

AGMA

HEALTH FUND PLAN A

**SUMMARY
PLAN
DESCRIPTION**

NOVEMBER 2017

IMPORTANT NOTE:

This Document, together with the Aetna Booklet-Certificate, constitutes your Summary Plan Description (SPD).

AGMA HEALTH FUND

AGMA HEALTH FUND

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Updated November 2017

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SUMMARY PLAN DESCRIPTION

AGMA HEALTH FUND

November 2017

Dear Participant,

We are pleased to provide you with this updated booklet describing the benefits provided by the AGMA Health Fund, Plan A (the **Plan**). There have been important changes to this Plan since the last printing of this booklet.

This document, which serves as a **Summary Plan Description (SPD)**, is being provided to enable you to understand the benefits to which you and your family are entitled under the **Plan** and to help you use them well. The benefits described in this booklet are the results of continuous efforts of the **Board of Trustees** to furnish you and your **Eligible Dependents** with an excellent program of benefits that will help meet the needs of the entire family.

The **Plan** is administered by a **Board of Trustees**, composed of representatives from the American Guild of Musical Artists (“AGMA” or the “**Union**”) and **Contributing Employers**. The **Plan’s** benefit program covers health care benefits. In addition to describing these benefits, this booklet will tell you when you are eligible for benefits, how to claim benefits and your responsibilities to provide information to the **Plan**. You should read this booklet and share it with your family since many of the benefits apply to them as well.

Please note that Aetna insures the medical, hospital and prescription drug benefits through its Open Access Managed Choice POS Plan. Dental and vision coverage is available to purchase on a voluntary, self-pay basis from Aetna, which administers and insures the benefit. The specific benefits from Aetna are described in the attached Appendix at the end of this SPD.

The **Plan** is maintained in accordance with **Collective Bargaining Agreements** between the **Employers** and the **Union** and with certain **Participation Agreements**. The **Plan’s** contracts with Aetna, its Agreement and Declaration of Trust (“Trust Agreement”) and the **Collective Bargaining Agreements** and **Participation Agreements**, all legally govern the operation of the benefits program. These documents are available for your inspection at the Fund Office during normal business hours. All statements made in this booklet are subject to the provisions and terms of these documents; nothing in this booklet is intended to extend or change in any way the provisions expressed in the other official documents.

You will notice that certain words are in **bold-face** throughout this document. These words have specific meaning within the document and are defined in the Definitions section at the end of this document. Please note that “you” and “your” are defined in the Definitions section, however, these words are not **bold-face** throughout the document.

This booklet replaces any prior booklets you may have received. If you have any questions about any material contained in this booklet, or if you misplace this booklet, you may call the Fund Office at (212) 765-3664.

We believe that the **Plan** provides an excellent package of benefits. We request your assistance in using these benefits intelligently. Your prudent use of the benefits to which you and your dependents are eligible will help us to continue to provide you with a comprehensive program of high quality benefits.

Sincerely,

THE BOARD OF TRUSTEES

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IMPORTANT INFORMATION YOU OR YOUR DEPENDENTS MUST FURNISH TO THE FUND OFFICE

In addition to information you must furnish in support of any claim for **Plan** benefits under this **Plan**, you or your **Eligible Dependents** must immediately furnish to the Fund Office in writing any information you or they may have that may either affect eligibility for coverage under the **Plan** or the Fund Office's ability to properly administer your benefits. These events include, but are not limited to:

- Change of name.
- Change of address. (Advise the Fund Office promptly so its records will be up to date to communicate with you about any matters concerning your coverage.)
- The marriage, divorce, legal separation, or death of you or any covered **Spouse, Domestic Partner, or Dependent Child(ren)**.
- Any information regarding the status of your **Dependent Child(ren)**, including:
 - Your Dependent Child(ren) reaching the Plan's age limit (26);
 - The existence of any physical or mental handicap of a Dependent Child age 26 or older to ensure continued coverage.
 - **Medicare** enrollment or disenrollment.
 - Social Security Disability Benefits Award or Termination.
 - The existence of other medical or prescription drug coverage.

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INTRODUCTION

Plan A of the AGMA Health Fund is maintained and operated in accordance with **Collective Bargaining Agreements** between the **Union** and **Contributing Employers**, and Participation Agreements between other **Contributing Employers** and the **Trustees**.

This booklet describes the key features of the AGMA Health Fund Plan A benefits program. Complete details of the program are set forth in other official **Plan** documents, including the Fund's contracts and/or certificates of coverage with Aetna, the Trust Agreement and the **Collective Bargaining Agreements** and **Participation Agreements**, all of which legally govern the operation of the benefits program. All statements made in this booklet are subject to the provisions and terms of those documents.

Nothing in this booklet is intended to interpret, extend or change in any way the provisions expressed in the official **Plan** documents. In the event of a conflict or inconsistency between the official **Plan** documents and this booklet, the official **Plan** documents will govern in all cases.

Amendment, Modification or Termination

The **Trustees** hope to continue the AGMA Health Fund. However, the **Trustees** reserve the right, in their sole and absolute discretion, to amend, modify or terminate the Fund's benefit program (including any related documents or policies), in whole or in part, at any time and for any reason, with respect to you and your dependents who are or may become covered under the Fund. Among other things, the **Trustees** have the power to change the eligibility rules, to diminish the amount of benefits, to increase or require deductibles or coinsurance, to eliminate particular types of benefits, to substitute certain benefits for others, and, if deemed necessary by the **Trustees**, to change the amount of **Contributions** required as a condition for eligibility. If the program of benefits under the Fund is modified or terminated, the ability of you or your family members to participate in and receive benefits from the Fund may be modified or terminated.

Thus, all benefits provided under the Fund and eligibility rules for **Participants**:

- Are not guaranteed;
- May be changed or discontinued by the **Trustees** at any time, in their sole and absolute discretion;
- Are subject to the rules and regulations adopted by the **Trustees**; and
- Are subject to the Trust Agreement, the **Collective Bargaining Agreements** and the other official **Plan** documents that establish and govern the Fund's operations.

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Upon termination of the Fund, the **Trustees** will apply the monies in the Fund to provide benefits or otherwise to carry out the purposes of the Fund in an equitable manner until the entire remainder of the assets has been disbursed. Under no circumstances will any Fund benefits become vested or nonforfeitable with respect to **Participants** or their **Eligible Dependents**.

Interpretation

Please also note that no individuals, other than the **Trustees** or their duly authorized designee(s) (which may be one or more of the insurance companies with which the Fund has contracted for benefits), have any authority to interpret the **Plan** documents or to make any promises to you about the **Plan** of benefits, or to change any provision of the **Plan** of benefits. Only the **Trustees**, or their authorized designee(s), have the exclusive right and power, in their sole and absolute discretion, to interpret the **Plan** and to decide all matters arising thereunder.

OTHER PLAN INFORMATION

Maternity Care

The AGMA Health Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and health insurance issuers may not, under federal law, require that a provider or health care practitioner obtain authorization from the **Plan** or insurance company for prescribing a length of stay not in excess of the above periods. Consult the Aetna Appendix to this **SPD** for details about your maternity benefits.

Post-Mastectomy Breast Reconstructive Surgery Benefits

Under the Women's Health and Cancer Rights Act of 1998, if you or your covered dependent is receiving benefits in connection with a mastectomy, and you elect breast reconstruction in connection with the mastectomy, you are entitled to coverage for the following:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and

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- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

If you are a covered **Participant** or covered dependent, and are currently receiving, or in the future receive benefits under the **Plan** in connection with a mastectomy, you are entitled to coverage for the benefits described above in the event that you elect breast reconstruction.

Coverage for the mastectomy-related services or benefits required under the Women's Health and Cancer Rights Act of 1998 will be subject to the same co-payment or coinsurance provisions that apply with respect to the other medical or surgical benefits provided under the **Plan**.

Consult the Aetna Appendix to this **SPD** for details about your post-mastectomy breast reconstructive surgery benefits.

REQUIRED NOTICE OF PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of Primary Care Provider

Aetna does not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider (including a Pediatrician for a child); however, you may pay more if you use a non-network provider.

Direct Access to Obstetrical and Gynecological Care

You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Aetna at the telephone number listed on your member identification card.

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ELIGIBILITY

INDIVIDUAL COVERAGE

Collectively Bargained Employees

If you are an **Employee** of a **Participating Employer** who makes **Contributions** to Health Plan A on your behalf as a condition of the **Collective Bargaining Agreement**, you are eligible for coverage under the AGMA Health Fund Plan A if you meet the following requirements.

You are considered an “**Employee**” if you are employed full-time on a weekly contract of four weeks or more. “**Covered Employment**” is work as an **Employee** for a **Participating Employer** for which the **Participating Employer** is obligated to and does contribute to Health Fund Plan A on your behalf.

You become eligible for coverage once you have completed a two (2) month lag period from the month in which you have a full week of Covered Employment with a Participating Employer, as described above. If you begin Covered Employment with seven (7) or more calendar days left in a month, you will receive credit for that month and your lag period will begin at the beginning of that month. If you begin Covered Employment with less than seven (7) calendar days left in the month, your lag period will begin the first of the following month.

Non-Collectively Bargained Employees

There are special eligibility rules for covered **Employees** (such as Fund Office **Employees**) not covered by a **Collective Bargaining Agreement** with the **Union**. If you are not covered by a **Collective Bargaining Agreement**, contact the Fund Office for more information.

