound natural teeth required as the result of and within one year of an accidental Injury (and not as the result of biting or chewing) will be Covered Medical Expense;

- Charges for medicines; vitamins; nutritional supplements; support garments or other items purchased pursuant to the written order of a Physician, but which may be purchased without a written prescription. This exclusion does not apply to such items if they are specifically listed as a Covered Medical Expense in this benefit.
- Charges made by an individual who is a member of your or your Dependent's "Immediate Family" or is a member of your or your spouse's "Immediate Family." "Immediate Family" means the spouse, child, parent, brother, or sister of you or your Dependent.
- Charges due to broken or missed appointments.
- Charges due to confinement, services, supplies, or treatment that are required only for insurance purposes; for travel; for employment; for school; for camp; or similar services.
- Charges incurred for personal comfort items such as telephone, radio, television, or barber services.
- Charges incurred for routine foot care such as trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet.
- Charges incurred for Custodial Care, except as specifically provided under this Plan.
- Charges which you or your Dependent are not legally obliged to pay for; or treatment which you obtain, or are entitled to obtain, under any plan or program without charge, except Medicaid. This will include charges for treatment which is provided or paid for by the federal government at a Veteran's Administration facility for:
  - an Injury or Illness related to your or your Dependent's military service; or
  - you, or your Dependents. If you retired from the armed services.
- Charges incurred due to attempted suicide or intentionally self-inflicted injury unless such act occurs when diagnosed as clinically depressed or mentally ill.
- Charges incurred as a result of an act of war, whether declared or not or any related act.
- Charges incurred during participation or as the result of participation in a riot or a civil disorder.
- Charges incurred as the result of your or your Dependent's commission or attempt to commit a felony.
- Charges due to an Illness or Injury that is employment related or payable under any:
  - Workers' Compensation Law;
  - Occupational Disease Law; or
  - similar laws.

PRESCRIPTION DRUG BENEFITS

HOW THE PLAN WORKS

Prescription Drug benefits are available to Plan A+ and Plan A participants and their eligible dependents through Express Scripts. Prescription Drug coverage is not available to Plan B participants. There is an annual maximum of $5,000 for prescription drugs under Plan A.

How to Obtain Your Prescription Drugs

Express Scripts has established a Network of pharmacies through which you may fill prescriptions. If you use one of Express Scripts participating pharmacies, your out-of-pocket costs may be lower than if you use a non-participating pharmacy.

The Express Scripts Network consists of over 60,000 pharmacies nationally, including chain drugstores like CVS, Rite Aid and Walgreens. You may contact Express Scripts Member Services at (866) 544-2926 to find a pharmacy in your area that participates with Express Scripts. ***You can also locate a participating pharmacy on Express Scripts web site at www.expressscripts.com.***

For service, simply present your identification card and a valid prescription at any pharmacy for service. While a pharmacy can usually check eligibility online without an ID card, if you purchase a prescription at a participating pharmacy without your ID card, you might need to pay for the prescription and submit the prescription drug receipt to Express Scripts for reimbursement. The participating pharmacy will dispense a prescription in a quantity not to exceed a 30-day supply and collect the applicable Co-payment (as described on the next page).

If you purchase a prescription at a non-participating pharmacy, you will have to submit a claim form along with the prescription drug receipt to Express Scripts for reimbursement. You must submit the receipt(s) no later than 12 months from date of purchase in order to receive reimbursement. Please note that any difference between the cost of the prescription and the amount allowed by the Plan will be your responsibility (in addition to the applicable Co-payments). It is always to your advantage to use a Participating Pharmacy.

See the "Claims Information and Appeals" Section of this booklet for information on how to file a prescription drug claim.

Prescription Drug benefits are available for Plan A+ and Plan A participants. Plan B participants are not eligible for prescription drug coverage.

The prescription drug benefit is structured as a three-tiered program with Co-payments, as follows:

Plan A+

Be sure to use your Prescription Drug Card to get prescriptions filled at a local participating pharmacy for a 30-day supply or less. You may use the Mail Order service for chronic medications (30 days or longer, up to a 90-day supply).

Prescription Drug Co-payment	
Retail Generic	No Co-payment
Retail Preferred Brand-name	$15 Co-payment
Retail Non-preferred Brand-name	20% coinsurance; $30 minimum/$60 maximum
Mail Order Generic	$5 Co-payment
Mail Order Preferred Brand-name	$30 Co-payment
Mail Order Non-preferred Brand-name	$60 Co-payment

Plan A

Use your Prescription Drug Card for up to a 30-day supply from your local participating pharmacy and the Mail Order service for chronic medications (30 days or longer up to a 90-day supply). **Plan A has a Mandatory Generic Drug Program that is described on the next page**.

Prescription Drug Co-payment	
Retail	
Generic	$10, or 25% of total cost*
Preferred Brand-name	$20, or 25% of total cost*

Non-preferred Brand-name	$40, or 25% of total cost*
Mail Order	
Generic	$20, or 25% of total cost*
Preferred Brand-name	$40, or 25% of total cost*
Non-preferred Brand-name	$80, or 25% of total cost*

* Your cost is the greater of the Co-payment or the percentage of the total cost

Mandatory Generic Drug Program

If you are a Plan A participant, you must ask your provider to authorize a generic substitution for a brand-name prescription, if an approved generic is available and it is acceptable for you to use. If your doctor agrees, get a new prescription for the generic medication and take it to your local retail pharmacy or send to Express Scripts by Mail. You will pay an amount in addition to the Co-payment listed above when you purchase a brand-name medication that has a generic equivalent. The additional amount will be the difference between the approved cost of the brand-name and the generic medication. **Note**: The difference will be charged even if your provider indicates "Dispense as Written" or "No Substitution" on the prescription.

Save Money – For You and the Plan By Using Generics

Some interesting facts about generic drugs:

- Generics contain the same active ingredients and must meet the same standards as their brand-name counterparts.
- Generics must also be equivalent in strength and usage and produce the same effect as the original brand-name drug.
- Generics usually cost 30-60% less.
- Half of all prescription drugs are now available as generics.

Plan A Specific Exclusions

The following drugs are not covered and are excluded from Plan A coverage:

- All Proton Pump Inhibitors (PPIs), including Aciphex, Prevacid, Protonix, Omeprazole, and Nexium
- Non/Low Sedating Antihistamines (NSAs), including Allegra, Zyrtec, and Clarinex.

In addition, some PPIs and NSAs are excluded because they are now available as over-the-counter drugs – e.g., Prilosec OTC, and OTC NSAs such as Loratadine, Claritin 24-Hour Allergy, and Tavist ND among others.

Want to Know if a Drug is Covered?

Simply access the Express Scripts Health website at www.ExpressScripts.com for a list of preferred drugs on the formulary or to find out which medications may have been excluded. You can also call Member Services at (866) 544-2926.

Mail Order Prescriptions

If you are prescribed chronic medication or use "maintenance" prescription drugs, you have the option of participating in the Express Scripts By Mail prescription Mail Order program where you can obtain up to a 90-day supply of prescription drugs, rather than a 30-day supply at your local retail pharmacy. To participate in the program, ask your doctor to indicate the number of refills needed for the "maintenance" drug prescription. You can then mail your prescription, with an applicable Co-payment, as well as the patient profile/registration form available from the Plan Office to Express Scripts By Mail. **Remember: If you are in Plan A, you must use the Mandatory Generic Program if a generic equivalent is available and acceptable for you to use.**

In order to receive refills, simply complete the prescription order form provided with your order and mail it to Express Scripts By Mail.

Your medication will be delivered to you at no additional cost. Please allow 7-11 days turnaround time for delivery. It is recommended you have an adequate supply of medication to cover the delivery period. In an emergency situation, your prescription can be sent overnight for an additional fee. If your doctor faxes the prescription, please allow 5-8 days for delivery.

