Producers' Health Benefits Plan
Plan #501

Participant Handbook and Wraparound Summary Plan Description (SPD)

The information contained in this SPD is current as of January 1, 2019

LETTER FROM THE CHAIRPERSON

July 2019

Dear Plan Participants,

Welcome to the Producers' Health Benefits Plan. The Producers' Health Benefits Plan Trustees are pleased to provide you with the Summary Plan Description Booklet which explains your Plan benefits and guidelines.

This booklet has been updated with all Plan changes effective January 2019 and is available on the www.phbp.org website along with many important plan documents.

Please review this booklet carefully and if you should have any questions you may contact the Plan Office at 855-696-2909 ext. 8604 or via email staff@phbpbenefits.org.

Please remember to keep our Third Party Administrators, BeneSys, informed of any change in your contact information, so you will always receive important notices regarding your Plan Benefits. You may contact BeneSys at 855-696-2909 or via email at staff@phbpbenefits.org.

We are proud of the growth and success of the Producers' Health Benefits Plan and believe it will provide a significant measure of health care security to you and your families.

Thank you,

PRODUCERS' HEALTH BENEFITS PLAN

Sally Antonacchio, Chairperson

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INTRODUCTION

This Wraparound Summary Plan Description (SPD) is intended to provide you with an overview of the benefits (herein "component benefits") that are available under the Employee Welfare Plan offered by Producers' Health Benefits Plan (PHBP or the "Plan"). The Plan described in this document is effective January 1, 2019, and replaces all other plan documents, summary plan descriptions and applicable amendments to those documents previously provided to Plan participants.

- To determine if you are eligible for benefits under this Plan, refer to the Eligibility section in this document. Coverage for eligible dependents will be conditioned on you providing proof of dependent status satisfactory to the Plan and for Freelance Employees making the required monthly Dependent self-payments.
- This SPD is not a contract and does not guarantee any benefits. No individual will have accrued, vested or banked rights to benefits or eligibility under this Plan. Plan benefits are **not** vested and are **not** guaranteed.
- The Trustees reserve the right to terminate the plan and to change or discontinue (1) the types and amounts of benefits under the Plan and (2) the eligibility rules, even if extended eligibility has already been accumulated or banked (for example, as a Freelance Employee). Resolutions to amend the Plan are made by the Board of Trustees and become effective on the date as specified in the document or resolution amending the Plan.
- In carrying out their respective responsibilities under the Plan, the Board of Trustees, the Plan Administrator and other individuals with delegated responsibility for the administration of the Plan, will have discretionary authority to interpret the applicable facts and the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.
- The actual terms and conditions of the Plan's component benefits are contained in the various insurance policies, booklets, and plan documents etc. (herein "Benefit Documents") and are incorporated by reference. A listing of those documents is shown in the PLAN BENEFITS section.
- This SPD is also intended to provide you with certain information as required by the Employee Retirement Income Security Act of 1974 ("ERISA") as well as other important information. In the event of any conflict between the information contained in this SPD and any Benefit Document, the terms of the Benefit Document will control.

If you have any questions that are not answered by this Summary Plan Description, please contact:

Producers' Health Benefits Plan (PHBP)

ATTN: Sean Cooley, Executive Director c/o Raleigh Studios

650 N. Bronson Ave., B-138
Los Angeles, CA 90004
(323) 960-4781

IMPORTANT: The Employee Retirement Income Security Act (ERISA) is federal law. In general, it is not the intent of the SPD to provide benefit language or information that is mandated by any state insurance code. State-mandated benefits and information are as included in the Benefit Documents issued by the respective insurance carriers.

IMPORTANT PLAN INFORMATION

The following identifying information is disclosed to Plan participants to comply with the Employee Retirement Income Security Act (ERISA).

NAME OF PLAN	**Producers' Health Benefits Plan**
PLAN NUMBER	**501**
PLAN SPONSOR	**The Producers' Health Benefits Plan (PHBP) is administered by a joint Board of Trustees composed of Employer and Participant/Employee Trustees, whose names appear in this summary booklet. The office of the Board of Trustees may be contacted at:** **Board of Trustees** **Producers' Health Benefits Plan** 650 N. Bronson Ave., B-138, Los Angeles, CA 90004 (323) 960-4781
TYPE OF PLAN / TYPE OF BENEFITS	**This is a welfare plan providing the insured benefits reflected on the PLAN BENEFITS page(s) that follow.** The Plan is a group health plan which is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), providing medical, prescription drug, dental, vision, life and accidental death and dismemberment, and short and long-term disability benefits.
This SPD provides only a general description of Plan benefits. In each benefit section that follows, reference is made to one or more Benefit Documents. Additional benefit information is contained in those documents and is available to a Plan participant on request and without charge.	
TYPE OF ADMINISTRATION	(See the **PLAN BENEFITS** section for this information)
PLAN YEAR	**January 1st through December 31st**
PLAN SPONSOR TAX ID NUMBER	**31-6654730**
PLAN ADMINISTRATOR	**BeneSys Administrators** 1050 Lakes Drive, Suite 120 West Covina, CA 1790 (626) 646-1090
NAMED FIDUCIARY (see NOTE) Address	**Trustees of the Producers' Health Benefits Plan** 650 N Bronson Avenue, B-138 Los Angeles CA 90004
NOTE: For any Plan benefit that is fully insured (i.e., provided through a licensed insurance company), the insurance company is the Named Fiduciary for benefit determination purposes. See "Provider" in the following benefit sections for the identity of any such company.	
AGENT FOR SERVICE OF PROCESS	**BeneSys Administrators** 1050 Lakes Drive, Suite 120 West Covina, CA 91790 (626) 646-1090
Service of legal process may also be made on a Plan trustee or the Plan Administrator.	
ORIGINAL PLAN EFFECTIVE DATE	**January 1, 2004**

PARTICIPATING EMPLOYER(S)	Commercial Production and Post-Production Companies who are General Members and eligible Associate Members of the Association of Independent Commercial Producers', Inc. ("AICP"). A complete list of participating employers is available on the Plan Sponsor's website at www.phbp.org and from the Plan Sponsor, by written request.
Board of Trustees and Plan Professionals	The Trustees of the Plan as of January 1, 2019 are: Sally Antonacchio, The Artists Company (Board Chairperson) Mark Androw, Story Dave Bernstein, Participant/Employee Trustee Rich Carter, brother Andrew Colon, SMUGGLER Alanna Dillon, Alternate Participant/Employee Trustee Kerstin Emhoff, Prettybird Pictures, Inc. Robert Fernandez, Moxie Pictures Robert Fisher, Celsius Films Jason Groves, Participant/Employee Trustee Alana Mitnick, Participant/Employee Trustee Gary Rose, Go Film Daniel Rosenthal, RSA Films Carl Sturges, Michael Schrom & Company Norman Reiss, Participant/Employee Trustee Cathy Shannon, RadicalMedia, Inc. Executive Director Sean Cooley Senior Consultant Matt Miller, President and CEO, AICP Legal Counsel Kane Kessler, P.C. Consultants USI Insurance Services Auditor BDO Plan Administrator BeneSys Administrators

PLAN BENEFITS

The Plan's benefits are financed through group insurance contracts with the providers shown below. The insurer is responsible for investing the premiums and paying benefit claims. The insurer guarantees the payment of claims incurred before the group insurance contract terminates.

The Plan offers four insured medical benefit plans: Plan A (PHBP Classic Premier PPO Plan); Plan B (PHBP Classic Plus PPO); Plan C (PHBP California Classic HMO); and Plan D (PHBP High Deductible Health Plan/Health Savings Account (HSA)). The SPD will designate the rules for each Plan option; however, the benefits in each plan are set forth in the group insurance contracts and may change from year to year. For more information about the benefits in each plan option, please contact the Plan Administrator or see the Benefit Summaries at the Plan's website at www.phbp.org/documents.