Effective Date of Coverage

Your coverage becomes effective on the first of the month following the completion of the two-month lag period, as described above, provided you **Enroll** in the **Plan**.

Example:

Jane completes a full week of **Covered Employment** with a **Participating Employer** on the 11th of January. Her waiting period would begin on January 1st and runs through February 28th (or 29th during a leap year). Jane’s coverage becomes effective on March 1st, provided she completes the necessary Enrollment Forms.

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*Suppose that Jane begins **Covered Employment** with a **Participating Employer** on the 26th of January, and completes her first full week of **Covered Employment** on February 1st. Her waiting period would begin on February 1st and run through March 31st. Jane's coverage then becomes effective on April 1st, provided she completes the necessary Enrollment Forms, as described below.*

Generally you will have one month of coverage for each month that your **Employer** makes the necessary **Contributions** on your behalf. Due to the lag period prior to the commencement of coverage (described above) your coverage will generally continue for a period of time equal to your initial lag period (the "lag period extension") after **Contributions** cease.

DEPENDENT COVERAGE

The **Plan** covers your **Eligible Dependents**, provided you are still covered by the **Plan** (i.e., are still a **Plan Participant**) and either you or your **Employer** pay for your **Eligible Dependents'** coverage. Your **Eligible Dependents** include:

- your legal **Spouse**;
- your **Dependent Child(ren)** – to the last day of the month in which they reach age 26. For the purposes of this **Plan**, a **Dependent Child** is any of the **Employee's/Participant's** children listed below who are under the age of 26 (whether married or unmarried):
 - Your son or daughter (proof of relationship and age will be required);
 - Your stepson or stepdaughter (proof of relationship and age will be required);
 - Your legally adopted child or child placed for adoption with you (proof of adoption or placement for adoption and age will be required). Placed for adoption means the assumption and retention by you of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement for adoption terminates upon the termination of such legal obligation;
 - A child named as an "alternate recipient" under a **Qualified Domestic Child Support Order (QMCSO)**;
 - Any children for whom you are the legal guardian under court order;
 - Your grandchildren in your court ordered custody;
 - The biological or legally adopted child of your **Domestic Partner**;

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- For insured benefits provided by Aetna, an unmarried **Dependent Child** remains eligible for coverage until the end of the month in which they turn 30.
- Your **Domestic Partner** as defined below.

A **Domestic Partner** is an adult who, as of the date of **Enrollment**:

- provides proof of habitation with you (e.g., driver's license or tax return);
- is of the age of consent in the State of residence;
- is not related to you by blood in any manner that would bar marriage in the State of residence;
- has a close, committed and monogamous personal relationship with you;
- has been sharing the same household with you on a continuous basis for at least 6 months;
- has registered with you as a **Domestic Partner** where such registration is available;
- is not married to anyone other than you and is not separated from an other person;
- has not been registered as a member of another domestic partnership within the last six months; and
- demonstrates financial interdependence by submissions of proof of 2 or more of the following:
 - 1) common ownership of real property or a common threshold interest in such property;
 - 2) common ownership of a motor vehicle;
 - 3) designation as a beneficiary for Life insurance or retirement benefits or under the partner's will;
 - 4) assignment of a durable power of attorney or health care power of attorney; or
 - 5) such other proof as is sufficient to establish economic mutual dependency under the circumstances of the specific case.

Special tax information for those who Enroll their Domestic Partners and children of their Domestic Partners: The Domestic Partner will generally not qualify as a federal tax dependent and as such, the Participant will be taxed on the value of the benefit provided to him or her. This is called "imputed income" and the Participant will have to pay tax on this amount. However, the tax treatment for this coverage may be different under certain state tax laws. Please contact the Fund Office for further information.

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Continuation of Coverage for Dependent Child(ren)

- In addition your unmarried **Dependent Child(ren)** will be eligible to continue coverage past age 26 if he or she is Fully Handicapped (as described below) provided you are still covered by the **Plan** (i.e., are still a **Plan Participant**) and either you or your **Employer** pay for your **Eligible Dependent's** coverage.
- Your child is Fully Handicapped if:
- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for **Dependent Child(ren)** under the **Plan**; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is Fully Handicapped must be submitted to Aetna no longer than 31 days after the date your child reaches the maximum age for a **Dependent Child** under the **Plan**. As described in the Aetna Appendix to this **SPD**, Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under the **Plan**.

With the exception of an eligible **Dependent Child** who is permanently and totally disabled prior to age 26, coverage will terminate at the end of the month in which the individual attains age 26.

Proof of Dependent Status

Specific documentation to substantiate dependent status will be required by the **Plan**. Also, if the adult child you cover is over age 26 and does not qualify as a tax dependent under IRC § 152 or where a state law definition of a dependent does not match the federal law definition of a dependent, your gross income includes the fair market value of employer-paid coverage provided to the adult child. This is known as "imputed income." This will likely increase both your taxable income and tax liability.

Below are other items the Plan requires to substantiate dependent status:

- **Marriage/Spouse:** The certified marriage certificate.
- **Birth/Dependent Child:** The certified birth certificate for the child of an **Employee** or **Domestic Partner**.

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- **Stepchild:** The certified birth certificate plus certified marriage certificate between the **Employee** and the child's parent and the divorce decree between the child's parents (if applicable).
- **Adoption or placement for adoption:** Court order signed by the judge showing that the **Employee, Spouse, or Domestic Partner** has adopted or intends to adopt the child plus a certified birth certificate.
- **Legal Guardianship:** The court-appointed legal guardianship documents and certified birth certificate.
- **Fully Handicapped Dependent Child:** Current written statement from the child's physician indicating: (i) the child's diagnoses that are the basis for the physician's assessment that the child is Fully Handicapped (as that term is defined in this document); (ii) that these diagnoses existed before the child's attainment of the **Plan's** maximum age limit for **Dependent Child(ren)**; (iii) that the child is incapable of self-sustaining employment as a result of being Fully Handicapped; and (iv) that the child is dependent chiefly on you and/or your Spouse or **Domestic Partner** for support and maintenance. The **Plan** may require that you show proof of initial and ongoing disability and that the child meets the **Plan's** definition of **Dependent Child**.
- **Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document signed by judge or National Medical Support Notice.
- **Domestic Partner:** See prior section on definition of **Domestic Partner** for the required documentation.

The Fund Office will make copies of any original documents and return the originals to you if you do not have an extra certified copy.

ENROLLMENT

You must **Enroll** for coverage by submitting the completed written Enrollment Forms to the Fund Office, before coverage is effective. Enrollment Forms should be obtained from the Fund Office immediately following the date you begin **Covered Employment** to ensure that your coverage becomes effective. You will have three opportunities to **Enroll** for coverage under this **Plan**: Initial Enrollment, Open Enrollment and Special Enrollment.

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Opportunities to Enroll for Coverage Under the Plan

INITIAL ENROLLMENT

In order to receive benefits, you must **Enroll** no later than 31 days after the date in which you initially became eligible for coverage. If you submit the Enrollment Forms within 31 days of the date of your initial eligibility, your coverage is retro-active to the date of your initial eligibility.

You must also Enroll any Eligible Dependents within 31 days after the date you initially became eligible for coverage.

Failure to Enroll during Initial Enrollment: If you do not Enroll yourself or your Eligible Dependents during the Initial Enrollment period, you will not be able to Enroll yourself and/or your Eligible Dependents until the next Open Enrollment period, unless you satisfy the requirements for Special Enrollment.

OPEN ENROLLMENT

Open Enrollment is the period of time during the Fall of each year to be designated by the **Plan** during which **Eligible Participants** may make elections or changes to their benefits. Enrollment Forms and information may be obtained from the Fund Office. The Open Enrollment period is usually held every November for benefits starting on January 1st.

Once you have properly **Enrolled** during the Open Enrollment period, changes to your coverage will be effective on the designated effective date, usually January 1st.

Failure to Enroll During Open Enrollment (Very Important Information):

If you fail to **Enroll** yourself and/or any of your **Eligible Dependents** within the Open Enrollment period (unless you and/or your **Eligible Dependents** qualify for Special Enrollment described later in this section), you will not be able to **Enroll** yourself and/or them until the next Open Enrollment period.

DEPENDENT ENROLLMENT

You may **Enroll** your **Eligible Dependents** at the same time you become eligible for benefits. However, unless your **Employer** is obligated to pay for dependent coverage, you must pay for such coverage. Your premiums for dependent coverage typically will be taken out of your payroll check through payroll deductions

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by your **Employer** and forwarded to the Fund. Such payments are due by the last business day of the month before coverage begins. If you elect dependent coverage, you must notify your **Employer** and complete the necessary paper work authorizing applicable payroll deductions in order for coverage to be effective. If your **Employer** will not deduct the amounts or you are paying for dependent coverage when you are no longer employed, you must remit payment to the Fund Office. Such payment must be received by the last business day of the month before coverage begins. For example, payment must be received by April 30 for coverage starting May 1.

Your dependents' coverage will be effective at the same time as your coverage provided you **Enroll** them at the same time. You must complete and submit the necessary Enrollment Forms for you and your dependents to the Fund Office for your dependents' coverage to be effective the same time as your coverage. If you do not immediately **Enroll** your dependent, you must wait for the next Open Enrollment period, unless you satisfy the requirements for Special Enrollment, described below. The Open Enrollment period is usually held every November for benefits starting on January 1st.

