

ENTERTAINMENT INDUSTRY

Flex Plan

Summary Plan Description

Table of Contents

Introduction	1
What is the purpose of the Flex Plan?	1
The Flex Plan vs the Traditional Plan	1
A Plan for Everybody	1
Who is Eligible to Participate in the Flex Plan?	2
Employer Contributions	2
Employee Contributions	2
The Difference between Employer and Employee Contributions	2
Can You Lose Any Part of Your Employee Contributions?	2
What Effect Does Making Employee Contributions have on Your Social Security Benefits?	2
Flexible Payroll Deduction Request	3
The Flex Plan "Account" System	3
What Benefits are Available Through Employer Contributions?	3
Alternate Benefit (AB) Account	3
When Do You Become Eligible to Participate?	3
What if I do not Accumulate Sufficient Funds to become Eligible?	3
Enrollment in the Plan	4
Can Plan Elections be changed?	4
Insurance Coverage from the Flex Plan Providers	4
Am I required to have Medical Insurance?	4
Are Domestic Partner Benefits Available under the Plan?	5
What is the cost to cover a Domestic Partner?	5
What is the purpose of Disability Insurance Coverage?	5
When does my Disability Insurance Coverage Begin?	5
When does my Disability Coverage End?	5
Once Coverage is terminated, will it be reinstated?	5
May I Decline Enrollment for Disability Coverage through the Group Contract?	5
Can I be denied Disability Insurance Coverage?	6
Can I be Covered by the Flex Plan Group Disability Insurance Contract and also Maintain an Individual Disability Policy?	6

What if your Account Balance is not sufficient to cover your Insurance Premium Payment(s)? _____ 6

How Can I ensure there is No Lapse in My Insurance Coverage? _____ 6

When Does Coverage Run Out? _____ 6

What Are the Rules on the Continuation of Coverage under the Flex Plan? _____ 7

Your Flex Plan Account Balance _____ 7

How does the Reimbursement Process Work? _____ 7

The Reimbursement Process _____ 8

Medical Expense Reimbursement (MR) _____ 8

Direct Payment of Medical and Dependent Care Expenses to the Provider of Services _____ 9

Dependent Care Assistance (DC) _____ 9

Medical Insurance Premium Reimbursement _____ 9

Other Insurance Premium Reimbursements _____ 9

Claims and Appeals Procedures under the Plan _____ 9

What are Your Rights under ERISA? _____ 10

Important Information _____ 11

Closing... _____ 12

A Brief History of the Entertainment Industry Flex Plan _____ 12

2008 Administration Fees _____ 12

This summary is not meant to interpret, extend or change the Flex Plan in any way. In case of a conflict between this Summary Plan Description (SPD) and the actual provisions of the documents or the insurance policies, the provisions of the documents and such insurance policies will govern your rights and benefits.

Should a discrepancy arise between information contained within the SPD and oral information provided by a Flex Plan representative, the SPD shall prevail.

The Flex Plan is intended to continue indefinitely; however, it may be amended or terminated.

Introduction

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

The Plan offers a “cafeteria style” benefit option list in which you design your individual plan according to your needs. Since you are under no obligation to participate in a “one size fits all” benefit arrangement, you will find that you can custom tailor benefit selections that are right for you.

It is important to note that if you want to get the most out of the Plan, your active involvement is necessary, so please read the following Description carefully.

After reviewing the information you will see that the Entertainment Industry Flex Plan is truly a flexible benefit plan designed with you and your family in mind.

If you have any questions after reviewing this summary, please call our Member Services Department.

What is the purpose of the Flex Plan?

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

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

The Flex Plan vs. the Traditional Plan

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

Traditional Plan

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

Flex Plan

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

A Plan for Everybody

The number of options you choose from the “menu of benefits” will be determined by your personal needs as well as how much money you have in your Flex Plan account. If you are employed regularly by one or more Employers, you will probably have enough money in your account to have medical insurance premiums paid by the Plan, for you and your family, on a monthly basis. If your work is not consistent, you may not wish to enroll in optional insurance benefits such as dental, vision and life, as you will be responsible for the total cost of the premiums when your account balance is short; you will not be able to change your insurance options until the next open enrollment period.