Staff Employees may choose a plan from the available plan options and will pay the appropriate portion of contributions based on the plan chosen and the amount of contributions paid by their Employer. Freelance Employees may be eligible for coverage based on the plan for which they qualify, completion of appropriate election documents, and payment of appropriate fees and contributions.

The Plan's medical benefits provider is:

Anthem Blue Cross
21555 Oxnard St.,
Woodland Hills, CA 91367
800-759-3030

The Plan's dental benefits provider is:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 551,
Minneapolis, MN 55440-0551
(877) 567-1804

The Plan's vision benefits, Basic Life Insurance and Accidental Death and Dismemberment Insurance, and Short-term and Long-term Disability Insurance provider is:

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166

(855) 638-3931 (Vision)

(800) 638-6420 (Life)

(800) 638-2242 (Disability)

These are the plans offered depending on your eligibility:

- Classic Premier PPO Medical Plan
- Classic Plus PPO Medical Plan
- California Classic HMO Medical Plan
- High Deductible Health Plan/Health Savings Account (HSA)
- Dental Classic Complete Dental Plan
- Vision Insurance Plan
- Basic Life and Accidental Death and Dismemberment Insurance Plan
- Short Term Disability Insurance Plan
- Long Term Disability Insurance Plan

DEFINITIONS

AICP means the Association of Independent Commercial Producers, Inc.

California Resident means a Staff Employee or Freelance Employee determined to be a resident of California for purposes of income taxation by the state. Specific documentation to substantiate residency may be required by the Plan as part of the process to enroll in coverage or change benefit election(s).

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code means the Internal Revenue Code of 1986, as amended.

Coverage period is the 12-month period during which coverage is provided.

Day For purposes of calculating eligibility, a Day is defined as at least eight (8) hours worked in a continuous 24-hour period in a PHBP covered category throughout the day, except for meal breaks and rest periods. Work periods of less than eight (8) hours will not be credited in whole or part. Work periods in excess of eight (8) hours in a continuous 24-hour period will receive one Day of credited service for eligibility purposes.

Effective Date means, for this amendment and restatement, January 1, 2019.

Eligible Employee means an Employee who satisfies the eligibility provisions of this Plan.

Employee means a Freelance or Staff employee (as defined in ERISA) of a Participating Employer. The plan does not cover independent contractors.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

FMLA means the Family and Medical Leave Act of 1993.

Freelance Employee means an employee of a Contributing Employer, who is not working under a collective bargaining agreement, who works on a project-by-project basis, and holds one of these titles in commercial production:

- Producer or Line Producer
- Production Manager/Production Supervisor
- Production Coordinator/Assistant Production Supervisor
- Bidder
- Production Assistant, Compliance Assistant

Covered categories include the above categories in combination with “assistant,” and/or any modifier, prefix and/or suffix including but not limited to “Travel Coordinator” and “Talent Coordinator”, except “post” or other modifiers that indicate work done in a Post Production capacity. All modifiers to the forgoing categories only pertain to work performed in the “production department” as generally understood in the commercial production industry and excludes modified Job categories outside the production department. For example, “stunt coordinator” or “food producer” are not covered job categories.

Employees with any of these titles working for a Participating Employer must have contributions made on their behalf by Participating Employers so that employment credit can be earned.

GINA means the Genetic Information Nondiscrimination Act of 2008.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH means the Health Information Technology for Economic and Clinical Health Act.

Insurance Company means the Insurance Company selected by the Board of Trustees to provide insured coverage under the Plan.

MHPAEA means the Mental Health Parity and Addiction Equity Act.

Michelle's Law means the law that requires group health plans to allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence.

NMHPA means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

Open Enrollment*:* For eligible Freelance Employees, open enrollment is the 30 day period prior to the start of your next coverage period. For eligible Staff Employees, open enrollment is the period, as defined by the plan, prior to the effective date of the next 12 month coverage period (usually January first). For Eligible Freelance and Staff Employees, open enrollment is the period of time in which you may make changes to your benefits and /or beneficiaries as explained herein.

Participant means an Eligible Employee or the covered eligible Dependent of an Eligible Employee who has been determined by the PHBP to meet the Plan's eligibility criteria for the applicable coverage period.

Participating Employer or **Contributing Employer** means an employer as defined by ERISA that contributes to the Plan for its employees working in covered Freelance job categories on all commercial productions starting on the signature date of the Participation Agreement, and/or that contributes on behalf of Staff Employees.

Plan means this PHBP Health Insurance Plan.

Plan Administrator means BeneSys Administrators or such other Administrator as selected by the Board of Trustees to provide plan administration services.

Plan Sponsor means the Board of Trustees of the PHBP Health Insurance Plan on behalf of contributing employers.

PPACA or **ACA** means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA).

Qualification Period means the period, not to exceed 12 months, during which a Freelance Employee must meet the earnings threshold or days-worked threshold in order to become an eligible employee.

Staff Employee means a full-time (regularly scheduled to work at least 30-hours per week) regular, non-union employee of a Contributing Producer who is hired for an indefinite period, i.e., not on a freelance, project-by-project, or temporary basis. Staff Employees may include owners, senior management, production, administrative, and maintenance employees.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994.

WHCRA means the Women's Health and Cancer Rights Act of 1998.

GENERAL ELIGIBILITY

Please note: These eligibility rules are effective January 1, 2019 unless otherwise noted and are intended to comply with the Affordable Care Act.

Should you have any questions please contact the Plan Office at 323-960-4781or our Third Party Administrators, BeneSys Administrators at 855-696-2909.

GENERAL RULES, INCLUDING ELIGIBILITY INFORMATION FOR FAMILY MEMBERS AND SPECIAL ENROLLMENT RULES

ELIGIBLE FAMILY MEMBERS

Your Dependents are eligible for Plan coverage when you are eligible provided you properly enroll them and pay any applicable contributions. When you lose eligibility, your Dependents will also lose their coverage. Your Eligible Dependents include your Spouse or registered Domestic Partner, and your or your Spouse's or your Registered Domestic Partner's Children, defined as follows.

SPOUSE

1. A Spouse is the Eligible Employee/Participant's opposite sex or same-sex spouse who is legally married as recognized under the laws of any state or federal law. Spouse does not include any person who is in the armed forces.

2. As used in this Document, the term "state" includes possessions, territories, the District of Columbia and the Commonwealth of Puerto Rico.

DOMESTIC PARTNER

A Domestic Partner is the Employee/Participant's same-sex or opposite domestic partner, provided that the domestic partnership is registered with your state of residence, or if your state does not permit registration, with the California Secretary of State, regardless of their state of residence. All of the following requirements must be met:

1. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.

2. The two persons are not related by blood in a way that prevent them from being married to each other in California.

3. Both persons are at least 18 years of age, except as provided in Section 297.1 of the California Family Code.

4. Either of the following:
   a) Both persons are members of the same sex
   b) One of both of the persons meet the eligibility criteria under Title II of the Social Security act as defined in Section 402(a) of Title 42 of the United States Code for old-age insurance benefits of Title XVI of the Social Security Act defined in Section 1381 of Title 42 of the United States Code for aged individuals. Notwithstanding any other provision of this section, persons of opposite sex may not constitute a domestic partnership unless one or both of the persons are over 62 years of age.