You must submit a copy of your marriage certificate to **Enroll** your **Spouse** and a birth certificate(s) – and other legal documents when applicable – to **Enroll** your **Dependent Child(ren)**, an affidavit and accompanying documentation for a **Domestic Partner**, and the Social Security numbers for all your **Eligible Dependents**.

SPECIAL ENROLLMENT

Newly Acquired Spouse, Domestic Partner and/or Dependent Child(ren)

If you are Enrolled for individual coverage and if you acquire a **Spouse** by marriage, enter into a domestic partnership or if you acquire any **Dependent Child(ren)** by birth, adoption or placement for adoption, you may **Enroll** your newly acquired **Spouse, Domestic Partner**, and/or any **Dependent Child(ren)** provided you notify the Fund in writing and **Enroll** your **Eligible Dependent** within 31 days of the marriage/domestic partnership/birth/adoption. You must include all necessary proof with **Enrollment**. Enrollment Forms may be obtained from the Fund Office.

If you are not **Enrolled** for individual coverage and if you acquire a **Spouse** by marriage, enter into a domestic partnership or if you later acquire any **Dependent Child(ren)** by birth, adoption or placement for adoption, you may **Enroll** yourself and your newly acquired **Spouse, Domestic Partner** and/or any **Dependent Child(ren)**, provided you do so within 31 days.

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If you did not **Enroll** your **Spouse** or **Domestic Partner** for coverage when he or she first became eligible for coverage, and if you later acquire a **Dependent Child** by birth, adoption or placement for adoption, you may **Enroll** your **Spouse** together with your newly acquired **Dependent Child**, provided you do so within 31 days.

Special Enrollment for Individuals who Lose Coverage Under Medicaid or a State Children's Health Insurance Program (CHIP)

If you did not **Enroll** yourself or your **Dependent Child(ren)** in the **Plan** when first eligible, you may **Enroll** yourself or your **Dependent Child(ren)** if they had coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and lose eligibility for that coverage. In addition, you may also **Enroll** yourself and/or your **Dependent Child(ren)** in this **Plan** if you and/or they become eligible for a premium assistance program through Medicaid or CHIP.

However, you must request **Enrollment** in this **Plan** within 60 days after you (or your dependents) are determined to be eligible for such premium assistance.

To request Special Enrollment or obtain more information, contact the Fund Office.

Loss of Other Health Coverage

You may also **Enroll** yourself and any **Eligible Dependents** whom you did not **Enroll** in this **Plan** when they first became eligible because they had other coverage, when they or you lose that other group health coverage or health insurance, provided you inform the Fund in writing and **Enroll** yourself and/or your dependents within 31 days of the loss.

When Coverage Starts Following Special Enrollment

Coverage for your new **Spouse** begins the day you marry, for your **Domestic Partner**, the day he or she becomes a Domestic Partner as defined by the Fund, and for your new child as of the child's date of birth or placement for adoption as explained above, all provided you **Enroll** them within 31 days of marriage, domestic partnership, birth or adoption. If you notify the Fund Office of your intention to **Enroll** your dependent within 31 days of marriage, domestic partnership, birth or adoption, but you do not **Enroll** them within those 31 days, you will need to wait until the next Open Enrollment to **Enroll** them in the **Plan**.

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If you adopt a child, your adopted **Dependent Child** will be covered from the date that the child is “Placed for Adoption” with you. A child is “Placed for Adoption” with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. Adopted newborns are covered from the moment of birth, provided that the child is placed for Adoption with you no later than 31 days after the child is born and you comply with the **Plan’s** requirements for obtaining coverage for a newborn **Dependent Child**. However, if a child is Placed for Adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

If you lose other group health coverage, and you provide timely notification to the Fund in writing and request **Enrollment**, your coverage starts on the day after your other group health coverage ends provided payment is received, if applicable. If you are eligible for Special Enrollment because you or your **Eligible Dependents** lose or gain coverage under Medicaid or CHIP, and you timely notify the Fund in writing and request **Enrollment**, such coverage starts on the day after your Medicaid or CHIP coverage ends provided payment is received, if applicable.

Late Enrollment

This **Plan** does not offer a Late Enrollment provision. See the Special Enrollment or Open Enrollment provisions of this section.

TERMINATION OF COVERAGE

Generally you will have one month of coverage for each month that your **Employer** makes the necessary **Contributions** on your behalf. Due to the lag period prior to the commencement of coverage (described above) your coverage will generally continue for a period of time equal to your initial lag period (the “lag period extension”) after **Contributions** cease. Your eligibility for coverage under the Health Fund will end:

- if the **Plan** is discontinued;
- at the end of the month in which your lag period extension ends after the earlier of (1) your employment terminates, or (2) your **Employer** fails to make the necessary **Contributions** on your behalf; or

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- if you have been continuously employed since October 1, 1998, at the end of the month in which employment terminates or if earlier, the end of month in which your **Employer** fails to make the required **Contributions** on your behalf. For example, if you worked in June, and your **Employer** was obligated to contribute to the Fund for that work by July 10, your coverage will end July 31 if the Fund has not received the **Contributions** due for work in June.

Coverage for your **Eligible Dependents** ends upon the earliest date of the following events:

- your coverage ends;
- your dependent no longer meets the definition of **Eligible Dependent**
- you (or your **Employer**) fail(s) to pay the necessary premium for dependent coverage by the due date (payment is due the last day before the start of the month of coverage); or
- you die or divorce your **Spouse**.

When the Plan Can End Your Coverage For Cause

The **Plan** may rescind your coverage and/or your dependent's coverage for an act, practice, or omission that constitutes fraud or if you make an intentional misrepresentation of material fact. However, coverage will not be rescinded until after the **Plan** provides you with 30 days advance written notice of that rescission of coverage. The **Trustees** have the right to determine, in their sole discretion, whether there has been an act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the **Plan**. However, the following situations will not be considered rescissions of coverage and do not require the **Plan** to give you 30 days advance written notice:

- The **Plan** terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the **Plan** of your termination of employment.
- The **Plan** retroactively terminates your coverage and/or your dependent's coverage because of your failure to timely pay required premiums or contributions for such coverage.

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- The **Plan** retroactively terminates your former **Spouse's** coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your dependents were covered by the **Plan** when you should not have been covered, the **Plan** will cancel your coverage prospectively – for the future – once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the **Plan** to give you 30 days advance written notice.

Recovery of Overpayments

If for any reason benefit payments are made to any person from the Fund in excess of the amount which is due and payable for any reason (including, without limitation, mistake of fact or law, reliance on any false or fraudulent statements, information, or proof submitted by a **Participant**, or a **Participant's** failure to timely inform the Fund of relevant information, such as a divorce), the **Trustees** (or the **Plan Administrator** or any other designee duly authorized by the **Trustees**) shall have full authority, in their sole and absolute discretion, to recover the amount of any overpayment (plus interest and costs). That authority shall include, but not be limited to:

- the right to reduce benefits payable in the future to the person who received the overpayment
- the right to reduce benefits payable to a surviving **Spouse** or other beneficiary who is, or may become, entitled to receive payments under the **Plan** following the death of that person, and/or
- the right to initiate a lawsuit or take such other legal action as may be necessary to recover any overpayment (plus interest and costs) against the person who received the overpayment, or such person's estate.

SPECIAL CIRCUMSTANCES AFFECTING YOUR AND YOUR DEPENDENTS' COVERAGE

Qualified Medical Child Support Orders (QMCSO)

According to Federal law, you might be required to Enroll your children in the **Plan** due to a **Qualified Medical Child Support Order (QMCSO)** or a National Medical Support Order (NMSO) – a support order of a court or state administrative agency that usually results from a divorce or legal separation. The Fund Office will provide on request (without charge) a copy of the Fund's **QMCSO** procedures.

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Family and Medical Leaves of Absence

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- the birth, adoption, or placement with you for adoption of a child;
- to provide care for a **Spouse**, child, or parent who is seriously ill;
- your own serious illness; or
- qualifying exigencies arising out of the fact that the **Active Participant's Spouse**, son, daughter, or parent is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation.

The Family and Medical Leave Act (FMLA) allows you to take up to 26 weeks of unpaid leave during any 12-month period to provide care for a covered service member. If you are the **Spouse**, son, daughter, parent or next of kin (i.e., nearest blood relative) of a service member, you are now entitled to a total of 26 weeks of leave during a 12-month period to care for the service member. A covered service member is a member of the Armed Forces (including National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy (including on an outpatient basis) for a serious injury or illness. The injury or illness must have been incurred in the line of duty while on active duty, and it must be an injury or illness that may render the service member unfit to perform the duties of his/her office, grade, rank or rating. If you are taking this type of leave, along with FMLA for any other purpose (e.g., birth of a child), the combined total leave required during one 12-month period is 26 weeks.

During your leave, you can continue all of your medical coverage and other benefits offered through the Fund. You are generally eligible for a leave under the FMLA if you:

- have worked in **Covered Employment** for at least 12 months;
- have worked at least 1,250 hours over the previous 12 months; and
- work at a location where at least 50 **Employees** are employed by the **Employer** within 75 miles.