In some cases, individuals will not require health insurance because it may already be provided by a spouse’s employer or another plan; once the member has satisfied Plan certification requirements the member may then use the funds in their account on other benefits offered by the Plan.

Who is Eligible to Participate in the Flex Plan?

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

Employer Contributions

The amount of Employer Contributions placed in your account is determined by the Collective Bargaining Agreement (CBA) between your Local Union and your Employer. The CBA requires that the Employer remit these contributions to the Plan by the 15th of the month following the month you worked (some employers remit more frequently). For example, if you worked any time during the month of January, your Employer would be obligated to remit the contribution on your behalf to the Plan no later than the 15th of February.

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

Employee Contributions

Increasing the contribution to your account through *pre-tax* payroll deductions can decrease your *taxable* wages and is particularly valuable in instances where your insurance premiums or Dependent Care (childcare) expenses exceed the monthly Employer Contributions to your account. This option is not available through every Employer. Call the Flex Plan to see if your Employer allows this option.

In addition, adding extra money to your account through Employee Contributions can avoid the need to make "self-payments" (after-tax) to continue your insurance coverage when your account does not have sufficient funds to pay your premiums. Employee Contributions may be made in increments of one percent (1%), up to fifteen percent (15%) of your gross earnings.

In order to exercise this option you must complete a "Flexible Payroll Deduction Request Form" and submit it to your payroll department within 30 days of your notice of eligibility or during the Open Enrollment period.

The Difference between Employer and Employee Contributions

It is very important that you understand the difference between Employer Contributions and Employee Contributions.

Excess Employer Contributions left over at the end of the year will roll over to be used in future Plan Years. Your Employee Contributions are used first (if any), then Employer Contributions. Although Employee Contributions are used before Employer Contributions, it is important to estimate Employee Contributions carefully because any Employee Contributions left over after March 31st of the following year will be forfeited.

Note: Employee Contributions can be used for all benefits *except* Medical Expense Reimbursement and reimbursement of premiums for coverage through a spouse's employer.

Can You Lose Any Part of Your Employee Contributions?

Yes. This is a very important difference between Employee and Employer Contributions. If at the end of a year it turns out that you allocated too much of your pay to cover benefits offered under the Employee Contribution part of the Plan (insurance premiums and child care expenses), you will forfeit those monies. This is called the "use it or lose it" rule. This provision is a Federal Tax requirement (not a rule created by the Flex Plan); any Employee Contributions forfeited are applied toward the administration expenses of the Plan.

Employer Contributions made to the Flex Plan on your behalf are not subject to forfeiture. Because the Flex Plan first uses your Employee Contributions before using Employer Contributions to fund your benefits, the likelihood of you losing some part of your Employee Contributions is greatly reduced.

If your employer has the ability in their payroll system to allow you to set a maximum annual deduction and provided you do not set the maximum deduction amount higher than the cost of your insurance premiums and your Dependent Care expenses combined, you will never have to worry about forfeiting your employee contributions.

What Effect Does Making Employee Contributions have on Your Social Security Benefits?

Employee Contributions under the Flex Plan will normally result in both you and your Employer making lower contributions to the Federal Social Security System. This reduction in Social Security contributions might ultimately reduce your Social Security benefits, although the impact will likely be minimal. In addition, other benefits based upon taxable compensation could be reduced, such as workers' compensation, unemployment and certain fringe benefits.

For example, if an Employee who retired in 1999 with earnings of \$15,000 each year had \$1,000 of his/her pay contributed to the Flex Plan in the five years prior to his/her retirement, his/her primary Social Security benefit would be reduced by *less* than one percent.

Flexible Payroll Deduction Request

This option allows you to authorize your Employer to deduct a percentage between 1%-15% of your wages on a *pre-tax* basis and deposit it to your Alternate Benefit (AB) Account. This pre-tax contribution is in addition to the Employer Contributions already made on your behalf.