If you need assistance or have questions about Express Scripts By Mail, call Member Services at (866) 544-2926 or access their website at www.Express Scripts.com.

Limitations Under the Mail Order Program

The following limitations would apply for mail order prescriptions:

- No prescription may exceed a three (3) month supply.
- There will be an additional charge for injectables, other than injectable insulin for the treatment of a diabetic condition, which are not covered under the Medical benefits.
- Prescription drugs administered in a Physician's office and prescription drugs compounded for IV infusion are not covered.
- Maintenance prescription drugs that are limited to two retail fills must be submitted to the mail order service.

WHAT'S COVERED

Covered prescriptions include:

- Prescriptions which require compounding.
- Prescriptions for legend drugs (drugs which cannot be dispensed by a pharmacy without a prescription)
- Insulin (daily dosage includes needles and syringes), diabetic drugs, and birth control pills.

WHAT'S NOT COVERED

Please contact Express Scripts for the most up-to-date information on which drugs are not covered by the Plan. This list is reviewed from time to time, in light of new drugs approved by the FDA and other considerations, and the list is revised from time to time based on criteria established by Express Scripts.

VISION BENEFITS

HOW THE PLAN WORKS

The Fund provides Vision benefits through a variety of cooperating vision care providers. Once a year, you and your Dependent are eligible for a routine eye examination, one pair of eyeglasses, and one pair of frames (limited selection). For a list of vision providers, you can call or e-mail the Plan Office.

WHAT'S COVERED

Vision benefits are paid according to the following schedule. You will not be reimbursed for any amount over those listed in the Schedule of Benefits below.

Vision Schedule of Benefits

Service	Maximum Allowance Per Year
Routine Eye Examination (one per Calendar Year)	$15.00
Eyeglass Frames	$11.00
Lenses:	
Single Vision	$13.00
Bi-Focal	$19.00
Tri-Focal	$24.00

WHAT'S NOT COVERED

Benefits are not payable for examinations, lenses and frames in excess of one of each (two lenses) per Calendar Year; sunglasses unless they are prescribed to work essentially at all times; tinted-lens glasses unless they are prescribed by an ophthalmologist for medical reasons; and routine annual examinations required by an employer in connection with the occupation of the covered individual.

LOSS OF TIME BENEFIT

The Loss of Time benefit applies to Plan A+ (with hospitalization), Plan A+ and Plan A participants. The benefit will be paid when you provide proof that while covered under this benefit, you became Totally and Continuously Disabled as a result of:

- a non-occupational accidental Injury; or
- an Illness, not due to Occupational Disease.

The Fund will pay $75 per week for up to a maximum of 13 weeks. For any Period of Disability that is less than one week in duration, the benefits will be paid at one-seventh of the weekly amount multiplied by the number of days.

Benefits will be paid for the period stated on the claim form. If disability continues beyond that period, a second form must be filed.

Proof of Disability

You must provide the Board of Trustees with due proof of disability. The treating doctor must, within the scope of his/her license, certify: (a) your disability; (b) probable duration of the disability; and (c) medical facts within his/her knowledge.

Successive Period(s) of Disability

Successive Period(s) of Disability are considered one Period of Disability unless:

- you have returned to continuous active full-time employment for two (2)consecutive weeks; and
- the disability is due to causes entirely unrelated to and different from those that caused the previous disability and you have returned to work for at least one (1) full day.

Exclusions

No benefits are payable for any Period of Disability:

- During which you are not under the direct care of a doctor. It is understood that no disability will be considered as having begun more than three (3) days prior to the first visit made to or by a doctor for the condition which caused the disability;

- Due to accidental bodily Injury arising out of and in the course of your employment;
- Due to Occupational Disease;
- Due to intentional self-inflicted injury unless such act occurs when diagnosed as clinically depressed or mentally ill;
- Participation in a felony or a riot;
- War or act of war, declared or undeclared or any act related to war, or insurrection;
- Service in the Armed Forces or units auxiliary to the Armed Forces; or
- Which did not start while you were covered under this benefit.

File Loss of Time claims with:

Gloria McCormick
Fund Administrator
Local 802 Musicians Health Fund
322 West 48th Street
New York, NY 10036

For Loss of Time (Disability) Claim, the Fund Administrator will make a decision on the claim and notify you of the decision within 45 days. If the Fund requires an extension of time due to matters beyond the control of the Fund, you will be notified of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the time the Fund notifies you of the delay. The period for making a decision may be delayed an additional 30 days, provided the Fund Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Fund's request for the information, you will be notified of the Fund's decision on the claim within 30 days. For Disability Claims, the Fund

reserves the right to have a Physician examine you (at the Fund's expense) as often as is reasonable while a claim for benefits is pending.

SICK PAY BENEFIT

The Sick Pay benefit applies to participants who are covered under Plan A+ (with or without hospitalization), Plan A and Plan B. The benefit will be paid when you provide the Fund Office with proof that, while covered under this benefit, you became Totally and Continuously Disabled as a result of:

- a non-occupational accidental Injury; or
- an Illness, not due to Occupational Disease

Eligibility for Sick Pay Benefits

You are eligible to begin accruing Sick Pay benefits on the date you become covered under an employment agreement with the Broadway League [on your first performance played].

Accrual of Sick Pay Benefits

You will accrue sick days during the year that runs from Labor Day to Labor Day. You accrue benefits for all employment covered under an agreement with the Broadway League as a regular employee or substitute. There is no minimum number of shows

performed to begin to be eligible to accrue sick time you will accrue one (1) sick day for every fifty-two (52) Broadway performances played. For purposes of this benefit, absences for [**paid**] vacation are counted as performances played.

Your Sick Pay Benefits

Sick Pay Benefits are paid directly by the Fund. However, you are not eligible for a paid sick day until you have performed at least 52 performances. You may claim sick pay benefits if you are ill and miss a performance for which you are engaged.

Sick days may be accrued retroactively. In other words, if you take a sick day before you have played 52 performances, you may be reimbursed for that previous sick day as of the date that you have played 52 performances.

The Plan allows for a maximum of eight paid sick days per year. If you do not use your accrued sick days by Labor Day, you will forfeit any unused days. However, in the case of a prolonged, continuous illness that lasts for longer than seven (7) consecutive days, you may claim any unused sick days from the preceding year. To claims these benefits,

you must provide the Fund Office with a physician's certification attesting to your continued illness.

Make sure you notify your employer of your illness when you give notice of your absence and your substitute.

Amount of Sick Pay Benefit

The amount of the benefit payable for each sick day is equal to the gross wages (subject to Medicare and Social Security taxes) you lost due to the absence caused by your illness.

How to Claim Sick Pay Benefits

In order to claim benefits, you must complete the "Application for Benefits from the Sick Pay Fund of Local 802 American Federation of Musicians" form. You must have your employer complete the form and certify that you were absent on the date claimed**.** You must submit the completed claim form to the Fund Office within **30 days** of your illness in order to receive benefits. If your claim form is not received by the Fund Office within 30 days, you will not receive benefits for the day(s) you were out sick. Mail or bring your completed claim form to the Fund Office, 322 West 48th Street, New York, NY 10036.

If you are claiming benefits due to an extended illness (over 7 days) and wish to use the prior year's unused benefits, you must attach a physician's certification to the benefit claim form.

If you are claiming benefits before you have worked the necessary number of days to have accrued a sick pay day, submit your claim as soon as you return to work, and within 30 days from the date you take the sick day. You will receive payment of benefits as soon as you have worked the necessary number of days to be eligible for this benefit.