The Fund will maintain the **Employee's** eligibility status until the end of the leave, provided the **Contributing Employer** properly grants the leave under the FMLA and the **Contributing Employer** makes the required notification and payment to the Fund. Of course, any changes in this **Plan's** terms, rules or practices that go into effect while you are away on leave apply to you and your dependents, the same as to active **Employees** and their dependents. Call your

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Employer to determine whether you are eligible for **FMLA** leave. Call the Fund Office regarding coverage during **FMLA** leave.

Leaves of Absence for Military Service

A **Participant** who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA?

USERRA continuation coverage is a temporary continuation of coverage when it would otherwise end because the **Employee** has been called to active duty in the uniformed services. USERRA protects **Employees** who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An **Employee's** coverage under this **Plan** will terminate when the Employee enters active duty in the uniformed services.

- If the **Employee** elects USERRA temporary continuation coverage, the **Employee** (and any **Eligible Dependents** covered under the **Plan** on the day the leave started) may continue **Plan** coverage for up to 24 months measured from the last day of the month in which the **Employee** stopped working.
- If the **Employee** goes into active military service for up to 31 days, the **Employee** (and any **Eligible Dependents** covered under the **Plan** on the day the leave started) can continue health care coverage under this **Plan** during that leave period if the **Employee** continues to pay the appropriate contributions for that coverage during the period of that leave.

Duty to Notify the Plan

The **Plan** will offer the **Employee** USERRA continuation coverage only after the **Plan Administrator** has been notified by the **Employee** in writing that he or she has been called to active duty in the uniformed services and provides a copy of the orders. The **Employee** must notify the **Plan Administrator** as soon as possible but no later than 60 days after the date on which the **Employee** will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage

Once the **Plan Administrator** receives notice that the **Employee** has been called to active duty, the **Plan** will offer the right to elect USERRA coverage for the **Employee** (and any **Eligible Dependents** covered under the **Plan** on the day the leave started). Unlike **COBRA** Continuation Coverage, if the **Employee** does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the **Employee** (and any **Eligible Dependents** covered under the **Plan** on the day the leave started) may also be eligible to elect **COBRA** temporary continuation coverage. Note that USERRA is an alternative to **COBRA**. Therefore, either **COBRA** or USERRA continuation coverage can be elected and coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the **COBRA** or USERRA election forms. Completed USERRA election forms must be submitted to the **Plan** in the same timeframes as is permitted under **COBRA**.

Paying for USERRA Coverage

- If the **Employee** goes into active military service for up to 31 days, the **Employee** (and any **Eligible Dependents** covered under the **Plan** on the day the leave started) can continue health care coverage under this **Plan** during that leave period if the **Employee** continues to pay the appropriate contributions for that coverage during the period of that leave.
- If the **Employee** elects USERRA temporary continuation coverage, the **Employee** (and any **Eligible Dependents** covered under the **Plan** on the day the leave started) may continue **Plan** coverage for up to 24 months measured from the last day of the month in which the **Employee** stopped working. USERRA continuation coverage operates in the same way as **COBRA** coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with **COBRA** coverage. See the **COBRA** chapter for more details.

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). This **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 better choice.

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After Discharge from the Armed Forces:

When the **Employee** is discharged from military service (not less than honorably), eligibility will be reinstated on the day the **Employee** returns to work in **Covered Employment** provided the **Employee** returns to employment within:

- 90 days from the date of discharge from the military if the period of service was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days and the **Contributing Employer** or **Employee** pays the required premium.

If the **Employee** is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The **Employee** must notify the **Plan Administrator** in writing within the time periods listed above. Upon reinstatement, the **Employee's** coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to the Fund Office.

Continuation of Coverage

See the **COBRA** section for information on continuing your health care coverage.

CONTINUATION OF COVERAGE

CONTINUATION THROUGH COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, (**COBRA**), requires the **Plan** to offer each "Qualified Beneficiary" the opportunity for a temporary extension of health care coverage at their own expense under certain circumstances when health care coverage would otherwise end (called "Qualifying Events"). Under the law, a Qualified Beneficiary is any

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Employee, Spouse, or Dependent Child of an **Employee** who is covered by the **Plan** when a COBRA-Qualifying Event occurs, and who is therefore entitled to elect **COBRA** Continuation Coverage. A child who becomes a **Dependent Child** by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of **COBRA** is also a Qualified Beneficiary. However, a person who becomes the new **Spouse** of an existing **COBRA Participant** during a period of **COBRA** may be added to the COBRA coverage of the existing **COBRA** Participant but is not a “Qualified Beneficiary.” This means that if the existing **COBRA** Participant dies or divorces before the expiration of the maximum **COBRA** coverage period, the new Spouse is not entitled to elect **COBRA** for him/herself. **Domestic Partners** are not eligible for COBRA Continuation Coverage.

COBRA-Qualifying Events are those shown in the chart shown on the next page. Qualified Beneficiaries are entitled to **COBRA** Continuation Coverage when Qualifying Events (which are specified in the law) occur, and, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. A Qualifying Event triggers the opportunity to elect **COBRA** when the covered individual **LOSES** health care coverage under this **Plan**. If a covered individual has a Qualifying Event but, as a result, does not lose their health care coverage under this **Plan** (e. g. **Employee** continues working even though entitled to Medicare), then **COBRA** is not available.

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

The benefits under **COBRA** are the same as those for people who are not on Continuation Coverage. You should also keep in mind that each individual entitled to coverage as a result of the Qualifying Event has a right to make his or her own election of coverage. For example, your **Spouse or Dependent Child(ren)** may elect **COBRA** coverage even if you do not and covered parents/legal guardians may elect **COBRA** for a minor child.

Under **COBRA**, you and your **Spouse or Dependent Child(ren)** may continue the same coverage that you had before the **COBRA**-Qualifying Event, including:

- Medical coverage.
- Hospital coverage.
- Prescription drug coverage.
- Dental coverage (traditional reimbursement (the Alternate Coverage) or comprehensive DMO).
- Vision.

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RIGHTS UNDER NEW YORK STATE CONTINUATION OF COVERAGE UNDER AETNA

A Qualified Beneficiary who has exhausted continuation coverage pursuant to the provisions described in this section has the opportunity to continue coverage under Aetna for up to thirty-six months from the date the **Employee's, Spouse's or Dependent Child(ren)'s** continuation coverage began, if the **Employee, Spouse or Dependent Child(ren)** is entitled to less than thirty-six months of continuation benefits under federal law. Contact the Fund Office for information on extending your **COBRA** period. This extension applies only to benefits insured by Aetna and not to other benefits such as prescription drug coverage.

See the end of this **COBRA** section for information on continuing coverage for unmarried young adults through age 29.

For additional information regarding your Rights under New York State Continuation Coverage see the Aetna Appendix to this SPD.

COBRA ELIGIBILITY (COBRA-QUALIFYING EVENTS)

The following chart lists the COBRA-Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

COBRA-AT-A-GLANCE

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries ¹		
	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in weeks worked (making Employee ineligible for health care coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have dependent status.	N/A	N/A	36 months

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1: When a covered Employee's Qualifying Event (e.g. termination of employment or reduction in weeks) occurs within the 18-month period after the Employee becomes entitled to Medicare (entitlement means the Employee is eligible for and enrolled in Medicare), the Employee's covered Spouse and Dependent Child(ren) who are qualified beneficiaries (but not the Employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.

MAXIMUM PERIOD OF COBRA CONTINUATION COVERAGE

The maximum period of **COBRA** Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date of the loss of **Plan** coverage. The 18-month period of **COBRA** Continuation Coverage may be extended for up to 11 months under certain circumstances (described below). The maximum period of **COBRA** coverage may be cut short for the reasons described in the section on "Early Termination of **COBRA** Continuation Coverage" that appears later in this section.

COBRA COVERAGE IN CASES OF SOCIAL SECURITY DISABILITY

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

- The disability occurred on or before the start of **COBRA** coverage, or within the first 60 days of **COBRA** coverage.
- The disabled Covered Person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration (SSA).
- The **Plan** is notified in writing that the determination was received:
 - No later than 60 days after it was received; and
 - Before the 18-month **COBRA** continuation period ends.

This extended period of **COBRA** coverage will end at the earlier of:

- The last day of the month, 30 days after SSA has determined that you and/or your **Spouse or Dependent Child(ren)** are no longer disabled.
- The end of 29 months from the date loss of coverage due to the **COBRA** qualifying event.
- The date the disabled individual becomes entitled to **Medicare** benefits.

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COST OF COBRA COVERAGE IN CASES OF SOCIAL SECURITY DISABILITY

If the 18-month period of **COBRA** Continuation Coverage is extended because of Social Security disability, the **Plan** will charge members and their families 150% of the cost of coverage for the **COBRA** family unit that includes the disabled person for the 11-month Social Security disability extension period. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

HOW COBRA COVERAGE WORKS

Your Employer will usually notify the Fund Office of your death, termination of employment, reduction in weeks, retirement, or enrollment in **Medicare** benefits (Part A, Part B, or both). However, you or your family must also notify the Fund Office promptly and in writing if any such event occurs in order to avoid confusion over the status of your or their health care in the event there is a delay or oversight in providing that notification.

In order to have the opportunity to elect **COBRA** Continuation Coverage after a divorce, legal separation, or a child ceasing to be a **Dependent Child** under the **Plan**, **you and/or a family member must notify the Fund Office in writing within 60 days after the occurrence of that event.**

IF WRITTEN NOTICE IS NOT RECEIVED BY THE END OF THE 60-DAY PERIOD, THE AFFECTED SPOUSE OR DEPENDENT CHILD WILL NOT BE ENTITLED TO CHOOSE COBRA.