5. Both persons are capable of consenting to the domestic partnership.

6. Both persons must be financially interdependent.

CHILD

Your Child is an Eligible Family Member under the plan until the end of the month in which they reach age 26. Your child is your Eligible Family Member, and therefore eligible for coverage, regardless of your child's marital status, financial dependency, or school enrollment. Child includes

1. Your natural child.

2. The child of your Spouse or Domestic Partner as long as they remain married to you or remain your Domestic Partner.

3. A legally adopted child and a child placed for adoption from the start of any waiting period prior to the finalization of the child's adoption. Placed for adoption means the assumption and retention by the participant 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.

4. An unmarried child under age 26 with respect to whom the employee/participant has legal guardianship under a court order (proof of guardianship and age is required).
5. Your child who is over age 26, totally disabled prior to reaching age 26, and primarily supported by you and incapable of self-sustaining employment because of mental or physical disability. Proof of the child's condition and dependence, including a certification by a physician, must be submitted to the Plan Administrator, BeneSys, no later than 31 days after the date the child reaches age 26. The Plan may, from time to time, require proof of the continuation of such condition and will require an annual verification from the child's physician. Coverage under this extension ends if the dependent child marries or becomes able to earn a living.
6. Children subject to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Order (NMSO). Participants may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Orders (QMCSO) from the Plan Administrator.

This Plan does not cover children or spouses of Dependent Children unless required to do so under applicable state law.

PROOF OF DEPENDENT STATUS

For your Eligible Dependents to be eligible for coverage under the Plan you must provide the Fund Office with proof of Dependent status. The Fund Office will accept a copy of the following documents as proof of Dependent status:

1. **Spouse/Marriage**: Copy of your certified marriage certificate and most recent tax return if the marriage certificate was issued more than 1 year prior. (you will also need to notify the Fund Office of other coverage for your Spouse or family, if applicable).

2. **DOMESTIC PARTNER:** Copy of your registered Declaration of Domestic Partnership and documents to support at least two of the following conditions as evidence of your financial interdependence:

    - Most recent Mortgage statement or Title showing joint ownership of a residence.

    - Most recent Car loan statement or Title showing join ownership of an automobile.

- Most recent statement of a joint credit account.
- A lease for a residence identifying both partners as tenants.
- A will and/or life insurance policies which designates the other as primary beneficiary.

3. **Child/Birth**: Copy of your child's certified birth certificate showing the parents' names and a copy of the child's social security card.

4. **Adoption or placement for adoption**: Copy of certified court order signed by a judge, copy of birth certificate and copy of social security card.

5. **Stepchild**: Copy of certified birth certificate (if adopted, see above) showing your spouse or Domestic Partner as the biological/adoptive parent of the child and a marriage certificate and tax return between you (the Participant) and the child's parent (if stepchild's parent is your Domestic Partner, see above "Domestic Partner" for proof requirements) and copy of the child's social security card.

6. **Child covered pursuant to a Qualified Medical Child Support Order (QMCSO)**: Valid QMCSO document signed by judge or National Medical Support Notice.

7. **Disabled Dependent Child**: Current written statement from the child's Physician indicating the child's diagnoses that are the basis for the Physician's assessment that the child is currently mentally or physically disabled (as that term disabled is defined in this document), that disability existed before the attainment of age 26, that the child is incapable of self-sustaining employment as a result of that disability; and proof the child is dependent chiefly on you and/or your Spouse 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 including proof that the child is claimed as a Dependent for federal income tax purposes.

Social Security Numbers of Dependents: To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must provide the Fund Office with a copy of the Social Security card or Social Security Number for each and every Eligible Dependent you wish to enroll in the Plan and information on whether you or any Dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

Notification of Change in Status: A Participant must reimburse the Plan for any benefits that were paid for a Dependent at a time when that Dependent did not satisfy the definition of a Dependent or was not otherwise eligible for benefits under this Plan. By electing coverage for your Dependents (either by affirmative election or through the default process), you are confirming that they meet the Plan's Dependent eligibility requirements and agree to notify the Plan Office within 30 days but not less than 60 days of an event that causes any of these Covered Dependents to no longer meet the definition of an Eligible Dependent. The Plan, in its sole discretion, maintains the right to audit any and all Dependent information on file, and may require that you promptly provide sufficient documentation verifying your Covered Dependents' continued eligibility at any time.

SPECIAL ENROLLMENT

If you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption after your Initial Eligibility, you may enroll your new Dependent(s). However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption and complete the proper enrollment paper work required by the Plan.

State Children's Health Insurance Program

You and your Dependents may also enroll in this Plan if you and/or your Dependent(s) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you and/or your Dependent(s) lose eligibility for that coverage or if you and/or your Dependent(s) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends or are determined to be eligible for such assistance. To request special enrollment or obtain more information, contact Fund Office.

Qualified Medical Child Support Order (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), including a National Medical Support Order (NMSO). These are support orders of a court or state administrative agency that usually results from a divorce or legal separation. For a copy of the PHBP's procedures concerning QMCSOs please contact the Plan Administrator.

ELIGIBILITY AND ENROLLMENT FOR FREELANCE EMPLOYEES

Freelance Employees (see Definitions) may earn medical coverage under one of three (3) benefit options, depending on which plan eligibility requirements they satisfy and whether they reside in or outside California. These medical plans are:

1. Plan A (PHBP Classic Premier PPO Plan);
2. Plan B (PHBP Classic Plus PPO Plan – non-California employees); and
3. Plan C (PHBP California Classic HMO – California only).

All Covered Freelance Employees will be enrolled in the plans noted below regardless of which medical plan you are enrolled in, and all coverages begin concurrently on the first day of the coverage period.

- Dental Classic Complete Dental Plan
- Vision Insurance Plan
- Basic Life and Accidental Death and Dismemberment Insurance Plan
- Short Term Disability Insurance Plan
- Long Term Disability Insurance Plan

Freelance Employees should always notify BeneSys of any changes to their contact information. The Plan routinely sends mailings and emails to Participants to notify them of plan updates and changes.

FREELANCE EMPLOYEES ELIGIBILITY

If you are a Freelance Employee, you become an Eligible Employee by meeting one of these requirements during a Qualification Period. Contributions for work performed during a Qualification Period must be received by the Fund before work requirements can be considered to be satisfied.

1. Earn a minimum of $35,000* during the Qualification Period in gross earnings from work in PHBP covered freelance categories, or

2. Work 100 Days or more in a Qualification Period.

Only covered work for a PHBP Participating Employer counts toward eligibility.

* Earnings figures are stated for convenient reference only and eligibility is based on at least $3,150 contributions timely received by the Plan derived from 9% of such earnings amount. The amount of contributions received by the Plan will vary depending on the individual rates charged by Freelance Employees as will the time frame over which contributions are generated.

INITIAL QUALIFICATION PERIOD FOR FREELANCE EMPLOYEES

When a contribution is first received on behalf of a Freelance Employee, the plan will examine contributions to determine whether you have met the eligibility requirements. If a Freelance Employee does not meet the eligibility requirements, the plan will continue to examine contributions made on your behalf on a monthly basis. During each monthly review, the plan will look back at the 12 consecutive preceding months to determine whether you have satisfied the work requirements. This period of review is called the “Initial Qualification Period.” The Initial Qualification Period will begin on the first of the month of your first day of employment in a covered job category at a Contributing Employer for which contributions were received. When the work requirement is met at any point during the 12 consecutive months reviewed, enrollment will be offered to the Freelance Employee. If no contributions are received for 12 consecutive months, the Initial Qualification Period is over and the Plan will stop examining for eligibility. If a contribution is received at a later date, a new Initial Qualification Period will begin.