PLAN A+ WITH HOSPITALIZATION (ONLY) REIMBURSEMENT FOR FAMILY COVERAGE

The Plan offers you a family premium reimbursement policy. Under this provision of the Plan, the Fund will reimburse you the full weekly amount contributed on your behalf towards the cost of your family policy if you had family hospitalization coverage before you began to work in Covered Employment and you wish to continue that coverage instead of being covered under the Fund. In order to claim this benefit, you must provide proof of the expense to the Fund Office. The proof must include a copy of the policy and the bill as well as a cancelled check (or other proof) proving that you or your spouse paid the premium amounts for that family coverage. Reimbursement will be made twice a year in January and July.

PREMIUM REIMBURSEMENT PLAN

NEW YORK STATE RESIDENTS

If contributions are made on behalf of a musician and the minimum threshold is not reached for Plan B coverage, then he/she may be able to claim up to 50 percent of the employer contributions made to the plan on his/her behalf in order to help defray part of the cost of purchasing medical coverage elsewhere. In order to do so, the musician must present proof of payment for the applicable period from a privately purchased health insurance plan with a hospitalization component. Please contact the Local 802 Musicians Health Fund for an application.

NEW JERSEY RESIDENTS

For participants who are New Jersey residents and obtain alternative health coverage with respect to a six-month coverage period, the Fund will reimburse the participant in the amount of *the lesser of*:

1) 90% of the contributions made to the Fund on behalf of the participant during the relevant six-month period, or
2) 90% of the premiums paid by the participant for the alternative coverage for such six-month period,

provided that the participant submits appropriate evidence of payment for the alternative coverage.

If both spouses are participants in the Fund, the reimbursement provided by the Fund will not exceed 90% of the actual total cost of the alternative coverage provided to the participants, though each participant may submit the same documentation as proof of payment. For example, assume that contributions in the amount of $5,000 were made to the Fund for each participant (i.e., a total of $10,000), and the alternative coverage costs $6,000 in total for the two participants. If each participant presents the bill for $6,000, the Fund will not reimburse each participant $4,000 (i.e., 90% of the contributions paid on each of their behalf), for a total of $8,000; the Fund will reimburse, in total, 90% of the $6,000 cost (i.e., $5,400), which is less than 90% of the total contributions.

Participants who wish to receive this reimbursement must complete a Reimbursement Form and must waive all medical/hospitalization benefits offered through the Local 802 Musicians Health Fund. Premium Reimbursement will not be issued if the Fund has not received the notarized waiver form.

Please contact the Fund office to receive the Reimbursement and Waiver Form.

These clarifications are meant to confirm that this reimbursement is designed to defray the costs of purchasing alternative coverage, and in no case will the Fund reimburse any amount above 90% of the actual cost of the alternative coverage.

CLAIMS AND APPEALS PROCEDURES - FOR MEDICAL BENEFITS (INCLUDING VISION AND PRESCRIPTION DRUGS)

This Section applies to *medical benefits only (including vision and prescription drug)*. The Claims and Appeals Procedures for hospitalization benefits are described in the Empire BlueCross Certificate of Coverage, which also describes procedures and requirements for pre-certification and pre-authorization.

As explained previously in this booklet, if you use a MagnaCare PPO Network provider for medical benefits or an Express Scripts Participating Pharmacy for prescription drug benefits, you do not need to file a claim. However, if you use an Out-of-Network provider or non-participating pharmacy, you will need to file a claim.

When you file a claim for a non-Network service or non-Participating Pharmacy prescription benefit, make sure you include with your claim all itemized bills that include employee name and Social Security Number; patient's name; date and type of service; diagnosis; charge for each service; and provider's name, address, telephone number and tax identification number.

You must submit the original claim forms, bills and supporting documentation to receive benefits. Please maintain a copy of these documents for your records.

Claim forms must be completed in their entirety by all parties called for (i.e., participant, patient, provider, etc.) and should be submitted to the appropriate Claims Administrator (listed on page 94) within 90 days of the date the medical service was performed. Improperly completed claim forms will cause a delay in the payment of your claim.

CLAIMS AND APPEALS

Definition of a Claim

A claim for benefits is a request for Fund benefits made in accordance with the Fund's reasonable claims procedures including filing a claim (where necessary). The claims procedures vary depending on the specific benefit you are requesting. When the procedures require that you file a claim for benefits offered under the Fund, you must submit a completed claim form.

The following are not considered to be claims for benefits:

- Simple inquiries about the Fund's rules that are unrelated to any specific benefit claim or are exclusively about eligibility.
- A request for prior approval of a benefit that does not require prior approval by the Fund.
- The presentation of a prescription to a pharmacy that exercises no discretion on behalf of the Fund.
- The presentation of your identification card to a participating provider that exercises no discretion on behalf of the Fund.

In order to file a claim for benefits offered under the Fund, you must submit a completed claim form if the service was provided by an Out-of-Network Provider.

Authorized Representatives

Your authorized representative may complete the claim form for you if you are unable to complete the form yourself and/or wish to designate another individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim (defined below) without you having to complete the special authorization form.

TYPES OF CLAIMS

The following is a summary of the types of medical claims (including vision and prescription drug) and the procedures applicable to each type of claim.

Pre-Service Claims

A Pre-Service Claim is a claim for a benefit for which the Fund requires approval of the benefit (in whole or in part) before medical care is obtained. The only claims that require precertification are under the Hospitalization and HMO benefit. Please refer to the Empire BlueCross Certificate for information on those requirements .

If you improperly file a Pre-Service Claim, you will be notified as soon as possible but not later than 5 days after receipt of the claim, of the proper procedures to be followed in filing a claim. You will only receive notice of an improperly filed Pre-service claim if the claim includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim.

For properly filed Pre-Service Claims, you will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Claims Administrator. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case you and/or your doctor will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Claims Administrator then has 15 days to make a decision on a Pre-Service Claim and notify you of the determination.

Urgent Care Claims

An Urgent Care Claim is any claim for medical care or treatment with respect to which the application of the time periods for making pre-service claim determinations:

(1) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or

(2) 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 the care or treatment that is the subject of the claim.

Whether your claim is an Urgent Care Claim is determined by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a Physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above, shall be treated as an Urgent Care Claim.

If you improperly file an Urgent Care Claim, you will be notified as soon as possible but not later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is re-filed properly, it will not constitute a claim.

If you are requesting precertification of an Urgent Care Claim, the time deadlines are different. The Claims Administrator precertifying your claim will respond to you and your doctor with a determination by telephone as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt of the claim. The determination will also be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, you will be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You must provide the specified information within 48 hours. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided no later than 48 hours after the plan receives the specified information or the end of the period given for you to provide this information, whichever is earlier.

Note: Claims involving Urgent Care must be submitted by telephone to the Claims Administrator that administers the benefit requested, by calling the number listed in this booklet, followed by written notice within 24 hours with the information listed above. (See "Where to File Claims" below.) Urgent Care Claims may not be submitted in writing.

Concurrent Care Claims

A Concurrent Care Claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment. A reconsideration of a benefit with respect to a Concurrent Care Claim that involves the termination or reduction of a previously-approved benefit (other than by plan amendment or termination) will be made as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend approved Urgent Care treatment will be acted upon within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

Post-Service Claim

A Post-Service Claim is a claim that is not a Pre-Service Claim (for example, a claim submitted for payment *after* health care services and treatment have been obtained). Ordinarily, you will be notified of the decision on your Post-Service claim within 30 days from receipt of the claim. This period may be extended one time by the Claims Administrator for up to 15 days if the extension is necessary due to matters beyond the control of the Claims Administrator. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided

within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Claims Administrator then has 15 days to make a decision on a Post-Service Claim and notify you of the determination.