PROCEDURES FOR PROVIDING NOTICE TO THE FUND

You (the **Employee**) and/or **Spouse** or **Dependent Child** must give the Fund Office notice in writing as soon as possible, but no later than the applicable deadline set out above, for the following events:

- a divorce;
- a child ceasing to be a dependent;
- a second qualifying event that entitles a **Spouse** or **Dependent Child** to additional **COBRA** coverage;
- a **Spouse** or **Dependent Child** is determined to be disabled by the Social Security Administration;
- a **Spouse** or **Dependent Child** who had been determined to be disabled under the Social Security Administration receives notice that he or she is no longer considered disabled.

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Please include the following in your notice:

- your name,
- the names of your **Spouse** or **Dependent Child(ren)**,
- your Social Security number and the Social Security numbers of your **Spouse** and/or **Dependent Child(ren)**,
- your address, and
- the nature and date of the occurrence you are reporting to the Fund.

That notice should be sent to:

Derek J. Davis
Executive Director
AGMA Health Fund
1430 Broadway Suite 1203
New York, NY 10018
(212) 765-3664

The Fund Office will then send you information about **COBRA** coverage. The Fund must notify you and your **Spouse** and/or **Dependent Child(ren)** of your right to **COBRA** coverage within 14 days after it receives notice or becomes aware that a Qualifying Event has occurred. You will have 60 days to respond if you want to continue coverage—measured from the date coverage would otherwise end, or if later, the date the **COBRA** notice is sent to you.

HOW TO ELECT COBRA CONTINUATION COVERAGE

When your employment terminates or you experience a reduction in weeks of work so that you are no longer entitled to coverage under the **Plan**, or when the Fund Office is notified on a timely basis that you died, divorced, changed coverage under the **Plan** from family to single coverage, or that a **Dependent Child** lost dependent status under the **Plan**, the Fund Office will give you and/or your covered **Spouse** and/or **Dependent Child(ren)** notice of the date on which your coverage ends and the information and forms you and/or they need to elect **COBRA** Continuation Coverage.

Under the law, you and/or your covered **Spouse** and/or **Dependent Child(ren)** will then have **60 days** from the date coverage would otherwise end, or if later, the date the **COBRA** notice is sent to you to elect **COBRA**.

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IF YOU AND/OR ANY OF YOUR SPOUSE AND DEPENDENT CHILD(REN) DO NOT CHOOSE COBRA CONTINUATION COVERAGE WITHIN 60 DAYS FROM THE DATE COVERAGE WOULD OTHERWISE END, OR IF LATER, THE DATE THE COBRA NOTICE IS SENT TO YOU, YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN AFTER COVERAGE ENDED.

Each Qualified Beneficiary has an independent right to elect **COBRA** Continuation Coverage. **COBRA** Continuation Coverage may be elected for some members of the family and not others. In addition, one or more covered dependents may elect **COBRA** even if the **Employee** does not elect it. However, in order to elect **COBRA** Continuation Coverage, the members of the family must have been covered by the **Plan** on the date of the Qualifying Event (except in the case of newly acquired dependents, as described below). A parent may elect or reject **COBRA** Continuation Coverage on behalf of covered **Dependent Child(ren)** living with him or her.

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

Instead of enrolling in **COBRA** Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a **Spouse's** plan) through what is called a "special enrollment period." Some of these options may cost less than **COBRA** Continuation Coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a **Spouse's** plan), even if that plan generally doesn't accept late enrollees. You can learn more about many of these options at www.healthcare.gov.

During the **COBRA** election period, your health coverage under the **Plan** will be discontinued until you notify the Fund, on a timely basis, that you elect **COBRA**. Upon such notice, the Fund will reinstate your coverage to the date it had been terminated. If claims are filed on your behalf prior to such notification, they will be denied. However, you can refile them as soon as you have elected your **COBRA** coverage and made payment of the applicable payment on a timely basis.

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NOTICE OF UNAVAILABILITY OF COVERAGE

When you, your **Spouse**, or your covered **Dependent Child(ren)** have provided notice to the Fund Office of a divorce, a change in coverage under the **Plan** from family to single, a **Dependent Child** ceasing to be eligible for coverage under the **Plan**, **Medicare** entitlement and voluntary termination of active coverage, a second qualifying event, or a Social Security disability determination, but you, your **Spouse** and/or your **Dependent Child(ren)** are not entitled to **COBRA** (or an extension of **COBRA** coverage), the Fund Office will send you a written notice stating the reason(s) why **COBRA** Coverage is not available. This notice will be provided within 14 days from the day the Fund Office receives Notice of the Qualifying Event.

THE COBRA CONTINUATION COVERAGE THAT WILL BE PROVIDED

If you choose **COBRA** Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the **Plan** to end, but you must pay for it. See the section entitled “Paying for **COBRA** Coverage,” below, for information about how much **COBRA** will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the **Plan** to similarly situated active **Employees** and their families, that same change will be made to your **COBRA** Continuation Coverage.

PAYING FOR COBRA COVERAGE

Individuals who continue full coverage under **COBRA** pay 102% of the **Plan’s** cost, except in cases of extended **COBRA** coverage due to Social Security disability. See the section entitled “**COBRA** Coverage in Cases of Social Security Disability” for details. **COBRA** payments are due on a monthly basis.

The Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to **COBRA** coverage, and of any monthly **COBRA** premium amount changes. The cost of **COBRA** Continuation Coverage may be subject to future increases during the period it remains in effect.

Your first payment is due no later than 45 days after the date you elect **COBRA** coverage. If this payment is not made when due, **COBRA** Continuation Coverage will not take effect and cannot then be purchased. After that, payments are due on the first day of each month. There will then be a grace period of 30 days to pay these monthly payments. **If payment of the amount due is not made by the end of this grace period, your COBRA Coverage will be terminated.**

SUMMARY PLAN DESCRIPTION

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ACQUIRING A NEW DEPENDENT(S) WHILE COVERED BY COBRA

If you, your **Spouse**, or your **Dependent Child(ren)** elects **COBRA** and acquires a new dependent through marriage, birth, adoption or placement for adoption while enrolled in **COBRA** Continuation Coverage, that person may add the dependent to **COBRA** Coverage for the balance of the **COBRA** Coverage period. For example, if you have five months of **COBRA** left and you get married, you can Enroll your new Spouse for five months of **COBRA** Coverage.

To **Enroll** your new dependent in **COBRA** Coverage, you must notify the Fund Office within 31 days after acquiring the new dependent. There may be a change in your **COBRA** premium amount in order to cover the new dependent.

If **COBRA** Coverage ceases for you, your Spouse or your Dependent Child(ren) before the end of the maximum 18, 29, or 36-month **COBRA** Coverage period, **COBRA** coverage also will end for the newly added dependent. However, **COBRA** Coverage can continue for your newly added newborn child, adopted child or child placed with you for adoption until the end of the maximum **COBRA** Coverage period if the required premiums are paid on time. Check with the Fund for more details on how long **COBRA** Coverage can last.

LOSS OF OTHER GROUP HEALTH PLAN COVERAGE OR OTHER HEALTH INSURANCE COVERAGE

If, while you are enrolled in **COBRA** Continuation Coverage, your **Spouse** or **Dependent Child(ren)** loses coverage under another group health plan, you may Enroll the **Spouse** or **Dependent Child(ren)** for coverage for the balance of the period of **COBRA** Continuation Coverage.

You must Enroll the dependent within 31 days after the termination of the other coverage. Adding a **Spouse** or **Dependent Child** may cause an increase in the amount you must pay for **COBRA** Continuation Coverage.

MULTIPLE QUALIFYING EVENTS WHILE COVERED BY COBRA

If, during an 18-month period of **COBRA** Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in weeks, you die, divorce, change coverage under the **Plan** from family to single, become enrolled in **Medicare** benefits (Part A, Part B, or both), or if a covered child ceases to be a **Dependent Child** under the **Plan**, the maximum **COBRA** Continuation period for the affected **Spouse and/or Dependent Child** is extended to up to 36 months from the date of loss of coverage due to the occurrence of your termination of employment or reduction of weeks.

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For example, assume you lose your job (the first **COBRA**-Qualifying Event), and you Enroll yourself and your **Spouse and Dependent Child(ren)** for **COBRA** coverage. Three months after your **COBRA** coverage begins, you divorce and your former **Spouse** is no longer eligible for **Plan** coverage. Your former Spouse can continue **COBRA** coverage for 33 months, for a total of 36 months of **COBRA** coverage.

This extended period of **COBRA** Continuation Coverage is not available to anyone who became your **Spouse** after your loss of coverage due to the termination of employment or reduction of weeks. However, this extended period of **COBRA** Continuation Coverage is available to any child(ren) born to, adopted by, or placed for adoption with you (the active member) during the 18-month period of **COBRA** Continuation Coverage.

In no case are you entitled to **COBRA** Continuation Coverage for more than a total of 18 months if your employment is terminated or if you have a reduction in weeks (unless you are entitled to an additional **COBRA** Continuation Coverage period on account of Social Security disability).