By completing the Flexible Payroll Deduction Request Form, you irrevocably elect to redirect a portion of your pay for the year, and have this amount contributed by your Employer to the Flex Plan. Once established, you will not be able to change the amount of your Employee Contributions during the remainder of the calendar year except if you have a "change in family status", as described below in "Can Plan Elections be Changed". Also, the percentage you select must be the same for each employer (which makes pre-tax contributions on your behalf). Your authorization terminates at the end of each calendar year. You may only change your election during the Open Enrollment period. The Open Enrollment Period is your initial enrollment period and each November/December (to take effect January 1 of each year) thereafter.

If you do not submit a completed Flexible Payroll Deduction Request Form to the Flex Plan Office by the due date given you waive your right to make pre-tax contributions to the plan. You will not have any Employee Contributions made to the Flex Plan by your Employer on your behalf for such Plan Year. This will not impact any Employer Contributions made on your behalf for such year.

The Flex Plan "Account" System

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

What Benefits are Available Through Employer Contributions?

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

- MI - Medical Insurance Premiums
- DI - Dental Insurance Premiums
- VI - Vision Insurance Premiums
- LI - Group Term Life Insurance Premiums
- DB - Group Disability Insurance Premiums
- ID - Individual Disability Insurance Premiums
- MR - Medical Expense Reimbursement
- DC - Dependent Care Assistance

Alternate Benefit (AB) Account

All contributions to the Flex Plan are deposited into your AB Account. This is where your funds remain until used for premium payments or an allocation is made to the Optional Benefit Account - Dependent Care Assistance (childcare). If applicable, funds will be transferred from your Alternate Benefit (AB) Account to your premium accounts (MI, DI, VI, LI, DB, ID) to make monthly payments to the insurance plan(s) of your choice.

When Do You Become Eligible to Participate?

Once your account has accumulated approximately \$100.00 you are eligible to participate, subject to the following enrollment rules.

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

What if I do not Accumulate Sufficient Funds to become Eligible?

If you do not accumulate an account balance of \$100 within 3 months of the first month contributions are received from a participating employer, you will be eligible to submit either a Medical Insurance or Medical Expense Reimbursement claim. Further you will not be assessed a claim processing fee. This provision may only be exercised 2 times per calendar year.

Enrollment in the Plan

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

If you have not made insurance elections (during your normal enrollment period) and your account accumulates \$1000 or more, you will receive a reminder notice to enroll. If you do not respond, you will automatically be enrolled under the default option with single coverage. In addition, you will now have the option to make other insurance elections such as the addition of dental, vision or life insurance.

Changes to insurance coverage options and Optional Benefit Account Allocations (Dependent Care Assistance) may only be made once a year during the Open Enrollment period. Your Optional Benefit Allocation is reset to zero each year. However, your Optional Benefit Account balance will carry over according to Plan guidelines. Open Enrollment takes place during November and December and is effective January 1.

Can Plan Elections be changed?

Once you enroll in the Flex Plan, you may not withdraw or make any changes to benefit selections, cancel or change insurance elections until the next Open Enrollment period unless you have a change in family status. Also, the change to your benefit selection(s) must be consistent with your change in family status. A "change in family status" may be one of the following:

- birth
- marriage or divorce
- death of a spouse or child
- your spouse terminating or changing employment
- your spouse changing from full-time to part-time or visa versa
- adoption or obtaining legal guardianship of a child

Note: In order to process your change, the Flex Plan must receive notification of your change in writing within 30 days of the event.

Insurance Coverage from the Flex Plan Providers

You may elect coverage from one of the Flex Plan Providers. If you elect this option, the Flex Plan will make monthly premium payments on your behalf to the carrier(s) you select (provided your account balance is sufficient to pay the premiums). Please see the Flex Plan Summary of Benefits brochure for descriptions and monthly costs of the coverage offered.