In order to file a post-service claim:

1. Obtain a claim form from the Fund Office or insurer, if applicable.
2. Complete the employee's portion of the claim form.
3. Have your Physician either complete the Attending Physician's Statement section of the claim form, submit a completed Universal/CMS-1500 claim form, or submit a HIPAA-compliant electronic claims submission.
4. Attach all itemized bills or doctor's statements that describe the services rendered.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

Reminder: Benefits obtained through an In-Network Magna Care Provider or Participating Express Scripts Pharmacy do NOT require the submission of a claim form. The provider will complete the paperwork for you.

Your claim will be considered to have been filed as soon as it is received at the applicable address below by the Claims Administrator that is responsible for making the initial determination of the claim. You must submit a claim for the following to the appropriate Claims Administrator as detailed below:

MagnaCare – Medical Claims

MagnaCare is the Claims Administrator for all medical claims other than vision and prescription drug claims. All such claims must be submitted to:

Local 802 Musicians Health Plan
c/o MagnaCare,
P.O. Box 1001
Garden City, NY 11530

If you reside in New York or New Jersey, MagnaCare is your PPO Network. If you live outside New York or New Jersey, a MagnaCare-subsidiary network will be available to you. Make sure you check your MagnaCare ID card for appropriate network access.

Prescription Drug Claims

Express Scripts is the Claims Administrator for all prescription drug benefits.

When you present a prescription to a pharmacy to be filled under the terms of this Plan, that request is not a "claim" under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures**. In addition, if you use a *non-participating pha*rmacy, you will need to file a claim form in order to obtain reimbursement.**

Submit prescription drug claims to:

Express Scripts
Fairfield
P.O. Box 747000
Cincinnati, OH 45274-7000

Vision Benefit Claims

The Fund Office is the Claims Administrator for all vision benefits.

Submit vision claims to:

Gloria McCormick
Fund Administrator
Local 802 Musicians Health Fund
322 West 48th Street
New York, NY 10036

WHEN CLAIMS MUST BE FILED

MagnaCare and Vision claims must be filed within two years of the date of service. Non-participation pharmacy claims must be filed one year of the date of service. Failure to file claims within the time required will not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible.

NOTICE OF DECISION ON A CLAIM

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge; and
- If the determination was based on the absence of Medical Necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.
- For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally, followed by written notification.

For Urgent Care Claims and Pre-Service Claims, you will receive notice of the determination even when the claim is approved.

REQUEST FOR REVIEW OF DENIED CLAIM

If your claim is denied, in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the applicable Claims Administrator within 180 days after you receive notice of the denial. Appeals involving Urgent Care Claims may be made orally by calling the Claims Administrator at the number listed on your ID card.

REVIEW PROCESS

- The review process works as follows. You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Claims Administrator in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.
- Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Claims Administrator on your claim, without regard to whether their advice was relied upon in deciding your claim.
- A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.
- If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Timing of Notice of Decision on Appeal

- ***Pre-Service (including Urgent and Concurrent) and Post-Service Hospital Claims***. Refer to the Empire Blue Cross Certificate of Coverage for details as to timing of pre-service, urgent, concurrent and post-service hospital claims by Empire BlueCross BlueShield.
- ***All other Post-Service Claims***: Ordinarily, decisions on appeals involving Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for

review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

- ***Loss of Time Claims***: Ordinarily, decisions on disability claims will be reached within 45 days of your request for review. However, in special circumstances, up to an additional 45 days may be necessary to reach a final decision on a disability claim. The Fund Office will advise you in writing within the 45 days after receipt of your request for review if an additional period of time will be necessary to reach a final decision on your disability claim.

Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination.
- Reference to the specific Plan provision(s) on which the determination is based.
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on Medical Necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Limitation on Legal Actions

You may not start a lawsuit to obtain benefits relating to a denied claim until after you have exhausted the Plan's administrative claims and appeals procedures. In other words, you must have requested a review and received a final decision on review of your appeal, or if you have not received such a decision, then the appropriate time frame described above must have elapsed. You may also pursue your remedies under Section 502(a) of ERISA without exhausting the Plan's claims and appeals procedures if the Claims Administrator has failed to follow them. No lawsuit may be started more than 3 years after the end of the year in which the services were provided or, if the claim is for short term disability benefits (loss of time), more than 3 years after the start of the disability.

COORDINATION OF BENEFITS (COB)

All medical (including prescription drug and vision) benefits under this Plan are subject to this Coordination of Benefits (COB) provision. COB applies when you are covered for medical benefits under more than one plan. There are specific COB rules that apply to the Empire BlueCross BlueShield Hospitalization benefits, which are described in detail in the Empire Certificate.

If this COB provision applies, the Order of Benefit Determination Rules below should be reviewed first. Those rules determine whether this Plan is a Primary Plan or a Secondary Plan. A "Primary Plan" means the plan that pays benefits first under the rules. A "Secondary Plan" is any plan that is not a Primary Plan. When there are more than two plans covering you or your Dependent, this Plan may be a Primary Plan as to one or more other plans and a Secondary Plan to another.

If this Plan is considered:

- Primary, COB will not apply and benefits will not be reduced; or
- Secondary, COB will apply, and benefits may be reduced so that the total payment from all plans will not exceed 100% of total Allowable Expenses. This reduction is described later in this Section.

Plans Considered for COB

"Plan" is any of the following that provides benefits or services for or because of medical care or treatment:

- Group, blanket or franchise insurance or other group type coverage, whether insured or self insured. This includes HMOs and other prepayment, group practice, or individual practice coverages;
- Union welfare plans, employee organization plans, or labor-management trustee plans;
- Individual "no-fault" coverage to the extent required by law or the medical expense benefits under group automobile "no-fault" policies;
- coverage under a governmental plan or coverage required or provided by law. This does not include benefits payable under any state plan under:

a. Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or

b. Any plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

Each contract or other arrangement for coverage as noted above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

“Plan” will not include:

- individual or family policies, or individual or family subscriber contracts;
- group hospital indemnity benefit amounts which are less than $150 per day; or
- school accident type coverage.

Order of Benefit Determination Rules

General

When there is a basis for a claim under this Plan and another plan, this Plan is a Secondary Plan and its benefits are determined after those of the other plan, unless;

- the other plan has rules coordinating its benefits with those of this Plan; and
- both those rules and this Plan's COB Rules require that this Plan's benefits be determined before those of the other plan.

Rules

This Plan determines its order of benefits using the first of the following rules which applies:

- Non-Dependent/Dependent—The benefits of the plan which covers the individual as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the individual as a dependent.
- Dependent Child/Parents *not* Separated or Divorced— Except as stated in the next bullet, when this Plan and another plan cover the same child as a dependent of different individuals called “parents:”

a. the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;

b. but, if both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time;

c. however, if the other plan:

i. does not have this “birthday rule”, but

ii. has a rule based upon the gender of the parent; and

if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- Dependent Child/Parents Separated or Divorced—If two or more plans cover a child as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a. first, the plan of the parent with custody of the child;

b. then, the plan of the spouse of the parent with the custody of the child; and

finally, the plan of the parent not having custody of the child.

However. if the specific terms of a court decree state:

a. that one of the parents is responsible for the health care expense of the child; and

b. the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms,

the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any:

a. Claim Determination Period; or

b. Plan Year

during which any benefits are actually paid or provided before the entity has the actual knowledge.

- Active/Inactive Employee—The benefits of a plan which covers the individual as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers the individual as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- Longer/Shorter Length of Coverage—If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, person or subscriber longer are determined before those of the plan which covered the employee, person or subscriber for the shorter term.