As a result, if you experience a reduction of weeks and then have a termination of employment, the termination of employment is not treated as a second qualifying event and **COBRA** may not be extended beyond 18 months from the date of loss of coverage due to the occurrence of the initial Qualifying Event.

TERMINATION OF EMPLOYMENT/REDUCTION OF WEEKS FOLLOWING MEDICARE ENROLLMENT

If you become enrolled in **Medicare** benefits (Part A, Part B, or both) and you later have a termination of employment or reduction of weeks, then you, your **Spouse** and/or your **Dependent Child(ren)** would be entitled to **COBRA** Continuation Coverage for a period of 18 months from the date of your loss of coverage due to your termination of employment or reduction of weeks or 36 months from the date you become enrolled in **Medicare** (Part A, Part B, or both), whichever is longer.

FMLA AND COBRA

Taking a leave under the Family and Medical Leave Act (**FMLA**) is not a **COBRA** Qualifying Event. A Qualifying Event can occur after the **FMLA** period expires, if the person does not return to work and thus loses coverage under the group health plan. Then the **COBRA** period is measured from the date of the Qualifying Event – in most cases, the last day of the **FMLA** leave. Note that

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if the **Employee** notifies the **Employer** that they are not returning to employment prior to the expiration of the maximum **FMLA** 12-week period, a loss of coverage could occur earlier.

LEAVE OF ABSENCE (LOA) ACT COBRA

If an **Employee** is offered alternative health care coverage on LOA and this alternate coverage is not identical in cost (increase in premium), or benefits to the coverage in effect on the day before the LOA, then such alternate coverage does not meet the **COBRA** requirement, and is considered to be a loss in coverage requiring **COBRA** to be offered. If a Qualified Beneficiary rejects the **COBRA** coverage, the alternative plan is considered to be a different group health plan and, as such, after expiration of the LOA, no **COBRA** offering is required under this **Plan**.

WHEN COBRA COVERAGE WILL END PRIOR TO THE APPLICABLE 18, 29 OR 36 MONTHS

Once **COBRA** coverage has been elected, it will end prior to the applicable 18, 29 or 36 months on the occurrence of any of the following events:

- The first day of the time period for which you don't pay the **COBRA** premiums within the required time period.
- The date on which the **Plan** is terminated.
- The date, after the date of the **COBRA** election, on which you or your **Spouse** or **Dependent Child(ren)** first become covered by another group health plan.
- The date, after the date of the **COBRA** election, on which you or your **Spouse** or **Dependent Child(ren)** first become enrolled in **Medicare** benefits (Part A, Part B, or both), usually age 65.
- If you and/or your family members have the 11-month extension for Social Security disability and the person is deemed no longer disabled by SSA.

NOTICE OF EARLY TERMINATION OF COBRA

If **COBRA** Continuation Coverage is terminated before the end of the maximum coverage period, the Fund Office will send you a written notice as soon as practicable following the determination that Continuation Coverage will terminate. The notice will set out why **COBRA** Continuation Coverage will be terminated early, the date of termination, and your rights, if any to alternative individual or group coverage.

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WHEN COBRA COVERAGE ENDS

Your **COBRA** Coverage ends on the earliest of the date that:

- Any of the above-listed events occurs.
- The **COBRA** period (18, 29, or 36 months) applicable to you and/or your dependents ends.

Full details of **COBRA** Continuation Coverage will be furnished to you, your **Spouse**, or your **Dependent Child(ren)** when the Fund Office receives notice that a Qualifying Event has occurred. It is important to contact the Fund Office as soon as possible after one of these events occurs.

NON-COBRA CONTINUATION

The dependents of an **Employee** who changes coverage under the **Plan** from Family to Single coverage shall be eligible to continue coverage for 36 months by paying the applicable **COBRA** rates, pursuant to the rules of **COBRA**.

NEW YORK CONTINUATION RIGHTS OF HEALTH INSURANCE FOR UNMARRIED YOUNG ADULTS THROUGH AGE 29 FOR AETNA BENEFITS

Eligibility

Young adult means: a child of the **Participant** who (a) is age 29 or younger; (b) is not married; (c) is not covered, or eligible for coverage, under his or her employer-sponsored group health benefits plan; (d) lives, works or resides in New York State, or in the network area of Aetna's plan; and (e) is not covered under **Medicare**.

To be eligible for coverage, the young adult need not live with you, or be financially dependent on you for support and maintenance, or be enrolled in an educational institution, or be covered as your **Dependent Child** under the **Plan**.

Coverage

This applies to: (1) a young adult who has ceased to be eligible for health insurance coverage under the **Plan** as a result of his or her attainment of an age limit; or (2) a young adult who is eligible for dependent coverage, but not covered, under the **Plan**. Such person will have the option to obtain or continue Aetna health insurance coverage from the **Plan**. Either the young adult or the **Participant** may make the election to continue coverage in writing and pay

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the first premium within 60 days of the young adult's date of eligibility, and on a monthly basis thereafter. "Health insurance" means hospital, surgical or medical coverage under the **Plan**.

The continued health insurance coverage shall be identical to the group coverage provided from Aetna to the **Participants** under the **Plan**, and is subject to the same terms and conditions that apply to other **Participants**. Such extension only covers insured benefits provided through Aetna.

Conditions for Continuation

The parent of the young adult must continue to be covered by the **Plan** in order to be eligible for this continual coverage.

The eligible young adult, or the **Participant**, must request this continuation option in writing as follows:

- Within 60 days after the young adult's loss of coverage under the Plan on account of attainment of a limiting age

You or your adult child may elect this continuation option within 60 days of the date on which the adult child would otherwise lose eligibility for coverage under the **Plan** on account of his or her attainment of the limiting age for **Dependent Child(ren)**. If the option is elected within the 60 days, coverage will be retroactive to the date as of which coverage ended.

- Within 60 days after becoming eligible for this option due to a change in the young adult's personal circumstances

You or your adult child may elect this continuation option within 60 days of the date on which the adult child becomes eligible for continuation due to a change in his or her personal circumstances (such as a change of residence to New York State, or becoming divorced).

- During the **Plan's** Annual 30-day Open Enrollment Period

You or your adult child may elect this continuation option during the **Plan's** annual 30-day open Enrollment period.

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Termination of Coverage

Coverage continuation shall terminate upon the first to occur of:

- The date the adult child ceases to be eligible for coverage continuation;
- The date on which your coverage ends;
- The end of the period for which the required premium has been paid, if premium payment is not made within the grace period; or
- The date as of which the group policy terminates.

For additional information regarding your rights under New York State Continuation Coverage and also to convert to an individual policy see the Aetna Appendix to this **SPD**.

ENTITLEMENT TO CONVERT TO AN INDIVIDUAL HEALTH PLAN AFTER COBRA ENDS

At the end of the 18-month or 36-month period of **COBRA** Continuation Coverage, you will be allowed to Enroll in an individual conversion health plan as provided by the **Plan**, if that right is offered by the **Plan** at the time your **COBRA** Continuation Coverage period runs out. However, no conversion rights are available for the dental or vision coverage. You will be advised if conversion rights are available when your **COBRA** Continuation Coverage ends.

See the Aetna Appendix to this **SPD** for information on conversion from a group to an individual plan.

SPECIAL COBRA SUBSIDY FOR ENTERTAINMENT INDUSTRY EMPLOYEES WHO ARE RESIDENTS OF NEW YORK STATE

Effective January 1, 2005, you may be eligible to receive 50% of your **COBRA** premiums for up to 12 months from the New York State Insurance Department.

Eligibility

In order to qualify for this **COBRA** premium subsidy, you must meet the following requirements:

- You must be currently receiving **COBRA** Continuation Coverage from this Fund;
- You must have held a position in the entertainment industry before the **COBRA** Qualifying Event;

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- You must be a New York State resident; and,
- Your current household monthly income must fall within the limits established for the program by the New York State Insurance Department.

Applying For Benefits

If you are currently receiving **COBRA** Continuation Coverage, are a New York State resident in the entertainment industry, and believe you may be eligible for this **COBRA** premium subsidy, you should request and complete the application as soon as possible. To request an application, contact the Fund Office.

All completed applications should be mailed to the New York State Insurance Department at:

NYS Continuation Assistance Program
New York State Insurance Department
P.O. Box 7184
Albany, NY 12224-0184

Once the Fund Office is notified by the New York State Insurance Department that your application has been approved, you will only need to pay 50% of the **COBRA** premium. The New York State Insurance Department will pay the other 50% directly to the Fund. The Fund Office will tell you when you need to only pay 50% of the **COBRA** premium.

Please remember that until your application is approved by the New York State Insurance Department and you are notified by the Fund Office that your application has been approved, you must continue to pay 100% of your **COBRA** premium on time in order to maintain your eligibility in the Fund.

If you would like to find out more about this program or have any questions regarding this benefit, you can call the Consumer Services Bureau of the New York State Insurance Department at (800) 342-3736 or the Actors Fund at (212) 221-7301, ext. 166.

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CLAIM REVIEW AND APPEALS PROCEDURES

The procedures for filing claims for benefits under this **Plan** and for appealing adverse benefit determinations in connection with those claims are described in detail in the Aetna Appendix at the back of this **SPD**. Aetna maintains procedures for filing claims (including precertification and preauthorization procedures) and appeals (both internal and external) as well as timeframes for which decisions must be rendered for the insured hospital, medical, prescription drug, dental, and vision benefits. The terms, conditions, limits, and exclusions shown in the Aetna Appendix to this **SPD** shall govern. In addition, a claim regarding rescission of coverage will be treated as a post-service claim and the individual will be notified of the decision and allowed to file an appeal under the procedures described in the Aetna Appendix.