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

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

The Flex Plan's insurance contracts are "guaranteed issue" contracts which means you may enroll in any of the above insurance options during the enrollment period and cannot be denied the right to enroll due to a previous medical condition. There may be exclusions for pre-existing medical conditions; see the Summary of Benefits for your state for more information. Special rules may apply to the Disability and Life Insurance benefits.

Am I required to have Medical Insurance?

Because our contracts are "guaranteed issue" contracts, our insurance carriers require that all participants with sufficient account balances be insured. If your account balance reaches \$1000 or more, you are required to be insured.

Your coverage may be from one of the following sources:

- A Flex Plan provider (shown in the Summary of Benefits brochure)
- Another Collectively Bargained Plan or Employer
- Medicare
- Your spouse
- An Individual Policy you hold

If you do not elect medical insurance coverage from one of the Flex Plan providers, you are required to show proof of insurance. If the proof of insurance is not provided to the Plan within the period provided, the Flex Plan is required to enroll you under the default option with single coverage.

Additional information for Individual Policies: Once a member's account balance is greater than \$1000 and they have not made insurance elections they will have the following options:

Have the Flex Plan make payments on your individual policy directly to the provider of services.

You may make the payments directly to your insurer, provided you submit claims on the same frequency payments are due. If you fail to submit claims demonstrating your medical insurance policy is current with the insurer, you will not be eligible for reimbursement of either Medical Expense Reimbursement or Dependent Care Assistance claims.

Your medical insurance policy must be current to be eligible for reimbursement of either Medical Expense Reimbursement, Dependent Care Assistance Claims and Medical Insurance Premiums.

In order for the Flex Plan to pay for medical insurance coverage for your dependents, you must be on the policy with them.

Are Domestic Partner Benefits Available under the Plan?

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

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

For more detailed information on Domestic Partner Benefits, please call the Member Services Department and request a full copy of the Domestic Partner Guidelines.

What is the cost to cover a Domestic Partner?

The cost of coverage will be paid through your Flex Plan account and by self-payment (if necessary). However, if you do not claim your Domestic Partner as a tax dependent, there will be a tax cost as a result of the Plan providing these benefits which cannot be paid or reimbursed from your Flex Plan Account.

If your partner is not your IRS tax dependent, the relevant tax laws provide that you will owe Federal and State Taxes (including withholding taxes, such as Social Security) on the value of the coverage that the Plan provides to your Domestic Partner, since the value is considered wages for tax purposes. Accordingly, you must prepay the taxes on the value of the coverage on a monthly basis, including the employer portion of any withholding taxes. The Plan will require these tax payments be collected via an automatic debit to your bank account each month.

What is the purpose of Disability Insurance Coverage?

Disability Insurance was established by the Plan to provide income during a period for which you may be unable to work due to an injury. To receive benefits you must have worked for a signatory employer within 60 days of your date of disability and be disabled for a minimum of 3 months.

When does my Disability Insurance Coverage Begin?

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

When does my Disability Coverage End?

Your coverage will end after the Flex Plan does not receive at least \$100 per month of Contributions (excluding self-payments) on your behalf during six consecutive work months. At the end of the sixth month, your account will be credited for premiums paid for that month and the preceding 3 months. Therefore, your coverage will terminate the last day of the second month. This is done to allow a full six-month period for work to resume in an effort to continue your disability insurance coverage without interruption. Note: In order to be eligible to receive disability benefits, you must have worked for a participating employer within 90 days of the date of disability.

Once Coverage is terminated, will it be reinstated?

Coverage may be re-instated subject to the conditions described above in, "When does my Disability Insurance Coverage Begin?"

May I Decline Enrollment for Disability Coverage through the Group Contract?

Only if you meet one of the following requirements:

- You are covered by another disability insurance policy (other than state disability insurance) and can certify the policy is in force
- You can certify you are already disabled

If you wish to decline the Group Disability Insurance coverage you will need to submit proof (waiver) that the other policy is in force. If the Flex Plan does not receive the completed Waiver Form and required documentation within 30 days of your first notice, you will forfeit the right to decline enrollment until the next Open Enrollment period and premiums will be paid retroactive to your original effective date.