Effect on Benefits

COB applies to this Plan when, in accordance with the Order of Benefit Determination Rules, this Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of this Plan may be reduced under this COB provision. Such other plan or plans are referred to as “the other Plans” immediately below.

Reduction in This Plan's Benefits

The benefits of this Plan will be reduced when the sum of:

- the benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
- the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because you or your Dependent does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to:

- Second Surgical Opinions;
- preauthorization of admissions or services; and

- Preferred Provider arrangements.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The Board of Trustees has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or individual. The Board of Trustees need not tell, or get the consent of, any individual to do this. Each covered person claiming benefits under this Plan must give the Board of Trustees any facts it needs to pay the claim.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Board of Trustees may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under this Plan. The Board of Trustees will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the company is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- the individuals it has paid or for whom it has paid;
- insurance companies; or
- other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION OF BENEFITS AND MEDICARE

Medicare Benefits at Age 65

If you or your Dependent is entitled to benefits under Medicare because you are age 65, the following rules will determine which plan is primary under the Coordination of Benefits (COB) provision.

For Active Employees and Their Dependents

This Plan will be the Primary Plan to Medicare for you or your Dependent who is age 65 or older, and:

- an active employee; or
- a dependent of an active employee.

To determine the amount of reduction for COB purposes, the Claims Administrator will include all benefits for which you or your Dependent are eligible under Medicare Parts A and B. Such benefits will be considered payable under Medicare, whether or not you or your Dependent has:

- registered for Part A benefits; or
- enrolled for Part B benefits.

Medicare Benefits Due to Total Disability

You or your Dependent may become entitled to Medicare benefits prior to age 65 if you:

- are totally disabled; or
- have End Stage Renal Disease (ESRD).

The following rules apply with respect to COB with Medicare due to total disability or ESRD prior to age 65. Upon attainment of age 65, the rules for COB with Medicare at age 65 will apply.

During Medicare Waiting Period

The Plan will be a Primary Plan to Medicare during any waiting period for Medicare benefits due to total disability or ESRD.

After Medicare Waiting Period

After the Medicare waiting period has been met, and you or your Dependent are entitled to Medicare benefits, this Plan will be a:

- Primary Plan to Medicare for you or your Dependent who is an active employee and entitled to Medicare benefits due to total disability other than ESRD; and
- Secondary Plan to Medicare for you or your Dependent who is an active employee and entitled to Medicare benefits due to ESRD.

Electing Medicare as Primary Plan

You or your Dependent who is entitled to Medicare benefits at age 65 or as a result of total disability may elect to have Medicare as the Primary Plan by giving notice to the Fund Office. If you or your Dependent elect Medicare as your Primary Plan, your coverage under this Plan will cease.

PRIVACY POLICY

The Fund is required to protect the confidentiality of your Protected Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the rules issued by the U.S. Department of Health and Human Services ("HHS"). Protected Health Information (PHI) refers to all individually identifiable health information transmitted or maintained by the Plan that relates to your past, present, or future health, treatment, or payment for health care services.

This Notice of Privacy Practices describes the regulations that permit the Fund to use and disclose your PHI as well as your rights to access and control your PHI. The Fund is required by federal law to:

- maintain the privacy of your PHI;
- provide you with this Notice of the Plan's legal duties and privacy practices related to your PHI; and
- abide by the terms of this Notice as it may be updated from time to time.

The Fund protects your PHI from inappropriate use or disclosure. Fund employees and the Fund's business associates are required to protect the confidentiality of PHI; however, they may look at your PHI only when there is an appropriate reason to so do (for example, to determine Coordination of Benefits or services). Your PHI will not be disclosed to anyone for marketing purposes.

When the Fund May Use and Disclose PHI Without Your Authorization

The primary reasons that the Fund may use and disclose your PHI are to administer the Plan's health benefit programs effectively and to evaluate and process requests for benefit coverage and claims. The following outlines the permitted uses and disclosures:

- **For treatment, payment, or health care operations:**
  - *Treatment*—refers to the provision and coordination of health care by a doctor, hospital or other health care provider. The Fund may disclose your PHI to health care providers related to treatment (e.g., respond to an inquiry from a hospital about your eligibility for a particular surgical procedure). The Fund may also disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing or credentialing.

- *Payment*—activities related to collecting premiums and paying claims (e.g., if you had insurance coverage from your spouse's employer, we might disclose your PHI to the other insurer to determine Coordination of Benefits or services. Payment also refers to activities of a health care provider in obtaining reimbursement for services. For example, the Fund may use and disclose your PHI to pay and manage your claims, coordinate your benefits and review health care services provided to you. The Fund may use and disclose your PHI to determine your eligibility or coverage for health benefits and evaluate Medical Necessity or appropriateness of care or charges. In addition, the Fund may use and disclose your PHI as necessary to preauthorize services to you and review the services provided to you. The Fund may use and disclose your PHI to adjudicate your claims.
- *Health care operations*—refers to quality assessment and improvement activities; improving health or reducing health care costs, including development of health care procedures, case management and care coordination; informing you or a health care provider about treatment alternatives; reviewing the competence, qualifications, or performance of health care professionals, or conducting training programs; accreditation, certification, licensing or credentialing activities; contracting for health benefits or insurance covering health care costs; reviewing medical treatment, obtaining legal services, performing and/or obtaining audit services; detecting fraud and abuse; business management, planning, and administrative activities. The Fund may use or disclose your PHI for our health care operations. The Fund may use or disclose your PHI to conduct audits, for purposes of underwriting and rate-making, as well as for purposes of risk management. The Fund may use or disclose your PHI to provide you with customer service activities or develop programs. The Fund may also provide your PHI to our attorneys, accountants and other consultants who assist us in performing our functions. The Fund may disclose your PHI to health care providers or entities for certain health care operations activities, such as quality assessment and improvement activities, case management and care coordination, or as needed to obtain or maintain accreditation or licenses to provide services. The Fund will only disclose your PHI to these entities if they have or have had a relationship with you and your PHI pertains to that relationship, such as with other health plans or insurance carriers in order to coordinate benefits, if you or your family members have coverage through another health plan.

- **Disclosures to Business Associates**. The Fund contracts with individuals and entities (business associates) to perform various functions on our behalf or provide certain types of services. To perform these functions or provide these services, the Fund's business associates will receive, create, maintain, use or disclose protected health information. The Fund requires the business associates to agree in writing to contract terms to safeguard your information, consistent with federal law. For example, the Fund may disclose your PHI to

a business associate to administer claims or provide service support or utilization management.

The Fund's health benefit options together are called an “organized health care arrangement” and may share PHI with each other for the operating purposes of the organized health care arrangement. For example, the Fund might use your PHI to analyze data about treatment of certain conditions to develop a list of preferred medications. And, the Fund may contact you with information about treatment alternatives or other health-related benefits and services.