OPT OUT OF COVERAGE FOR FREELANCE EMPLOYEES AND/OR DEPENDENTS

If you opt out of auto-enrollment (waive coverage) of yourself and/or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and/or your Dependents in this Plan if you and/or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards your Dependents' other coverage) and you are eligible to enroll at such later date. However, you must request enrollment for and enroll for benefits within 30 days after you and/or your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage). You must provide proof of termination of other coverage. Declining coverage does not affect the Qualification Period dates and the eligibility dates will continue uninterrupted during the period where coverage is declined.

Otherwise, if a Participant declines enrollment and wants to enroll at a later date, the Participant and his/her Dependents may do so during the next open enrollment period. Declining coverage does not affect the Qualification Period dates and the eligibility determination dates will continue uninterrupted during the period where coverage is declined.

FREELANCE EMPLOYEE COVERAGE START DATE

When a Freelance Employee meets a requirement for coverage during the Initial Qualification Period, the Freelance Employee's Plan coverage begins on the first day of the first month following a 60-day processing period that commences with the Qualifying Event. The Qualifying Event is either the 100th day worked or the 35,000th dollar earned in covered work for Contributing Employers and for which contributions were received.

Examples

Example One: Mary is hired as a Freelance Employee on March 15, 2019. Mary's IQP begins on March 1, 2019. Mary earns $35,000 during April 2019. Mary has met the work requirement. Mary's coverage will begin on the first of the month after a 60-day processing period after she has met the work requirement. Therefore, Mary's coverage will begin on July 1, 2019.

Example Two: Bill is hired as a Freelance Employee on February 14, 2019. Bill's IQP begins on February 1, 2019. If Bill has not met the work requirement during his first month, his contributions will be reviewed monthly, up to a maximum measurement period of 12 months, to determine whether he has satisfied the work requirements. If Bill meets the work requirements during the 12-month period, he will attain initial eligibility. The plan will examine whether Bill met the work requirement monthly but will test for a maximum period of 12 consecutive months.

The Plan provides for an auto-enrollment process for employee only coverage. You will be automatically enrolled on your coverage start date in employee only Medical, Dental, Vision, Basic Life, AD&D, Short Term Disability and Long Term Disability. You must pay the $300 annual registration/enrollment fee or your coverage will be terminated as described in the annual enrollment/registration fee section.

FREELANCE EMPLOYEE CONTINUING COVERAGE

The first of the month in which the Qualifying Event takes place will be the start of the Freelance Employees Qualification Period and the Qualification Period will continue for 12 consecutive months. Your coverage renews automatically and you remain an Eligible Employee if you satisfy one of the following requirements during your Qualification Period:

1. Meet one of the coverage requirements (working 100 days or more, or earning at least $35,000);

2. Have a total of at least 100 days of combined days worked during the Qualification Period and banked days (see “Banked Days” for details).

3. Have a total of at least 50 days of combined work days and banked days and pay a contribution for bridge coverage (see “Bridge Coverage for Freelance Employees” for details).

The Coverage Period will always be the 12 consecutive months during which coverage is provided, the start of which lags the Qualification Period by two months.

If you do not meet any of the above eligibility requirements during your Qualification Period, your Plan coverage ends on the last day of the month of your Coverage Period, i.e. at the end of the 12th month of coverage.

DETERMINATION OF MEDICAL PLAN

At the end of the Initial Qualification Period and each subsequent Qualification Period, the Plan will review the Freelance Employee’s reported income from work performed on covered jobs during the Initial or subsequent Qualification Period and calculate the Eligible Employee’s Income Tier (described below). The Income Tier will determine which medical plan will be offered for enrollment to the Eligible Employee for the subsequent Coverage Period. Contributions for work performed during a Qualification Period must be received by the Fund before work requirements can be considered to be satisfied.

1. Tier One: Freelance Employees who earn up to a maximum of $74,999 in gross earnings from work in PHBP covered freelance categories during a Qualification Period will be eligible for coverage under Plan C (California Classic HMO, California only) or Plan B (Classic Plus PPO, non-California) depending on their state of residence.

2. Tier Two: Freelance Employees who earn a minimum of $75,000 up to a maximum of $109,999 in gross earnings from work in PHBP covered freelance categories during a Qualification Period will be eligible for coverage under Plan C (California Classic HMO, California only) or Plan B (Classic Plus PPO, non-California) depending on their state of residence, BUT may choose to buy-up from Plan B or C to Plan A (Classic Premier PPO). In order to buy-up, these employees must self-pay the difference between the plan costs at rates established by the PHBP.

3. Tier Three: Freelance Employees who earn a minimum of $110,000 in gross earnings from work in PHBP covered freelance categories during a Qualification Period will be eligible for coverage under Plan A (Classic Premier PPO). If a Freelance Employee who is eligible for Plan A chooses Plan B or C instead, the PHBP will waive the $300 annual enrollment fee.

Any Tier Three eligible participant who elects Tier One coverage, will have the annual enrollment fee waived.

All Eligible Freelance Employees will be enrolled in Dental, Vision, Basic Life, AD&D, Short Term Disability and Long Term Disability on the effective date of medical coverage.

If you are an Eligible Freelance Employee who opts out of individual coverage and elects to be covered as the dependent of your PHBP covered Spouse or Registered Domestic Partner for medical, prescription drug, dental and vision coverage, then as long as you remain an eligible Freelance Employee you will be covered for Basic Life, AD&D and Disability.

ANNUAL ENROLLMENT/REGISTRATION FEE

Freelance Employees must pay an annual registration/enrollment fee of $300 each year payable in advance of enrollment or annual re-enrollment. An invoice will be sent 30 days prior to the beginning of a new Coverage Period for Freelance Employees who are currently enrolled. For new Participants, an invoice will be sent with the eligibility letter 30 days prior to the effective date of coverage. For all Participants, payment is due by the effective date of coverage. If payment is not received by the Plan within 60 days of the effective date of coverage, your coverage is subject to cancellation retroactive to the effective date of coverage and you will be billed for reimbursement of premiums paid on your behalf and you will be responsible for any and all medical, dental, vision or other claims made for benefits.

DEPENDENT ENROLLMENT COSTS – FREELANCE EMPLOYEES

Covered Freelance Employees may add their Dependents at a cost of $250 per month for the first Dependent and $100 per month for each additional Dependent. Dependents may be added when the Freelance Employee enrolls in the PHBP. Dependents may also be added to the Freelance Employee's coverage the month prior to the annual renewal date, with coverage effective the first of the month of the Freelance Employee's first month of renewal.

NEW DISABILITY CREDIT POLICY FOR FREELANCE EMPLOYEES FOR ELIGIBILITY ON OR AFTER JANUARY 1, 2019

At the conclusion of each Qualification Period, the Plan will verify if a participant received any short-term disability benefits from Met Life, the Plan's disability insurance carrier.

- If claims were paid, the Plan will presume weekly income would have been earned for all weeks in which a disability benefit was paid during the 12-month Qualification Period and will include the total when determining *the Income Tier* for the next eligibility period. Note, there is no presumed salary when considering eligibility – this is for Income Tier calculations *only.*
- The Plan will use the same calculation as MetLife, which takes the three highest months of income of the last twelve months to determine the participant's average weekly income. Note the Plan will credit the entire average weekly income and is not subject to the same reductions or ceilings as the disability benefit.
- This presumed income will be used for Tier calculation only and will not be used for determining eligibility.

BANKED DAYS

When you work more than 100 work Days in any Qualification Period, you may bank the excess days and use them to qualify for coverage in the next immediately succeeding Qualification Period. Any banked days from your immediately preceding Qualification Period will be added to your current day count. If the sum of your current work Days and your banked Days is 100 Days worked or more, you will qualify for coverage as an Eligible Employee.