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

Can I be denied Disability Insurance Coverage?

If you do not waive coverage during your original enrollment period or during a later Open Enrollment period, you cannot be denied coverage. However, if you waive coverage at any time, you may be denied coverage and may be required to provide evidence of insurability at your own expense. If you have a pre-existing medical condition, you may not be covered if you become disabled by that specific medical condition until you have been covered by this group disability contract for a period of 12 months. Please refer to the Group Long Term Disability Income Insurance Certificate for specific details.

Can I be Covered by the Flex Plan Group Disability Insurance Contract and also Maintain an Individual Disability Policy?

Yes. In many cases, the Group Contract may pay independent of your Individual Policy with no reduction in benefits. However, you must contact the issuer of your individual disability insurance provider to see if they will decrease your benefit payments due to another policy being in force.

What if your Account Balance is not sufficient to cover your Insurance Premium Payment(s)?

If you do not have sufficient funds in your account to pay your premiums, the Flex Plan allows you to “self-pay” the necessary premiums for a period of 12 months. You may only self-pay the amount necessary for your current premium amount due. You may not pay in excess of the amount currently due. You will be sent a Self Payment Billing for the amount your account is short and you must remit payment to the Flex Plan Office by the due date provided to maintain your coverage. Self-Payment Billings are usually mailed between the 17th and 18th of the month and are due by the end of the month. You may be able to continue your insurance coverage beyond such 12-month period under the “COBRA” rules, as described below in “What Are the Rules on the Continuation of Coverage under the Flex Plan?”

Failure to remit prompt payment (for all enrolled coverage) to the Flex Plan Office by the due date may result in a lapse in coverage. If this occurs, you will be dropped from the group policy and will not be eligible until the next Open Enrollment period (subject to your eligibility at that time). If coverage is lost, the carrier may not cover pre-existing conditions for a period outlined by the carrier (refer to the individual carriers rules regarding pre-existing conditions). *You cannot self-pay to regain eligibility. You must become eligible by Employer Contributions.*

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

How Can I ensure there is No Lapse in My Insurance Coverage?

You may enroll in the Automatic Self-Payment Program. You may request that the Flex Plan collect your premium payment from one of the following sources:

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

The Flex Plan will mail a notice 5 days prior to debiting your account, providing the date the debit will occur and the exact amount. The amount will never exceed the premium cost with the exception of an employer collecting for an over payment to your account or months in which the administration fee is billed. Due to the nature of credit card processing, no advance notice is available. You will however receive a notice stating the amount of the charge.

When Does Coverage Run Out?

You will remain eligible for benefits under the Flex Plan as long as there are sufficient funds in your account after deducting administration charges to provide such benefits. However, your coverage for Medical Insurance, Dental Insurance, Vision Insurance, Group Term Life Insurance and Disability Insurance benefits are further governed under the terms of the policies providing such benefits and termination of such coverage for other reasons may take place as set forth in such policies.

There is no forfeiture of Employer Contributions.

Your beneficiary may use any remaining funds in your account. However, your beneficiary’s rights to obtain insurance coverage from the plan are subject to their rights under COBRA. They may however instruct the Flex Plan to make payments on individual insurance policies they may hold, but are not required to have medical insurance.

What Are the Rules on the Continuation of Coverage under the Flex Plan?

If your Medical Insurance coverage is lost (due to insufficient employer contributions) under the Flex Plan, continuation of coverage will be available as follows:

- a period not to exceed eighteen (18) months if a loss of benefits occurs because of termination of employment or reduction of hours (which may be extended to twenty-nine (29) months in the event a person is determined by the Social Security Administration to be “disabled” upon termination of employment or reduction in hours and such person notifies the Flex Plan Office before the end of such 18 months);

for a period not to exceed three (3) years for the other reasons given below;

- in the case of an employee becoming entitled to Medicare benefits, the period for his/her spouse and dependents shall not end before the close of the 36 month period beginning when the employee became eligible for Medicare;

However, in certain circumstances as provided by federal law, for reasons such as failure to pay continuation coverage cost, eligibility for coverage under another employer’s plan (whether as an employee or otherwise) without exclusion or limitation for pre-existing conditions, termination of the Medical part of the Flex Plan, it is determined that such person is no longer disabled (coverage will end with the month that begins within 30 days after such determination), or the beneficiary becoming entitled to Medicare benefits.