In addition to using and disclosing your PHI for the purposes mentioned above, the Fund may also use or disclose it in various situations where it is necessary for your benefit or when required by law:

- **Persons involved in care for notification purposes.** The Fund may disclose PHI to a family member, relative, close personal friend or any other person identified by you, provided that the PHI is directly relevant to that person’s involvement with your care or payment related to your care. We may also use or disclose PHI to notify a family member, your personal representative or another person responsible for your care of your location or general condition.
- **Abuse, neglect, or domestic violence situations.** In certain circumstances, the Fund may report cases of abuse, neglect, or domestic violence to public authorities.
- **Coroners, Medical Examiners and Funeral Directors.** The Fund may disclose PHI to coroners and medical examiners to identify a deceased person, determine a cause of death, or other purposes authorized by law. The Fund may disclose PHI to funeral directors to enable them to carry out their duties.
- **Public health purposes.** The Fund may disclose PHI to public authorities to prevent or control disease, injury or disability. If authorized by law, PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a contagious disease or condition. The Fund may also disclose PHI for purposes related to the quality, safety, or effectiveness of products regulated by the federal Food and Drug Administration.
- **Threats to health or safety.** The Fund may, under certain circumstances, disclose PHI to avert a serious threat to the health or safety of the person or the general public.
- **Donations.** The Fund may disclose PHI for organ, eye, or other medical transplants. .
- **Workers’ Compensation.** The Fund may disclose your PHI to the extent necessary to comply with Workers’ Compensation or other similar programs.
- **Law Enforcement and National Security purposes.** The Fund may, under certain circumstances, disclose PHI to appropriate officials for law enforcement or national security purposes.
- **Judicial and Administrative proceedings.** The Fund may, in certain cases, disclose PHI in connection with legal proceedings of courts or government agencies.
- **Health oversight activities.** The Fund may disclose PHI to certain governmental agencies to help them conduct audits, inspections, investigations, or legal proceedings. These agencies are authorized by law to oversee the health care system; government benefit programs for which health information is relevant to beneficiary eligibility; persons or organizations subject to government regulatory programs or to civil rights law to determine compliance.

- **Military personnel**. If you are in the armed services, the Fund may disclose your PHI for activities that military authorities consider necessary to accomplish a mission.
- **Inmates.** If you are incarcerated, the Fund may disclose your PHI to the appropriate authorities as needed for your health care and safety, the health or safety of others, or general administrative purposes.
- **Research.** Under certain circumstances, the Fund may disclose your PHI for research purposes.

Note: Special exceptions exist for psychotherapy notes.

When PHI Use and Disclosure Requires Written Authorization

The Fund will use or disclose your PHI other than as described previously in this section *only* when we receive your written authorization. You may revoke an authorization at any time by providing written notice to the Fund Office, and the Fund will honor the request to revoke as of the day it is received. It's important to note that your revocation will not affect any uses or disclosures of your PHI that have already occurred. To obtain an Authorization for Release of Information, contact the Fund Office at (212) 245-4802.

You may revoke an authorization by contacting the Fund's Privacy Officer listed at the end of this Section.

Your PHI Privacy Rights

Right to Request Restrictions on Uses and Disclosures. You may ask the Fund to restrict uses and disclosures of your PHI for treatment, payment or operating purposes, or to restrict disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care, or to restrict disclosures for notification purposes. While the Fund will consider all requests for restrictions carefully, the Fund is not required to agree to a requested restriction. However, the Fund must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for these services in full, out of pocket.

Right to Inspect, Copy and Amend Your Protected Health Information. As long as the Fund maintains records containing your PHI, you have a right to inspect and copy such information, and to have your records amended, as appropriate. These rights are subject to certain limitations and exceptions. Requests for access to your PHI or amendment of your records should be in writing and directed to the Privacy Officer identified at the end of this Section.

Right to a List of Disclosures. You have a right to an accounting of certain disclosures of your PHI by the Fund. A request for a list of disclosures should be directed to the Privacy Officer identified at the end of this Notice.

Right to Request Confidential Information. The Fund will accommodate a reasonable request by you to receive communications from the Fund by alternative means or at an alternative location if you believe that disclosure of your PHI could pose a danger to you. For example, you may request that the Fund only contact you by mail or at work. Requests for confidential communications should be made in writing and directed to the Privacy Officer identified at the end of this Section.

Changes to this Notice

The Board of Trustees reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI the Fund maintains. If we make changes to this Notice, you will receive a copy of the new Notice.

Right to File a Complaint

If you believe that your privacy rights have been violated, you may complain to the Fund in writing to the Fund Office, to the attention of the Privacy Officer, or to the Secretary of the Department of Health and Human Services, Office for Civil Rights, U.S. Department of Health and Human Services, 150 S. Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, PA 19106-9111. You will not be retaliated against for filing a complaint.

Health Information Privacy Officer. You may exercise the rights described in this Notice or obtain additional information by contacting:

Local 802 Musicians Health Fund
322 West 48th Street
New York, NY 10036
(212) 245-4802
ATTN: Privacy Officer

IMPORTANT INFORMATION YOU SHOULD KNOW

Qualified Medical Child Support Orders

The Fund will honor a court order or administrative notice that requires you to provide medical coverage for your child if the Fund determines that the court order or administrative notice is a Qualified Medical Child Support Order (QMCSO). The coverage will be provided in accordance with federal law and the Fund's QMCSO policies and procedures. You may receive a copy of the QMSCO policies and procedures from the Fund Office.

Your Rights Under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any otherwise covered hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's health care 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

Your Rights Under the Women's Health and Cancer Rights Act (WHCRA)

Because the Fund provides medical and surgical benefits in connection with a mastectomy, the Fund also provides benefits for certain reconstructive surgery. In particular, for individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications associated with all stages of the mastectomy, including lymphedemas.

This coverage will be subject to the same annual deductibles, benefit maximums, coinsurance and co-payment provisions that apply to other medical and surgical benefits provided under the Fund. If you would like more information regarding the Women's Health and Cancer Rights Act (WHCRA), please contact the Fund Office.

YOUR ERISA RIGHTS

As a participant in the Local 802 Musicians Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. ERISA provides that all Plan participants are entitled to the following rights:

Receive Information about Plan and Benefits

You have the right to:

- Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan. These include insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan. These include insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Fund's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this booklet for the rules governing your COBRA continuation coverage rights. In addition, the Fund Office will provide you with information governing your COBRA Continuation Coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under the Plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from the plan or insurer when:
  - You lose coverage under the plan;
  - You become entitled to elect COBRA Continuation Coverage; or
  - Your COBRA Continuation Coverage ceases.

In addition, you may request a Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time periods.

Under ERISA, there are steps you can take to enforce the above rights. For example, if you request a copy of plan documents or the latest annual report and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Fund's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration (EBSA), U.S. Department of labor, listed in your telephone directory, or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210
866-444-3272

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA). For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact EBSA by visiting their Website at ww.dol.gov/ebsa.

PLAN ADMINISTRATIVE INFORMATION

Plan Name

Local 802 Musicians Health Fund

Plan Type

The Plan is an employee welfare benefit plan maintained to provide group health and other welfare benefits to eligible participants and their eligible family members.

Plan Year

The Plan Year is October 1 through September 30.

Plan Identification Numbers

The number assigned to the Plan is 501. The Employer Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 13-1801294.

Plan Sponsor

The Plan is sponsored by a joint Board of Trustees made up of an equal number of Employer and Union representatives. The Board of Trustees may be reached at the following:

The Board of Trustees
Local 802 Musicians Health Fund
322 West 48th Street
New York, New York 10036
(212) 245-4802

Board of Trustees	
Union Trustees	**Employer Trustees**
Augustino Gagliardi Local 802, AFM 322 West 48th Street New York, NY 10036	Christopher Brockmeyer Broadway League 729 Seventh Ave. - 5th Fl. New York, NY 10019
John O'Connor Local 802, AFM 322 West 48th Street New York, NY 10036	Paul Libin Jujamcyn Productions 246 West 44th Street New York, NY 10036

Martha Hyde Local 802, AFM 322 West 48th Street New York, NY 10036	JoAnn Kessler Extreme Reach, Inc. 8 West 40th St. - 20th Fl. New York, NY 10018
Thomas Olcott Local 802, AFM 322 West 48th Street New York, NY 10036	Nancy Gibbs 321 Theatrical Management 321 West 44th St. - Ste. 801 New York, NY 10036
Maxine Roach Local 802, AFM 322 West 48th Street New York, NY 10036	David Lazar Ambassador Theatre Group 321 West 44th St. - Ste. 703 New York, NY 10036

Plan Administrator

The Board of Trustees is the "Plan Administrator" under ERISA. The Board has designated Ms. Gloria McCormick as the Fund Administrator to handle the day-to-day operations of the Fund. She is also the agent for service of legal process under ERISA.