Any accumulated bank days you earn for a future Qualification Period are not a vested benefit or entitlement. Accumulated bank days may be reduced or eliminated and are subject to the availability of funds and to other factors, as the Trustees determine in their sole judgement.

COVERAGE FOR FREELANCE EMPLOYEES

Freelance Employees may "bridge" the gap between actual days worked and the 100 days of work needed to requalify under certain circumstances. When a Freelance Employee has at least 50, but less than 100 work Days (including banked Days) in a Qualification Period, he/she may contribute to the cost of the Plan and remain an Eligible Employee with bridge coverage.

The cost of your coverage is based on a dollar amount per day times the number of days short of the needed 100 work Days and the number of banked Days there are in the Qualification Period. The amount charged per day is determined by the Trustees. The Freelance Employee will pay the full cost of coverage of all family members covered during bridge coverage. Bridge coverage continues for up to one year or until a Qualifying Event occurs, but only if you continue to make your required contributions.

If you are continuing coverage with Bridge Coverage, only Plan B (Classic Plus PPO, non-California) or Plan C (California Classic HMO, California-only) will be available. However, if an employee requalifies for coverage during a subsequent Qualification Period, the medical plan available to them will be based on their income Tier at the time of the requalifying event.

> Example: Helen has 122 work Days in her Qualification Period ending December 31, 2018. She uses 100 of those days to qualify for coverage that begins on March 1, 2019, and she banks the remaining 22 days. In Helen's second Qualification Period (January 1, 2019, through December 31, 2019), Helen works 42 days. Adding the 22 banked days from her prior Qualification Period, Helen has 64 days toward her qualification to continue coverage for another year. Helen chooses bridge coverage and contributes to the Plan to make up for the 36 work days she is short of her qualification. This allows Helen to have up to 12 months of bridge coverage, starting March 1, 2020. Bridge coverage is only available in Plan B or Plan C.

MOVING FROM STAFF EMPLOYEE TO FREELANCE EMPLOYMENT

Staff Employees may earn credited Days toward coverage as a Freelance Employee under certain conditions.

A Staff Employee who was covered by PHBP Staff coverage on the date staff employment ends with a participating PHBP employer is considered an Eligible Staff Participant." An Eligible Staff Participant will be credited with two (2) work Days for each completed month worked as a Staff Employee (but not earlier than March 1, 2013).The maximum credit is 36 days (based on 18 months) for all time employed in a staff position and such credited Days may be used toward Freelance Eligibility qualification.

Upon the first receipt of contributions for Covered Freelance work after the termination of Staff employment, a Qualification Period will commence and the plan will look back at the 9 consecutive preceding months to determine whether a Qualifying Event occurred and will count the credited Days in that calculation. If no qualifying event has occurred, each subsequent month the Plan will continue to look back 12 consecutive months.

Credited days may only be used post-termination from Staff Employment and may only be applied toward eligibility qualification during the nine (9) months immediately following termination of staff employment, after which all remaining, unused credited Days shall lapse. Credited Days may not be used for any other purpose but may be used in conjunction with any remaining qualifying days earned as a Freelance Employee (under other rules of the Plan) before taking the staff position, provided that at no time is the Qualification Period in which eligibility is attained using credited days for staff employment longer than 12 consecutive months. Such use shall not extend the period during which earned freelance eligibility or credited days under this rule must be used.

Credited Days may not be applied to reduce COBRA premiums. The individual would be eligible to elect COBRA as a qualified beneficiary based on termination, but the decision to elect and rely on COBRA or to attempt to reach freelance eligibility is strictly the individual's decision.

> Example: Melissa was first employed by a PHBP Freelance Contributing Employer in a staff position on January 5, 2018 and became covered by PHBP staff coverage on March 1, 2018. . Melissa remained in PHBP staff coverage until she was terminated on October 15, 2018.
>
> Based on two days per completed months (7 months from March through September) of both staff employment and staff coverage, Melissa would have 14 credited Days for use toward the 100 days per Qualification Period freelance eligibility requirement. The credited Days may be used toward freelance eligibility for the nine months immediately following termination.

Melissa must perform covered Freelance work with a PHBP Contributing Employer in order to use these credited Days. If Melissa never goes into PHBP covered Freelance work, the credited Days may not be used for any other purpose and would lapse as indicated.

TERMINATION FOR FRAUD OR MISREPRESENTATION

The Trustees and Plan Administrator will establish rules for reporting eligibility, including rules for submission of timecards or other verification of hours worked. Submission of false timecards or other verification of hours worked constitutes fraud. Coverage for you and/or your dependents may be terminated retroactively in cases of fraud or intentional misrepresentation (see the "Rescission" section of this document). If coverage is terminated, you may be required to repay to the Plan amounts incorrectly paid by the Plan, including insurance premiums and claims paid by the insurance carrier. The Board of Trustees may commence legal action against a Participant or other individual for restitution and hold them liable for all costs of collection, including interest and attorneys' fees. The Board of Trustees may also offset future claim payments with respect to the Participant or Dependent to recover amounts owed.

ELIGIBILITY AND ENROLLMENT FOR STAFF EMPLOYEES

You are a Staff Employee if you are a full-time (regularly scheduled to work at least 30 hours per week) regular, union employee of a Contributing Employer who is not covered by a collective bargaining agreement and who is hired for an indefinite period (i.e., not on a freelance, project-by-project, or temporary basis). Staff Employees include owners, senior management, production, administrative, and maintenance employees of Contributing Employers who have elected to participate in the Staff Plan.

Staff Employees may elect to be covered under one of the four (4) medical benefit options below:

1. Plan A (PHBP Classic Premier PPO Plan);
2. Plan B (PHBP Classic Plus PPO Plan);
3. Plan C (PHBP California Classic HMO – California only); and
4. Plan D (PHBP High Deductible Health Plan/Health Savings Account (HSA)). The PHBP will provide coverage through the HDHP, but the Plan will not make contributions to the HSA. Contributions may be made by an employee and/or employer as provided by law.

You may also be enrolled in dental and vision coverage if this coverage is elected by your Staff Employer on a company wide basis. It is not available a la carte and is not electable by the individual employee. If elected, those coverage periods are the same as the medical plan and are:

- Dental Classic Complete Dental Plan
- Vision Insurance Plan

WHEN STAFF COVERAGE BEGINS

If you are a Staff Employee, you become an Eligible Employee 30 days after your date of hire. Your coverage begins on the first day of the first month after you become an Eligible Employee.

> Example: Julie is hired as a Staff Employee on March 12. She becomes an Eligible Employee on April 12, 30 days after her date of hire. Julie's Plan coverage begins on May 1.

Special rules apply if you are covered as a Freelance Employee and later become a Staff Employee; see "Moving from Freelance Employment to Staff Employee" below.

If you were previously covered under the Plan and are hired as a Staff Employee by another Contributing Employer with an interruption that does not exceed 90 days from termination of your coverage from the Plan, the new Contributing Employer has the option to waive the waiting period. Coverage would then begin the 1st of the month following the date of hire.

For new and existing Contributing Employers upon their initial election of Staff coverage, Staff Employee coverage begins on the first of the month after a 60-day processing period, commencing on the date of receipt their fully executed Staff Coverage Election Form.

Example: a new Contributing Employer begins making contributions to the PHBP for Freelance Employees on February 20, 2019. Coverage for Staff Employees would begin on May 1, 2019. If the new Contributing Employer has no Freelance Employees working in PHBP covered job categories, they do not make any contribution until payment is due for the first month of staff coverage. If a Contributing Employer has been a Contributing Employer for any length of time but only for Freelance Employee contributions and later elects to add Staff coverage, Staff coverage begins the 1st of the month following a 60 day processing period commencing with the receipt of the Staff Election Form.