Please note that an eligibility inquiry determined by the Fund that does not request **Plan** benefits is not subject to the procedures described in the Aetna Appendix. A specific request for eligibility relating to a particular person or period (an “Eligibility Claim”) shall be subject to the procedures discussed below.

ELIGIBILITY CLAIM PROCEDURES

You may submit an Eligibility Claim under the **Plan** directly to the Fund Office. You do not have to fill out any claim forms to make an Eligibility Claim. However, you must provide the Fund Office with a written description of the circumstances surrounding your Eligibility Claim so that your Eligibility Claim can be adjudicated properly.

The Fund Office will make a decision on your Eligibility Claim and notify you or your beneficiary within 90 days. If the Fund Office determines that special circumstances require an extension of time for processing the claim, the Fund Office will notify you in writing prior to the termination of the initial 90 day period. Such notice will include an explanation of the special circumstances requiring an extension of time, and the date by which the **Plan** expects to render its decision. The extension period shall not exceed 90 days from the end of the initial 90 day period. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. Until you supply this additional information, the normal period for making a decision on the Eligibility Claim will be suspended.

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You will be provided with written notice if your Eligibility Claim is denied (whether denied in whole or in part). This notice will include:

- information sufficient to identify the Eligibility Claim involved
- the specific reason(s) for the determination
- a description of the **Plan's** standard, if any, that was used in denying the Eligibility Claim
- reference(s) to the specific **Plan** provision(s) on which the determination is based
- a description of any additional material or information necessary to perfect the Eligibility 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 Eligibility Claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

REQUEST FOR REVIEW OF DENIED ELIGIBILITY CLAIM

If your Eligibility Claim is denied in whole or in part, you may ask for a review, that is, an "appeal." Appeals of Eligibility Claims are made to the Fund Office for review by the **Board of Trustees** of the Fund.

Please make appeals of Eligibility Claims directly to the Fund Office. Your request for review must be made in writing within 180 days after you receive notice of denial.

REVIEW PROCESS

The review process works as follows:

- You have the right to review, free of charge, documents relevant to your Eligibility Claim. A document, record or other information is relevant if it was relied upon by the Fund Office in making its decision; if it was submitted, considered or generated in connection with your claim (regardless of whether it was relied upon in making the benefit determination); if it demonstrates compliance with the Fund Office's administrative processes for ensuring consistent decision making; or if

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it constitutes a statement of **Plan** policy regarding the denial.

- Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund Office on your claim, without regard to whether their advice was relied upon in deciding your Eligibility Claim.
- Your Eligibility Claim will be reviewed by the **Board of Trustees**, which is not subordinate to (and shall not afford any deference to) the person who originally made the 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.
- You will also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your Eligibility Claim. In addition, before an Eligibility Claim on review is denied based on a new or additional rationale, you will receive a statement of the rationale, free of charge.

TIMING OF NOTICE OF DECISION ON APPEAL

Eligibility Claims appeals are directed to the **Board of Trustees** of the Fund, which will decide such appeals. Ordinarily, decisions on appeals of Eligibility 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 Eligibility 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.

NOTICE OF DECISION ON REVIEW

The decision on any review of your Eligibility Claim will be given to you in writing. The notice of a denial of an Eligibility Claim on review will include:

- information sufficient to identify the Eligibility Claim involved
- the specific reason(s) for the determination
- a description of the **Plan's** standard, if any, that was used in denying the Eligibility Claim
- reference(s) to the specific **Plan** provision(s) on which the

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determination is based

- a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your Eligibility 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
- the statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

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.

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review without thereafter receiving a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under Section 502(a) **ERISA** without exhausting these appeal procedures if the **Plan** has failed to follow them. No lawsuit may be started more than three years after the end of the year in which the Fund rendered its final decision on eligibility.

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OTHER INFORMATION

BASIC PLAN INFORMATION

Name of the Plan:

AGMA Health Fund

Plan Identification Number:

13-2643045

Plan Number:

501

Type of Plan:

Welfare Plan

Plan Year:

September 1 – August 31

Plan Administrator:

Board of Trustees

The business address and telephone number of the Board of Trustees is:

Board of Trustees of the AGMA Health Fund

AGMA Health Fund

1430 Broadway – Suite 1203

New York, NY 10018

(212) 765-3664

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under this **Plan**, service of process may be made to the **Board of Trustees** or to any individual **Trustee**.

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

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FINANCIAL INFORMATION

Benefits are provided from the Fund's assets, which are accumulated under the provisions of the **Collective Bargaining Agreements**, the **Participation Agreements**, and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered **Employees** and **Eligible Dependents** and defraying reasonable administrative expenses.

All **Contributions** to the Funds are made by **Employers** in accordance with their **Collective Bargaining** and **Participation Agreements** with the AGMA Health Fund.

This **Plan** is maintained under **Collective Bargaining Agreements** and **Participation Agreements** between the Contributing Employers and the AGMA Health Fund. A copy of any such agreement may be obtained on written request to the Plan Administrator and is available for examination.

The Fund Office will provide you, on written request, with a complete list of the **Employer** and **Employee** Organizations sponsoring the **Plan** or information as to whether a particular Employer is contributing to this **Plan** on behalf of covered **Employees** working under a **Collective Bargaining Agreement**.

PLAN BENEFITS

The Fund provides hospital, medical and prescription drug benefits through an insured contract with Aetna Life Insurance Company (referred to as "Aetna" in this document). Aetna is an independent insurance company that administers the fully insured hospital and medical benefits and provides payment of claims associated with these benefits.

As a courtesy, the Fund allows you to purchase self-pay dental and vision coverage. The dental and vision benefits are insured and administered by Aetna.

INSURANCE CONTRACT GOVERNS

The hospital, medical, prescription drug, dental, and vision benefits are subject to the complete terms, conditions, limitations, and exclusions of the contract(s) issued by Aetna. If a difference exists between the information in this booklet and the actual contracts, the contracts govern. Please consult the group contract for additional information.

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AGMA HEALTH FUND

AMENDMENTS

This **Plan** may be amended by the Trustees at any time in accordance with the Agreement and Declaration of Trust.

In order that the **Trustees** may carry out their obligations to maintain a sound economic program dedicated to providing the maximum benefits for members as a whole, the Trustees expressly reserve the right in their sole discretion:

- (a) To terminate or to amend either the amount or conditions with respect to any benefits, even though such termination or amendment affects claims that have already accrued.
- (b) To alter or postpone the method of payment of benefits.
- (c) To amend any other provisions of this **Plan**.
- (d) To interpret the provisions of this **Plan**.

DISCRETIONARY AUTHORITY OF THE PLAN FIDUCIARIES

In carrying out their respective responsibilities under the **Plan**, the **Trustees**, and other **Plan** fiduciaries and individuals to whom responsibility for the administration of the **Plan** has been delegated, have discretionary authority to interpret the terms of the **Plan**, to determine eligibility and entitlement to **Plan** benefits in accordance with the terms of the **Plan**, and to decide any fact related to eligibility for and entitlement to **Plan** benefits. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

PLAN TERMINATION

The Fund intends to maintain the **Plan** indefinitely. However, if the obligation of all **Contributing Employers** to contribute to the Fund ceases, the Fund would have to terminate. In addition, the **Trustees** have the power to terminate the Fund for other reasons.

If termination were ever necessary, in accordance with the Agreement and Declaration of Trust, the **Trustees** would use Fund assets:

- To pay necessary expenses;
- To pay such benefits as the **Trustees** determine should be paid and for such other purposes that the **Trustees** decide would best carry out the purposes of the Fund.

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After all assets have been disbursed, the Health Fund would terminate.

NO LIABILITY FOR THE PRACTICE OF MEDICINE OR DENTISTRY

The **Plan**, the **Trustees**, or any of their designees are not engaged in the practice of medicine or dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the **Plan**, the **Trustees**, nor any of their designees will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

PRIVACY, CONFIDENTIALITY, RELEASE OF RECORDS OR INFORMATION

Any information collected by the **Plan** will be treated as confidential information, and will not be disclosed to anyone without your written consent, except as follows:

A federal law, the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) and privacy rules issued under that law, gives you certain rights with respect to your health information, and requires that the American Guild of Musical Artists (“AGMA”) Health Fund’s health plan (referred to below as the “**Plan**”) protect the privacy of your personal health information. A complete description of your rights under **HIPAA** will be found in the **Plan’s** Notice of Privacy Practices, which will be available to anyone upon request from the Office of the AGMA Health Fund (referred to below as the “Fund”). The statement that follows is not intended and cannot be considered to be the **Plan’s** Notice of Privacy Practices.

Since the **Plan** is required to keep your health information confidential, before the **Plan** can disclose any of your health information to the **Board of Trustees**, which acts as the sponsor of the **Plan**, the **Trustees** must also agree to keep your health information confidential. In addition, the **Trustees** must agree to handle your health information in a way that enables the **Plan** to follow the rules of **HIPAA**. The health information that the Board of Trustees receives about you from the **Plan** is referred to below as protected health information (“PHI”). In order to safeguard your PHI, the **Board of Trustees** has agreed to the following rules:

The **Board of Trustees** understands that the **Plan** will disclose PHI to the **Board of Trustees** only for the **Trustees’** use in **Plan** administration functions.