Any period of time during which you pay for your Medical Insurance coverage through self-pay contributions immediately after an event triggering this continuation coverage will reduce accordingly the period of time you or your spouse or dependents will remain eligible for this continuation coverage. The cost of continuation coverage is borne by the individual choosing such coverage. Though cost may not exceed 102% of the cost of the same coverage for a “similarly situated” employee or family member, and 150% of such cost for the 19th through 29th month for a disabled person, we choose instead to assess administration fees.

Spouses of Participants may choose continuation coverage for themselves, if they lose coverage for any of the following reasons:

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

Dependent children of participants may choose continuation coverage for themselves, if they lose coverage for any of the following reasons:

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

The notice you will receive when your account is deficient and self-pay contributions are required to maintain your Medical Insurance coverage will also constitute your notice of continuation coverage rights under these provisions. You will not receive another notice or election form regarding these continuation coverage rules when your 12 months of self-pay coverage expires.

It is the participant’s responsibility to notify the Flex Plan Office in writing of a divorce, legal separation or other change in marital status, change in a spouse’s address, or a child losing dependent status under the Plan, within sixty (60) days of the event. It is also the participant’s responsibility to notify the Flex Plan Office in writing within sixty (60) days if such participant is determined to be disabled and within thirty (30) days if such participant is determined no longer to be disabled.

Your Flex Plan Account Balance

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

Shortly after the close of each quarter, you will receive from the Flex Plan Office a detailed statement of your Alternate Benefit (AB) Account. This statement will include all contributions made to your account as well as disbursements. It is very important that you review this information for accuracy.

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

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

How does the Reimbursement Process Work?

Expenses may be reimbursed on a semi-monthly basis (subject to your eligibility as described below in the section “The Reimbursement Process”). Claim forms may be obtained by calling the Member Services Department or by downloading them from our web site. Medical Expense Reimbursement Claim Forms are mailed to eligible participants on a quarterly basis.

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

All claims incurred in a calendar year must be *received* by the Flex Plan by March 31 of the following year to be eligible for reimbursement. Special Note for Medical Expense Reimbursement: Even if your *prior year* claim has not been paid by insurance, submit your claim for expenses *incurred in the previous year* with the bills from your providers by March 31.

The Reimbursement Process

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

To request reimbursement, you must submit a properly completed Flex Plan Claim Form and attach evidence that the expense was incurred as well as proof of payment. There is a fee assessed each time you *submit* a claim. Therefore, you should wait to submit your claims until you feel the claim amount warrants the claim-processing fee. Claims paid over multiple months are *not* assessed additional fees. Please refer to the Administration Fee Schedule for the claim reimbursement fees.

Claims must be for you and/or your eligible dependents. (An eligible dependent is someone you claim on your tax return and provide at least 51% of his or her financial support.)

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

Evidence of Expense must be a billing from an independent third party or explanation of benefits from carrier and must:

- show the date the charges were incurred
- who the charges were for
- a description of the charges with name, address of facility/provider and phone number (balance forward billings cannot be accepted)
- the amount of the charges

Proof of Payment may be one of the following:

- copy of a canceled check
- an invoice or billing with the check number, amount and date of payment noted
- credit card statement and charge detail
- receipt from the provider
- a provider billing indicating 'payment received'

Please remember that your claim form and supporting documents cannot be returned to you so keep a copy for your records (do not submit originals).

Medical Expense Reimbursement (MR)

Medical Expenses may only be reimbursed from Employer Contributions; no Employee Contributions may be used to reimburse Medical Expenses.