OPT OUT OF COVERAGE FOR STAFF EMPLOYEES

If you opt out of auto-enrollment (waive coverage) of yourself and/or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and/or your Dependents in this Plan if you and/or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards your Dependents' other coverage). However, you must request enrollment for and enroll for benefits within 30 days after you and/or your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage). You must provide proof of termination of other coverage

Otherwise, If a Participant declines enrollment and wants to enroll at a later date, an eligible Participant and his/her Dependents may do so during the next open enrollment period.

MOVING FROM FREELANCE EMPLOYMENT TO STAFF EMPLOYEE

If, while you are covered by the Plan as a Freelance Employee, you are hired by a Contributing Employer as a Staff Employee, your coverage as a Freelance Employee continues through the end of the month in which you become a Staff Employee. Your Plan coverage as a Staff Employee begins on the next day, so you have no gap in coverage. Once hired as a Staff Employee by a Contributing Employer, the only coverage available is Staff coverage and the former Freelance Employee may not "run out" their coverage for the duration of the Coverage Period. The Coverage Period ends at the moment of full-time employment by a Contributing Employer.

Any remaining months of coverage you have as a Freelance Employee are banked for up to a maximum of 18 months. If your employment changes during those 18 months and you are no longer an eligible Staff Employee, you may again be covered by the Plan as a Freelance Employee for those remaining months. A new one-year IQP begins with the second period of Freelance employment.

> Example: Eli's coverage as a Freelance Employee begins on January 1, 2019. In May 2019, Eli is hired as Staff Employee. Eli's coverage under the Plan as a Staff Employee begins on June 1, 2019, and the remaining seven months of his Freelance Employee coverage (June – December) are banked.
>
> In December 2019, Eli's staff employment ends, and his coverage as a Staff Employee ends on December 31. On January 1, 2020, Eli begins the remaining seven months of his Freelance Employee coverage, even if he is not employed by a Contributing Employer as a Freelance Employee.

NEW HIGH DEDUCTIBLE HEALTH PLAN/HEALTH SAVINGS ACCOUNT OPTION FOR STAFF EMPLOYEES

Staff Employees may enroll in the PHBP High Deductible Health Plan with the option to open a HSA account through Anthem. Freelance Employees are not eligible for this plan.

If a Staff Employee enrolls in the PHBP High Deductible Health Plan, they may elect to open a HSA account and contribute their own money to the HSA. In addition, an employer or other entities such as a family member may contribute to the HSA, as permissible under law. PHBP does not contribute any funds to your HSA. In order to be eligible to contribute to an HSA you must meet the following criteria:

1. You must be covered by an HSA-compatible health plan, such as the HDHP with HSA plan, and you cannot be covered by any other medical plan that is not an HSA-compatible health plan. This would include being enrolled in your spouse's plan as secondary coverage.

2. You must be enrolled in the plan on the first day of the month; otherwise, your eligibility to make contributions to your HSA begins the first day of the following month.

3. You have no other health coverage except what is permitted under Other health coverage, defined in IRS Publication 969.

4. You are not enrolled in Medicare.

5. You cannot be claimed as a dependent on someone else's tax return.

   The IRS has specific rules on who can open an HSA. See those rules in IRS Publication 969. Frequently Asked Questions about the HSA plan are available on the PHBP website.

TERMINATION OF COVERAGE

ACTIVE PARTICIPANTS

If you are an Active Participant, your coverage ends on the earliest of:

- The date this Plan terminates or eliminates coverage for your class of employees;
- The last day of the month you no longer meet the eligibility requirements;
- For Staff Employees, the last day of the month in which:
    - your employment terminates or you are no longer working in Covered Employment, such as moving from full-time to part-time employment, or ceasing to be a common law employee of a Contributing Employer;
    - your Employer's participation in the Plan is terminated (your Employer is no longer a Contributing Employer); or
    - your Employer does not pay the cost of insurance coverage.
- For Freelance Employees, the day after the last Coverage Period in which you qualified for coverage;
- Thirty-one days after you enter military service; or
- The date of your death.

ELIGIBLE DEPENDENTS

Coverage for your Eligible Dependents ends on the earliest of the following:

- For Staff Employees, the date your (the Participant's) coverage ends;
- For Freelance Employees, Dependent coverage ends on the date that the Participant's coverage ends. However, if the coverage ends because of the Participant's death, the Dependent may continue coverage for the length of the Coverage Period for the established cost of Dependent coverage. The Dependent may elect COBRA at the end of the Coverage Period if he/she pays for continued coverage under this provision.
- The last day of the month following the date a Dependent Child no longer qualifies as a Dependent upon reaching age 26;
- The date a Dependent Child who is over the age of 26 is no longer considered totally disabled, marries or is no longer dependent upon you for support;
- The date you and your Spouse divorce or are legally separated; or the date you and your Registered Domestic Partner are no longer a Registered Domestic Partner.
- The date an Eligible Spouse enters active military service;
- The date of the Dependent's death; or
- The date the Plan discontinues coverage for Dependents or the Plan terminates.

RESCISSION OF BENEFITS

No benefits are payable on a claim if the person who files the claim or for whom the benefit is claimed, or if the provider of the service that is subject of the claim, attempts to perpetrate a fraud upon or misrepresent a fact to the Plan with respect to that claim. Failure to provide complete, updated and accurate information to the Fund Office on a timely basis regarding your marital status, employment status or information about other coverage of a spouse or child, or the existence of other coverage constitutes intentional misrepresentation of material fact to the Plan.

Coverage for you and/or your dependents may be terminated retroactively (rescinded):

- In cases of fraud or intentional misrepresentation (in such cases, you will be provided with 30-day notice). For example, if the plan determines that you made an intentional misrepresentation of a material fact as prohibited by the terms of the plan in seeking coverage for benefits, your coverage may be rescinded back to the date of the misrepresentation, and you will receive a 30-day advance notice of this rescission. All claims incurred on or after the date of the misrepresentation would be denied by the plan.

- Due to non-payment of the annual enrollment fee or premiums (including COBRA premiums). Failure to notify the Plan of a loss of dependent status for any dependents (including divorce or legal separation or a child aging out of the Plan) constitutes a failure to pay COBRA premiums. In these situations, coverage may and will be terminated retroactively to the date of the event (without advanced notice).

If coverage is terminated, you may be required to repay to the Fund amounts incorrectly paid by the Fund or its insurance carrier, including any and all medical, dental, vision or other claims made for benefits. The Board of Trustees may commence legal action against a Participant or other individual for restitution and hold them liable for all costs of collection, including interest and attorneys' fees. The Board of Trustees may also offset future claim payments with respect to the Participant or dependent to recover amounts owed.

NOTICE TO THE PLAN

You, your Spouse, or any of your Dependent Children ***must*** notify the Plan ***immediately*** but no later than 60 days after the date:

- a Spouse or Registered Domestic Partner ceases to meet the Plan's definition of Spouse (such as in a divorce or legal separation); or

- a Dependent Child ceases to meet the Plan's definition of Dependent.

LEAVE OF ABSENCE FOR FULL-TIME STAFF EMPLOYEE PARTICIPANTS

Special circumstances may entitle Staff Employees to continue eligibility for coverage under the Plan when on leave from work due to any of the following Leaves of Absence.

FAMILY AND MEDICAL LEAVE FOR STAFF EMPLOYEES

Under the Family and Medical Leave Act of 1993 (FMLA), you may be able to take up to 12 weeks of unpaid leave during any 12-month period:

- to care for a newly born or adopted child;
- to care for a spouse, parent or child who has a serious health problem;
- if you have a serious health problem that prevents you from performing your job; or
- due to 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.