Gloria McCormick
Fund Administrator
Local 802 Musicians Health Fund
322 West 48th Street
New York, New York 10036
(212) 245-4802

Legal process may also be served on any individual Trustee at the above addresses.

For disputes arising under those portions of the Plan insured by Empire BlueCross BlueShield, service of legal process may be made upon Empire at one of their local offices or upon the official of the Insurance Department in the state in which you reside.

MagnaCare handles administration of the self-insured medical benefits, Express Scripts handles administration of the prescription drug benefits, and Blue Cross handles administration of the insured hospitalization and HMO benefits. The Fund Office administers the vision, loss of time and sick pay benefits.

Documents Governing the Plan

If you want to review or receive copies of documents governing the Plan, contact the Fund Administrator at the Fund Office. You may be charged a reasonable fee for copies of any documents you request. However, you may examine these documents without charge by visiting the Fund Office during normal working hours.

Plan Funding

The Local 802 Musicians Health Fund is funded primarily by employer contributions made pursuant to collective bargaining agreements between various employers in the musical engagement industry and the Associated Musicians of Greater New York, Local 802 A.F.M. (the American Federation of Musicians). In addition, employee contributions are required for some benefits, and certain Fund participants may have the option of contributing to the Fund (so as to increase their level of eligibility) in accordance with the terms of the collective bargaining agreement that governs their employment and the Fund's rules.

The Fund's medical benefits are provided on a self-insured basis through the MagnaCare PPO, prescription drug benefits are provided on a self-insured basis through Express Scripts, and the hospitalization benefits are insured through Empire Blue Cross BlueShield. There is also an insured HMO buy-up option (for both medical and hospitalization benefits).

Contributions (and investment income thereon) are used to fund the self-insured benefits provided by the Fund and/or pay premiums for insured benefits. Contributions, income and reserves accumulated by the Fund are held in a trust for the purpose of providing the Plan's health and other welfare benefits to covered participants and their eligible dependents and for the purpose of paying reasonable administrative expenses.

Contributing Employers

As noted, participating employers contribute to the Fund on behalf of their eligible employees in amounts specified in the applicable collective bargaining agreements. A copy of any such collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the Fund Office, and the agreements are available for examination at the Fund Office. Upon written request, the Fund Office will also provide you with information as to whether a particular employer contributes to the Fund and/or a list of sponsoring employers and employee organizations.

Plan Amendment or Termination

The Board of Trustees intends to continue the Fund indefinitely. However, the Trustees reserve the right, in their sole and absolute discretion, to change, modify, amend or terminate the Plan, in whole or in part, at any time and for any reason, subject to the provisions of any applicable collective bargaining agreements. Resolutions to amend the Fund's rules are made by the Board of Trustees and become effective on the date as specified in the resolution.

Plan benefits and eligibility rules for eligible participants and dependents:

- are not guaranteed or otherwise vested;
- may be changed or discontinued by the Board of Trustees;
- are subject to the Plan documents and rules adopted by the Board of Trustees;
- are subject to the Trust Agreement which establishes and governs the Fund's operations; and
- are subject to the provisions of any applicable insurance policy and contracts.

The Fund also may be terminated by the Trustees when there is no longer in effect an agreement between the contributing employers and the Union requiring contributions to the Fund. Upon termination of the Fund, the Trustees will apply the assets of the Fund to provide benefits or otherwise carry out the purposes of the Fund in an equitable manner until the Fund's assets have been exhausted.

Board of Trustees' Discretion and Authority

The Board of Trustees (and its designees) has the sole and absolute discretionary authority to construe and interpret the terms of the Fund's plan of benefits, including this Summary Plan Description, insurance certificates, and any or all provisions, rules, regulations, and procedures adopted by the Board. The Trustees reserve the right to change or discontinue (1) the types and amounts of benefits provided under the Fund and/or (2) the eligibility rules, subject to the terms of any applicable collective bargaining agreements. The nature and amount of the Fund's benefits are always subject to the actual terms of the Plan as it exists at the time claims are incurred.

No Guarantee of Employment

Your coverage under the Fund does not constitute a guarantee of employment and you are not vested in the benefits described in this SPD.

Important Contact Information	
Medical Benefits	For a list of PPO participating providers: **MagnaCare** P.O. Box 1001 Garden City, NY 10530 Website: www.magnacare.com Phone: (800) 352-6465 If you participate in the Empire BlueCross BlueShield Direct HMO, contact *only**: **Empire BlueCross BlueShield Direct HMO** P,O, Box 1407 Church Street Station New York, NY 10008-1407 Website: www.empireblue.com Phone: (212) 476-1000 The HMO coverage is insured through a contract with Empire and is subject to the complete terms, conditions, limitations, and exclusions of the contract issued by Empire. **If you enroll in the HMO, you are no longer covered by Plan A+, Plan A or Plan B and are not eligible to use the MagnaCare network.*
Hospitalization Benefits	**Empire BlueCross BlueShield** P.O. Box 1407 Church Street Station New York, NY 10008-1407 Website: www.empireblue.com Phone: (212) 476-1000 These benefits are insured through a contract with Empire and are subject to the complete terms, conditions, limitations, and exclusions of the contract issued by Empire.
Prescription Drug Benefits	For participating pharmacies and a list of preferred drugs (on the formulary): **Express Scripts** Website: www.Express Scripts.com Phone: (866) 544-2926 (Member Services)
Vision Benefits	For participating providers: Local 802 Musicians Health Fund 322 West 48th Street New York, NY 10036 E-mail: www.local802hbp.org Phone: (212) 245-4802
Claims Administration	All MagnaCare PPO and Out-of-Network claims: Local 802 Musicians Health Fund **c/o MagnaCare** P.O. Box 1001 Garden City, NY 11530

	All Hospitalization claims (for Plan A+ $4,300.00 Level *Only*): **Empire BlueCross BlueShield** Empire BlueCross BlueShield P.O. Box 1407 Church Street Station New York, NY 10008-1407 Website: www.empireblue.com Phone: (212) 476-1000

DEFINITIONS

Throughout this booklet, defined terms begin with a capital letter. The following meanings apply to these terms when used in this SPD, unless otherwise defined where the term is used.

Allowable Expense—A Reasonable and Customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering you or your Dependent for whom the claim is made in terms of generally accepted medical practice or specifically defined in the Plan.

Ambulatory Care (in a Hospital Outpatient Facility)—Care provided in a facility for:

- diagnostic X-rays;
- lab and pathology exams;
- physical therapy; occupational therapy; and radiation therapy;
- services and medications used for non-experimental cancer chemotherapy; and
- cancer hormone therapy.

The service or medication provided must relate to and be necessary for the treatment or diagnosis of your or your Dependent's illness or Injury. The service and medication must be ordered by the Physician and, in the case of physical therapy services, be furnished in connection with surgical care.

Board Certified Physician—A board certified specialist whom, because of his or her specialty, is an appropriate Physician to consider the surgery being proposed.

Calendar Year—The period starting January 1 of any year and continuing through December 31 of that same year.

Claim Determination Period—Refers to a Calendar Year. However, it does not include any part of a year during which an individual has no coverage under this Plan or any part of a year before the date the COB provision or a similar provision takes effect.

Claims Administrator—The entity assigned to decide claims in accordance with the terms and conditions of this Plan.

Co-pay or Co-payment—The charge that you or your Dependent are required to pay for certain Covered Medical Expenses, as shown in the Schedule of Benefits. You or your

Dependent must pay the required Co-pay directly to the preferred provider at the time the treatment or service is rendered.