You may file claims for reimbursement of eligible medical expenses such as:

- deductibles and co-payments for your medical plan (including prescription co-pays)
- amounts over your medical plan's maximum limit
- visits to a doctor or medical group
- expenses that may not be covered by your insurance plan (for example: eyeglasses, prescription contact lenses, dental exams, dental work and much more)
- prescription drugs not covered by insurance
- counseling services: psychiatrist, psychologist, drug or alcohol abuse, impotency and infertility
- birth control pills or other prescribed birth control items
- acupuncture, acupressure
- chiropractic services
- cost of your Flex Plan administration and check fees

For a complete listing of items that may be reimbursed or if you are unsure and have any doubt if a specific expense will qualify, please contact the Member Services Department prior to purchasing the item or incurring the expense. You may also find a more detailed list of Medical Expenses on our web site.

Direct Payment of Medical and Dependent Care Expenses to the Provider of Services

You may request that the Flex Plan make a payment directly to the provider of medical or dependent care services on your behalf; any unpaid amounts will not be carried forward. You must complete a Medical Expense or Dependent Care Assistance Direct Payment Claim Form and must attach Evidence of Expense (as described above). The charge for this service may be found on the Administrative Fee Schedule.

Dependent Care Assistance (DC)

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

Claims may be submitted during the year for reimbursement of Dependent Care Expenses incurred in that calendar year. Each time a claim is paid, that amount will be deducted from the Allocation Amount made on the Enrollment Form. At the end of the year the unused portion (allocation amount less dependent care claims paid) will be subtracted from your Alternate Benefit (AB) Account balance and moved into a separate Dependent Care Account which may only be used for reimbursement of Dependent Care claims incurred in the current year or future years. It cannot revert back to the Alternate Benefit (AB) Account.

Any amounts paid for providing household services (baby-sitters, nurses) or out-of-home care for qualifying individuals may be paid or reimbursed from this account if these expenses are incurred in order to enable you to continue working. The maximum contribution allowed each year is the lesser of \$5,000 per family (or \$2,500 if you are married and file separate federal income tax returns), your earned income, or your spouse's earned income.

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

You must complete a Dependent Care Assistance Certification Form for each provider you wish to seek reimbursement.

For more information about the account limits and qualifying service providers, please refer to the Flex Plan pamphlet "Comparison of the Flex Plan and the Federal Income Tax Credit."

If you provide more than half of their support, qualifying individuals are:

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

Medical Insurance Premium Reimbursement

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

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

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

Important Note: In order to be eligible to receive reimbursement for premiums of your dependent(s) the member must be on the policy. The Flex Plan cannot reimburse the cost of any premiums for a dependent on a separate policy from the member.

Other Insurance Premium Reimbursements

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

- Disability Insurance Premiums (member only) Disability Insurance may be paid with before-tax dollars through the Flex Plan. However, the benefit you receive if you become disabled is taxable. No dependent coverage may be reimbursed under this benefit.
- Dental Insurance Premiums
- Vision Insurance Premiums
- You must submit a copy of your policy cover page as well as proof of payment for premiums.

Group Term Life Insurance Premiums are not reimbursable. You may however elect Group Term Life Insurance coverage under the Flex Plan group contract to be paid on a monthly basis.

Claims and Appeals Procedures under the Plan

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

As for the reimbursement type benefits provided by the Flex Plan, if you believe you are being denied any rights or benefits, you may file a claim in writing with the Flex Plan Office. If any such claim is wholly or partially denied, the Flex Plan Office will notify you of its decision in writing. Such notification will be written in a manner calculated to be understood by you and will contain the following:

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

Such notification will be given within 90 days after the claim is received by the Flex Plan Office (or within 180 days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to you within the initial 90-day period). If such notification is not given within such period, the claim will be considered denied as of the last day of such period and you may request a review of your claim.