In addition, FMLA may enable you to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member if that individual is your spouse, son/daughter, parent or next of kin, is undergoing treatment or therapy for an illness or injury that occurred in the line of duty, and is an outpatient or on the armed services' temporary disability retired list.

During your leave, you will maintain the coverage you were eligible for at the time of your leave until the end of your leave, as long as your Employer properly grants the leave under the FMLA and you and your Employer make the required notifications and contributions to the Fund Office. Contributions will remain at the same employer/employee levels as were in effect on the date immediately prior to the leave, unless contribution levels change for other employees in the same classification.

The PHBP has **no** role in granting FMLA leave. Your Employer can grant FMLA leave, and your PHBP coverage will continue for as long as you and your Employer continue to make the required contributions to maintain your eligibility. If you or your Employer stop making contributions on your behalf, or if you exhaust your FMLA leave, COBRA Continuation Coverage may become available.

Please note that in order to be eligible for continued coverage under FMLA, your Employer must properly grant the leave and make the required notification and payment to the Fund Office. Contact your Employer for more information regarding your rights under FMLA.

PAID OR UNPAID NON-FMLA LEAVES OF ABSENCE

You may continue coverage for up to 3 months while on an Employer approved paid or unpaid Non-FMLA Leave of Absence. During this 3 month period, you will maintain the same coverage that you had previously, as long as your Employer makes the required notifications and contributions to the Fund Office. Contributions will remain at the same employer/employee levels as were in effect on the date immediately prior to the leave, unless contribution levels change for other employees in the same classification. Your coverage will end, and you will be offered COBRA Continuation Coverage, on the first of the following dates to occur: (1) the last date that your Employer made the required contributions to the Fund Office for your coverage while on a Non-FMLA Leave of Absence, or (2) the date when you have received three months of coverage while on a Non-FMLA Leave of Absence. See "Continuation of Coverage" / COBRA for details.

If you return to active work within 6 months from the start of your Leave of Absence, and you are considered an Eligible Employee upon your return to active work, then you are immediately eligible for coverage on your first day back to work, and coverage will begin the 1st of the month following your return to work. If you return to active work more than 6 months from the start of your Leave of Absence, and you are considered an Eligible Employee upon your return to active work, then you are eligible for coverage beginning on the 1st of the month following a 30 day waiting period.

LEAVE FOR MILITARY SERVICE FOR STAFF EMPLOYEES

If you voluntarily or involuntarily leave your employment position to undertake military service, the Uniformed Services Employment and Reemployment Rights Act ("USERRA") permits you to continue health coverage under certain conditions. If your military service exceeds 31 days, you should receive military health care coverage from the U.S. Government at no cost. However, you may also elect to continue your coverage under this Plan for you and your Eligible Dependents for a maximum period of 24 months from the first day of your military leave. You must notify the Fund Office at the beginning of your military leave and fill out an election form in order to receive this continuation of 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). The cost, election periods, and grace periods for USERRA Coverage are the same as COBRA Continuation Coverage. However, 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 continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the COBRA/USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA. See the COBRA continuation coverage section for details.

PAYING FOR USERRA COVERAGE

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 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 twenty-four (24) months measured from the date 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 section for more details.

When your coverage under this Plan terminates because of your reduction in hours due to your military service, you and your Eligible Dependents may also have COBRA rights. See the COBRA section of this document for details. In addition, your Dependent(s) may be eligible for health care coverage under TRICARE. This Plan will coordinate coverage with TRICARE.

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The Uniformed Services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are discharged (not less than honorably) from military service, your full eligibility will be reinstated on the day you return to employment with a Contributing Employer, provided that you return to employment within:

- 90 days from the date of discharge if the period of service was more than 180 days; or
- 14 days from the date of discharge if the period of service was at least 31 days, 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 eight hours) if the period of service was less than 31 days.

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

The Employer must notify the Fund Office 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. If you have any questions about taking a leave of absence, please speak directly with your Employer. If you have any questions about how a leave of absence affects your coverage, please contact the Fund Office. Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

REINSTATEMENT OF COVERAGE AFTER LEAVES OF ABSENCE

If your coverage ends while you are on an approved FMLA leave or USERRA military service, your coverage will be reinstated on first day of the month following the day you return to active employment (see the Leave for Military Service section above for more details), subject to all annual and lifetime plan benefit maximums that were incurred prior to the leave of absence.

If you and your Employer have a dispute regarding your eligibility and coverage under the FMLA, the Plan will not have any direct role in resolving the dispute and your benefits may be suspended while the dispute is being resolved.

CONTINUATION OF COVERAGE

COBRA

In General

You can continue your health care coverage temporarily in certain circumstances where coverage would otherwise end. This extended health care coverage is called "COBRA coverage," named for the federal law that sets forth the rules for continuation coverage (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)). COBRA coverage is identical to the health, dental and vision care coverage provided under this Plan and is available to you and your Eligible Dependents at your own expense provided your coverage is lost due to a "Qualifying Event." However, COBRA does not include Life or Disability benefits.

Under the law, only "Qualified Beneficiaries" are entitled to elect COBRA coverage. Depending on the type of Qualifying Event, a Qualified Beneficiary can include any Active Participant or Eligible Dependent who is covered by the Plan when a Qualifying Event occurs. Qualified Beneficiaries have the same rights as active Participant or Eligible Dependents including special and open enrollment rights. A child who becomes an Eligible Dependent by birth, adoption, or placement for adoption with the Eligible Participant during a period of COBRA coverage is also a Qualified Beneficiary. A person who becomes your Spouse during a period of COBRA coverage is not a Qualified Beneficiary.

With regard to COBRA Continuation Coverage rights and those component benefits where COBRA applies, please examine your options carefully before declining COBRA coverage. Where COBRA applies, the COBRA provisions in the respective Benefit Document will supersede any COBRA provisions in this Wrap Plan/SPD.

ALTERNATIVES TO COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

You should also be aware that companies selling individual health insurance typically require a review of your medical history that could result in higher premiums. Also, be aware that voluntary termination of existing COBRA Continuation Coverage does not trigger a mid-year "special enrollment right" under another group health plan.

COBRA QUALIFYING EVENTS

To be eligible to elect COBRA coverage, (1) you or your Dependent must ***lose*** coverage under the Plan due to any one of the following Qualifying Events; and in the case of Staff Employees, the Qualifying Event must occur while your Employer is participating in the Plan and has paid all required Plan contributions through the date of the Qualifying Event.

Qualifying Event	Who May Purchase Continuation Coverage?	For How Long?
Voluntary or involuntary termination of your employment (unless the termination is due to	Active Participants and Eligible Dependents	18 months*

Qualifying Event	Who May Purchase Continuation Coverage?	For How Long?
gross misconduct)		
You lose eligibility due to a reduction in your work hours	Active Participants and Eligible Dependents	18 months*
* May be extended to 29 months in cases of Social Security Administration disability determination.		
Your Non-FMLA Paid or Unpaid Leave of Absence continues for more than 3 months	Active Participants and Eligible Dependents	18 months
You or your Dependents become disabled at some time before the 60th day of COBRA coverage and the disability lasts until the end of the 18-month COBRA coverage period	You or your Dependents become disabled at some time before the 60th day of COBRA coverage and the disability lasts until the end of the 18-month COBRA coverage period	Additional 11 months for total of 29 month (or until entitled to Medicare if earlier)
You die	Eligible Dependents	36 months
You become entitled to Medicare (and if causes a loss of coverage for dependents)	Eligible Dependents	36 months
You become legally separated or divorced from your Spouse	Eligible Spouse and Stepchildren (only step-children will lose coverage upon divorce)	36 months
Your Dependent Child is no longer considered a Dependent under this Plan's definition (e.g., he or she reaches the maximum age limit)	Eligible Dependent Child	36 months

AVAILABILITY OF COBRA COVERAGE

The Plan will offer COBRA coverage to Qualified Beneficiaries only after the Fund Office has been notified that a Qualifying Event has occurred. Your Contributing Employer is responsible for notifying the Fund Office of termination of employment, reduction in hours, or death of the Participant, and the Fund Office will determine when the loss of coverage occurs. However, you or your family should also notify the Fund Office promptly if any such Qualifying Event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notice.