Covered Facility—A Hospital, or any other medical facility, that is specifically covered under the terms of this Plan.

Covered Medical Expense—The Reasonable and Customary charge incurred by you or your Dependent for a Medically Necessary service, supply, or treatment that is:

- covered under this Plan; or
- provided by a Physician for medical conditions covered under this Plan; and
- in accordance with accepted standards of medical practice

A charge is deemed incurred on the date the treatment is provided. Covered Medical Expense does not include any charge for treatment, supply, or service that:

- exceeds any benefit limit or maximum under this Plan shown in the Schedule of Benefits.
- is excluded under any exclusion provision as well as the General Exclusions of this Plan.

Creditable Coverage—Creditable Coverage means any one of the following:

- group health plans;
- health insurance coverage (care under any hospital or medical service policy or certificate; hospital or medical service plan contract; or Health Maintenance Organization (HMO) contract offered by a health insurance insurer);
- individual coverage;
- Medicare (Parts A or B);
- Medicaid;
- TRICARE/CHAMPUS;
- a medical care program of the Indian Health Service or of a tribal organization;
- a state health benefits risk pool;
- a health program offered under the Federal Employees Health Benefits Program (FEHBP);
- a public health plan (such as one provided by a State or local governmental political subdivision); or
- any health plan under Section 5(e) of the Peace Corps Act.

Custodial Care ***(Not Covered; see General Exclusions section)*****—**Treatment, services, or confinement, regardless of who recommends, prescribes, or performs them, or where they are provided, which could be rendered safely and reasonably by a person not medically skilled, and are designed mainly to help the patient with daily living activities. Custodial Care includes:

- personal care such as help in walking, getting in and out of bed, bathing, eating (including tube or gastrostomy), exercising, dressing, using the toilet or administration of an enema;
- homemaking, such as preparing meals or special diets;
- moving the patient;
- acting as companion or sitter; and
- supervising medication which can usually be self-administered.

The determination of Custodial Care in no way implies that the care being rendered is not required by the patient; it only means that it is the kind of care that is not covered under this Plan.

Deductible—"Deductible" means the amount of Covered Medical Expenses incurred by you or your Dependent for which no benefit is paid under this Plan. You or your Dependent must satisfy any Deductible before benefits under this provision are paid, except as provided under the three-month carry-over, family limit or common accident provisions. Co-payments do not apply toward the Deductible.

Dependent—A spouse and/or child(ren) who is eligible for insurance under this Plan, as determined under the Eligibility and Participation section of this Plan.

Emergency/Emergency Care/Emergency Treatment—Emergency services provided after the sudden onset of a medical or behavioral condition:

- that manifested itself by acute symptoms of sufficient severity, including severe pain; and
- such that the absence of immediate medical attention could reasonably be expected to result in:
  - placing your or your Dependent's, or in the case of a behavioral condition, another's health in serious jeopardy;

- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part; or
- serious disfigurement.

Hospital—A facility, or part of a facility, that is operating as an acute care or general Hospital and which is an institution that:

- is primarily engaged in providing, by or under the continuous supervision of Physicians. inpatient diagnostic services and therapeutic services for the diagnosis, treatment and care of injured or sick persons who are confined for such services and treatment;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a Physician or a dentist,
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861(k) of United States Public Law 89-97, (42 USCA 1395x[k]); and
- is licensed pursuant to any State or agency of the State responsible for licensing hospitals.

Except as specifically provided by this Plan or State law, the term Hospital does not include a facility, or part of a facility or Hospital, which is licensed as and provides care primarily as:

- a Custodial Care or educational facility;
- a rest facility, nursing facility, convalescent facility, or facility for the aged;
- a skilled nursing facility, extended care facility, or a rehabilitation facility; or
- a facility or program for the treatment of tuberculosis, Mental Illness, behavioral problems, or chemical abuse or dependence.

Illness—A disorder or disease of the body or mind that IS not related to employment. Illness will include:

- congenital defects or birth abnormalities;
- pregnancy, complications of pregnancy, childbirth and your or your spouse's related medical conditions.

Injury—Bodily harm that is not the result of disease. Only an Injury that is *not* related to employment is considered for benefits under this Plan.

Medically Necessary/Medical Necessity—The Board of Trustees (or its designees, including the applicable insurer or Claims Administrator) will determine if treatment is Medically Necessary. To be considered Medically Necessary, the treatment must be ordered by a Physician to diagnose or treat an Injury or Illness and be:

- generally recognized in the Physician's profession as effective and essential to the treatment of the Injury or Illness for which it is ordered; and
- appropriate for the symptoms and consistent with the diagnosis; and
- the appropriate level of care which
  - is provided in the most appropriate setting, based on the diagnosis and condition; and
  - could not have been omitted without an adverse effect on your or your Dependent's condition or the quality of medical care; and
- based on generally recognized and accepted standards of medical practice in the United States; and
- not considered experimental, investigatory, or primarily limited to research in its application to the Injury or Illness; and
- not primarily for scholastic, educational, vocational or developmental training; and
- not primarily for the comfort, convenience or administrative ease of the Physician or other health care provider, or you or your Dependent or your family or care taker; and
- not Custodial Care.

The Board of Trustees (and its designees) reserve the right to review medical care and/or treatment plans. The Board of Trustees (and its designees) may rely on an independent medical reviewer to determine if treatment is Medically Necessary. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, in and of itself, make it Medically Necessary or make the expense covered under this Plan.

Medicaid—State programs of medical care for needy persons, as established under Title 19 of the Social Security Act of 1965, as amended.

Medicare—The health insurance program set forth in Title XVIII of the Social Security Act of 1965, as amended.

Mental Illness—Any disorder that affects the mind, intellect or behavior and includes but is not limited to neuroses, psychoneurosis, or psychopathy. Mental Illness does not include chemical abuse or dependence.

Occupational Disease—A disease for which you are provided benefits under the applicable Workers' Compensation, occupational disease Law or similar law.

Outpatient—Treatment that is provided to you or your Dependent when you are not confined in a Covered Facility as a bed-patient. This will include Outpatient treatment at a Covered Facility as well as visits to a Physician or other covered health care provider.

Period of Disability—The entire period of time you are Totally and Continuously Disabled and for which benefits are payable.

—An individual licensed as a doctor of Medicine (M.D.) or doctor of Osteopathy (D.O.). The term "Physician" will also include any licensed or certified health care provider as required by State law, for services that are:

- within the scope of the health care provider's license or certificate; and
- covered expenses under this Plan.

"Physician" does not include anyone who is your or your spouse's parent, child, brother, or sister.

Plan Year—The 12-month period starting October 1st of one year and ending September 30th of the next year.

Reasonable and Customary—A charge for treatment that is the lesser of the following:

- the usual charge made by the provider for that treatment; or
- the prevailing charge made by other providers of similar professional standing within the same or a similar geographic area for that treatment.

If the usual or prevailing charge cannot be determined, the Board of Trustees (or its designee, including the insurer or Claims Administrator) will determine what a reasonable charge is, taking into account:

- any unusual complications of the Injury or Illness;
- the complexity and degree of professional skill required; and
- other pertinent factors.

The fact that a treatment is determined to be Medically Necessary does not, in and of itself, mean that the charge will be determined to be Reasonable and Customary.

Second Surgical Opinion—An evaluation by a Board Certified Physician who personally examines you or your Dependent for the need for surgery. The evaluation must include review of all tests and medical data on which surgery was recommended; and may include additional tests and examination.

Totally and Continuously Disabled—You, as a result of a covered Injury or Illness, are prevented from performing any and every duty of your employment, and you are under the care of a Physician.