Within 60 days after the date on which you receive a written notice of a denied claim (or, if applicable, within 60 days after the date on which denial is considered to have occurred), you (or your duly authorized representative) may:

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

The Trustees will notify you of their decision in writing. Such notification will be written in a manner calculated to be understood by you and will contain specific reasons for the decision as well as specific references to pertinent Flex Plan provisions. The decision on review will be made within 60 days after the request for review is received by the Trustees (or within 120 days, if special circumstances require an extension of time for processing the request, such as an election by the Trustees to hold a hearing, and if written notice of such extension and circumstances is given to you within the initial 60-day period). If the decision on review is not made within such period, the claim will be considered denied. Failure to timely request review of your claim will bar you from further recourse of any kind to collect on your claim.

What are Your Rights under ERISA?

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

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
-
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Important Information

Name of Plan:

Entertainment Industry Flex Plan

Type of Plan:

The Flex Plan is a welfare benefit plan with both employer and cafeteria plan funding. It includes insured medical, life and disability benefits; self-insured medical and dependent care assistance expense reimbursement benefits.

Plan Number:

501

Federal Tax Identification Number of the Plan:

Tax ID Number: 95-6832043

Agent for Service of Process:

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

Plan Year:

January 1st to December 31st

Plan Administration:

The Plan is administered by Benefit Plans, Inc. The address and telephone number of the "Flex Plan Office" is:

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

Fund Manager:

Sean Dugan

General Manager:

Steve Schmit

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

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

Closing...

As you can see, the Entertainment Industry Flex Plan truly lives up to its name by making a flexible "cafeteria-style plan" available to all the participants. Please review all the information carefully. If you have any questions, please don't hesitate to contact the Member Services Department.

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

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

A Brief History of the Entertainment Industry Flex Plan

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

Benefit Plans, Inc. provides administration services to the Plan under the direction of Sean Dugan, the Fund Manager.

Since its inception, the Flex Plan has grown to over eighteen thousand participants and covers many unions in the Entertainment Industry throughout the United States.

2008 Administration Fees

Plan Enrollment Fee (1-time)	\$25.00	Claims Processing Fees *	2.50
Quarterly Administration Fee	14.50	Per claim form submitted	
Quarterly Fee Discount for Internet Delivery	-2.00	(maximum 12 items per claim)	
		Manual Check Fee	17.50
		Per Claim/Group/Year	
Monthly Premium Payments		Direct Payment to Provider *	5.00
MI Medical Insurance	2.50	Credit Card Convenience Fee	14.00
DI Dental Insurance	1.00	Insurance Reinstatement Fee	20.00
VI Vision Insurance	.50	Members whose payments are received late and wish immediate reinstatement are subject to this fee	
LI Group Term Life Insurance	.50		
DB Disability Insurance	.50	NSF/Returned Item Fee	20.00
ID Individual Disability Insurance	1.00	* Subject to eligibility	

Name and Address of the Trustees:

Employer Trustees:

Steven Berkowitz

Vice President Labor Relations West
NBC West, LLC
100 Universal City Plaza, Bldg 1280-3
Universal City, CA 91608

David Pill

Senior Vice President, Associate General Counsel
CBS Broadcasting, Inc.
4024 Radford Avenue.
Studio City, CA 91604

Marc Sandman

Senior Vice President of Labor Relations
ABC, Inc.
500 S Buena Vista St.
Burbank, CA 94521

Union Trustees:

Richard Daszkowski

President
NABET-CWA Local 57
6400 Laurel Canyon Blvd., Suite 301
North Hollywood, CA 91606

John Moffitt

Associate Executive Director
Art Directors Guild, IATSE Local 800
11969 Ventura Blvd. Second Floor
Studio City, CA 91604-2619

Robert Wratschko

Director
IBEW Broadcasting & Recording Department
900 7th Street N.W., Ste 342
Washington, DC 20001



Administration Office:

844 Seward St
Los Angeles, CA 90038

Mailing Address:

PO Box 17928
Los Angeles, CA 90017-0928

Phone:

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

Fax:

(323) 993-8834

Web Site:

www.flexplan.com