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Unless it has your written permission, the **Board of Trustees** will use or disclose that PHI only for **Plan** administration, as otherwise permitted by this **Summary Plan Description**, or as required by law.

The **Board of Trustees** will not disclose your PHI to any of its agents or subcontractors unless the agents and subcontractors agree to handle your PHI and keep it confidential to the same extent as is required of the **Board of Trustees** in this **Summary Plan Description**. Further, any agent to whom the **Plan** provides PHI must have agreed to implement reasonable and appropriate security measures to protect PHI.

The **Board of Trustees** will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the **Plan**.

The **Board of Trustees** will not use or disclose your PHI for any employment-related actions or decisions, or with respect to any other benefit or other employee benefit plan sponsored by the **Board of Trustees** without your specific written permission.

The **Board of Trustees** will report to the Plan's Privacy Officer if (i) the **Trustees** become aware of any use or disclosure of PHI that is inconsistent with the provisions set forth in this **Summary Plan Description**, or (ii) the **Trustees** become aware of any security incident.

The **Board of Trustees** will allow you, through the **Plan**, to inspect and photocopy your PHI to the extent, and in the manner, required by **HIPAA**.

The **Board of Trustees** will make available to the **Plan** your PHI for amendment and incorporation of any such amendments to the extent, and in the manner required by **HIPAA**.

The **Board of Trustees** will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of PHI received from the **Plan** in order to allow the Secretary to determine the **Plan's** compliance with **HIPAA**.

The **Board of Trustees** will keep a written record of certain types of disclosures it may make of PHI, so that it may make available to the **Plan** the information required for the **Plan** to provide an accounting of certain types of disclosures of PHI.

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The following categories of employees under the control of the **Board of Trustees** are the only employees who may obtain PHI in the course of performing the duties of their job with or on behalf of the **Board of Trustees**: the Executive Director, the Assistant to the Executive Director, and all other Fund claims staff routinely responsible for administration of **Plan** claims for the Fund.

Additionally, the individual **Trustees** may receive PHI from the **Plan** in the course of hearing appeals or handling other **Plan** administration functions. These employees and the individual **Trustees** will be permitted to have access to and use the PHI only to perform the **Plan** administration functions that the **Board of Trustees** provides for the **Plan**. Separation between the categories of employees listed above and other Fund employees will be supported by reasonable and appropriate security measures.

The employees listed above will be subject to disciplinary action and sanctions for any use or disclosure of PHI that violates the rule's set forth in this **Summary Plan Description**. If the **Board of Trustees** becomes aware of any such violations, the Board of Trustees will promptly report the violation to the **Plan's** Privacy Officer and will cooperate with the **Plan** to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the individual(s) whose privacy has been violated.

The **Board of Trustees** will return to the **Plan** or destroy all PHI received from the **Plan** when there is no longer a need for the information. If it is not feasible for the **Board of Trustees** to return or destroy the PHI, then the **Trustees** will limit their further use or disclosures of any such PHI that it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a **Participant** in the AGMA Health Fund, 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:

Receive Information About Your **Plan** and Benefits

- 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 copies of the latest annual report (Form

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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 **Plan Administrator's** office 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 Group Health **Plan** Coverage

- Continue health care coverage for yourself, your **Spouse or Dependent Child(ren)** if there is 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.

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 Health Fund benefits 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.

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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 that is denied or ignored, in whole or in part, you may file suit in federal court. In addition, if you disagree with the **Plan's** decision or lack thereof concerning the qualified status of a medical child support order (**QMCSO**), 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 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 Area 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.

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DEFINITIONS

Active Participant/Participant: The **Eligible Employee**, who meets this **Plan's** eligibility rules as described in the Eligibility section of this document and is enrolled for coverage under the **Plan**.

Calendar Year: The 12-month period beginning January 1 and ending December 31. The **Calendar Year** is not the same as the Plan Year. See also the definitions of **Plan Year** and **Contract Year**.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Collective Bargaining Agreement: The **Collective Bargaining Agreements** in force and in effect between AGMA and a **Contributing Employer**, together with any modifications or amendments thereto.

Contributions: The payments made by **Employers** to the AGMA Health Fund Plan A.

Contract Year: The 12 consecutive month period of the policy or administrative services contract under which **Plan** benefits are provided. The **Contract Year** is not the same as the **Plan Year**. See also the definitions of **Calendar Year** and **Plan Year**.

Covered Employment: Work as an **Employee** for a **Participating Employer** for which the **Participating Employer** is obligated to and does contribute to AGMA Health Fund Plan A on your behalf.

Dependent Child(ren): Your **Dependent Child(ren)** as defined in the Eligibility section of this document once you have enrolled your **Dependent Child(ren)** for coverage.

Domestic Partner: Your **Domestic Partner** as defined in the Eligibility section of this document once you have enrolled your **Domestic Partner** for coverage.

Eligible Dependents: Your legal **Spouse**, **Domestic Partner** and/or your **Dependent Child(ren)** as defined in the Eligibility section of this document once you have enrolled your **Spouse**, **Domestic Partner** and/or **Dependent Child(ren)** for coverage.

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Eligible Employee/Eligible Participant: An **Eligible Employee**, who meets this **Plan's** eligibility rules as described in the Eligibility section of this document.

Employee: An individual who is covered by a **Collective Bargaining Agreement** or **Participation Agreement** or other written agreement between **Employer(s)** and AGMA or AGMA Health Fund Plan A that requires his or her **Employer** to make **Contributions** to this Fund on his or her behalf. **Contributions** on an **Employee's** behalf are made in accordance with the applicable agreement.

Employer or Contributing Employer or Participating Employer: An **Employer** making **Contributions** to the Health Fund under a **Collective Bargaining Agreement** with AGMA or **Participation Agreement** or other written agreement between **Employer(s)** and AGMA or AGMA Health Fund Plan A that requires an **Employer** to make **Contributions** to this Fund.

Enroll, Enrollment: The process of completing and submitting a written Enrollment Form indicating that coverage under the **Plan** is requested by the **Employee**.

Employee Retirement Income Security Act of 1974 (ERISA): The **Employee Retirement Income Security Act of 1974**, as amended, commonly known as **ERISA**. See the section entitled "Your Rights under **ERISA**" in this booklet for more information.

Experimental or Investigational: Aetna maintains a detailed definition of **Experimental or Investigational** that is set forth in the Appendix of this document. See the Aetna Booklet-Certificate for their definitions.

FMLA: The Family and Medical Leave Act of 1993, as amended.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, as amended.

Medically Necessary: The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it **Medically Necessary** or make the expense a covered charge. Aetna maintains a detailed definition of Medical Necessity, Experimental and provider/physician that is set forth in the Appendix of this document. See the Aetna Booklet-Certificate for their definitions.

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Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

NMHPA: The Newborns' and Mothers' Health Protection Act of 1996, as amended. See the Aetna Appendix to this **SPD** for details regarding maternity benefits.

Participation Agreement: An agreement between the **Trustees** of this Fund and an **Employer** requiring **Contributions** to the AGMA Health Fund Plan A. **Plan:** The programs, benefits, and provisions described in this document and the applicable appendix.

Plan Administrator: The **Board of Trustees** of the American Guild of Musical Artists ("AGMA") Health Plan A is the legal entity which has the fiduciary responsibility for the overall administration of the **Plan** and which serves as the **Plan Administrator** pursuant to the **Employee Retirement Income Security Act of 1974 (ERISA)**.

Participant: The **Employee** or former **Employee**, who meets this **Plan's** eligibility rules as described in the Eligibility section of this document, and has **Enrolled** for coverage under the **Plan**. As used in this document, this term does not include the **Spouse** or **Dependent Child(ren)** of the **Participant**.

Plan Year: The twelve-month period from September 1 to August 31 designated to be the **Plan Year**. The **Contract Year** is not the same as the **Plan Year**. See also the definitions of **Calendar Year** and **Contract Year**.

Qualified Medical Child Support Order (QMCSO): A support order of a state or administrative agency that usually results from a divorce or legal separation, complies with requirements of federal law, requires an **Employee** to provide health care coverage for a **Dependent Child**. See the Eligibility section for additional information and the Fund Office's procedures.

Spouse: The **Employee's** lawful **Spouse** or former **Spouse** (if applicable) as determined by applicable state law.

Summary Plan Description (SPD): This document and the applicable appendix.

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Trustees/Board of Trustees: The terms “**Trustees**” and “**Board of Trustees**” are defined in the Agreement of Declaration of Trust for the AGMA Health Fund. The **Board of Trustees** is composed of the **Trustees** listed at the beginning of this **Summary Plan Description** and is charged with administering this **Plan**.

Union: The American Guild of Musical Artists (“AGMA” or the “**Union**”).

WHCRA: The Women’s Health and Cancer Rights Act of 1998, as amended. See the Aetna Appendix to this **SPD** for details about post-mastectomy breast reconstructive surgery benefits.

You, Your: When used in this document, these words refer to the **Eligible Employee** who is covered by the **Plan**. They do not refer to any dependent of the **Employee**.

There are other terms applicable to the **Plan** that are defined throughout this booklet and in the attached Aetna Booklet-Certificate.

AGMA HEALTH FUND PLAN A

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