NOTICE OF QUALIFYING EVENTS AND SECOND QUALIFYING EVENTS

For all other Qualifying Events (than those listed above), you must notify the Fund Office no later than 60 days after the Qualifying Event occurs. The notice of occurrence of any of these events and all Second Qualifying Events (as described in the section "Multiple Qualifying Events While Covered Under COBRA") must be provided to the Fund Office in writing. Notice may be provided by the Eligible Participant or Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Eligible Participant or Qualified Beneficiary. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same Qualifying Event. You must provide the Fund Office notice of the following Qualifying Events:

1. When an Eligible Participant divorces or legally separates from his or her Spouse, notice must be sent no later than 60 days after the date upon which coverage would be lost under the Plan as a result of the Qualifying Event. A copy of the court document must be included with the notice.

2. When a beneficiary ceases to be covered under the Plan as a Dependent Child of an Eligible Participant, notice must be sent no later than 60 days after the date upon which coverage would be lost under the Plan as a result of the Qualifying Event.
3. When the Eligible Participant becomes eligible for Medicare and such eligibility would cause a loss of coverage for Dependents.
4. When a Qualified Beneficiary experiences a Second Qualifying Event.

Failure to provide this notice within the form and timeframe described above may prevent you and/or your Eligible Dependents from obtaining or extending the COBRA coverage.

You must also notify the Plan Administrator when a Qualified Beneficiary is determined by the Social Security Administration to be disabled during a COBRA coverage period or when the Social Security Administration determines that a Qualified Beneficiary is no longer disabled. See the section below entitled, "COBRA Coverage for Disabled Eligible Participants" for details.

NOTICE OF UNAVAILABILITY OF COBRA COVERAGE

In the event the Plan is notified of a Qualifying Event but the Fund Office determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation indicating why the COBRA coverage is not available. This notice of the unavailability of the COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

HOW IS COBRA COVERAGE PROVIDED?

When the Plan Administrator is notified that a Qualifying Event has occurred, the Plan Administrator will then provide you and/or your Eligible Dependents with notice of the date on which your coverage will end, and the information and election form that you will need in order to elect COBRA coverage. Under the law, you and/or your Eligible Dependents will then have only ***60 days*** from the later of the date you ordinarily would have lost coverage because of the Qualifying Events, or the date you and/or your Eligible Dependents received the notice, to apply for COBRA coverage.

IF YOU AND/OR ANY OF YOUR ELIGIBLE DEPENDENTS DO NOT CHOOSE COBRA COVERAGE WITHIN **60 DAYS** AFTER THE QUALIFYING EVENT (OR, IF LATER, WITHIN 60 DAYS AFTER RECEIVING THAT NOTICE), YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN AFTER COVERAGE ENDS.

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

PAYMENT FOR COBRA COVERAGE

You are responsible for the entire cost of COBRA coverage and can pay for the coverage on a monthly basis. When you and/or your Eligible Dependents become entitled to this coverage, the Plan Administrator will notify you of the COBRA premium amounts that you must pay. Covered Persons who continue full coverage under COBRA pay 102% of the Plan's cost, except in the case of Social Security disability. (See the section below entitled "COBRA Coverage for Disabled Eligible Participants").

If you elect COBRA coverage, you do not have to send any payment with the Election Form. However, the first COBRA payment must be sent to the Fund Office not later than ***45 days*** after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for COBRA in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan.

Payments for subsequent months are due on the first day of the month for which coverage is provided. You will NOT be sent any bills or reminders for subsequent months. It is your responsibility to make payment by the first of the month. If you do not remit your payment by the due date or within the grace period for that payment, your COBRA coverage will end.

GRACE PERIOD FOR PAYMENTS

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

If the Fund Office has not received your Cobra payment by the due date (the first of the month), your COBRA coverage will be cancelled on the first day of the month. However, if your COBRA premium is paid within the 30-day grace period coverage will be reinstated back to the first day of that COBRA coverage period. Payment is considered made when it is postmarked.

COBRA COVERAGE FOR DISABLED ELIGIBLE PARTICIPANTS

If, during an 18-month COBRA coverage period the Social Security Administration determines that you (or a member of your family who is eligible for COBRA coverage) were disabled at some time before the 60th day of COBRA coverage, the disabled person and any Qualified Beneficiary who elected coverage may receive up to 11 additional months of COBRA coverage, for a total maximum of 29 months. **You must notify the Plan Administrator of the determination of your disability in writing within 60 days of the date of that determination and before the end of the 18-month period of COBRA coverage**. The notice of disability must be in writing. If the 18-month period of COBRA Coverage is extended because of Social Security disability, the COBRA premiums for any period of coverage covering the disabled person (whether single or family coverage) may be as high as 150% of the regular premiums for the additional 11 months of coverage.

This extended period of COBRA coverage will end on the earlier of:

- The last day of the month, 30 days after Social Security has determined that you and/or your Eligible Dependent(s) are no longer disabled;
- The end of the 29 months COBRA coverage;
- The date the disabled person becomes entitled to Medicare.

You must notify the Fund Office in writing within 30 days of a final Social Security determination that you are no longer disabled.

MULTIPLE QUALIFYING EVENTS WHILE COVERED UNDER COBRA

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

child(ren) is extended to 36 months from the date of your termination of employment or reduction in hours.

In no case are you (the Active Participant) entitled to COBRA coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA coverage on account of disability). As a result, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA coverage may not be extended beyond 18 months from the loss of coverage due to the initial Qualifying Event.

If your family experiences a Second Qualifying Event, you must notify the Fund Office of the Second Qualifying Event within 60 days of the event according to the procedures described in the section "You Must Give Notice of Some Qualifying Events and All Second Qualifying Events."

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

TERMINATION/REDUCTION IN HOURS THAT FOLLOWS MEDICARE ENTITLEMENT

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

EARLY TERMINATION OF COBRA COVERAGE

COBRA coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- The first date of the time period for which you do not pay the COBRA premiums within the required timeframe after electing COBRA.
- The date, after the date of the COBRA election, in which you or your Eligible Dependent(s) first become covered by another group health Plan.
- The date, after the date of the COBRA election, on which you or your Eligible Dependent(s) first become entitled to Medicare (usually age 65);
- The date the Plan terminates its group health plan and no longer provides group health insurance coverage to its members;
- The date the Employer that employed you prior to the Qualifying Event has stopped contributing to the Plan or the Employer is no longer eligible to be a Participating Employer;
- If coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled, the date you are no longer disabled.

NOTICE OF EARLY TERMINATION OF COBRA COVERAGE

The Plan Administrator will notify the Qualified Beneficiary(ies) if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the Qualified Beneficiary(ies) to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary(ies) may have under the Plan to elect alternate or conversion coverage. The notice will be

provided as soon as practicable after the Plan Administrator determines that COBRA coverage will terminate early.

OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION 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. You can learn more about many of these options at www.healthcare.gov.

COBRA QUESTIONS OR TO GIVE NOTICE OF CHANGES IN YOUR CIRCUMSTANCES

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP THE PLAN INFORMED

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

PLAN CONTACT INFORMATION

BeneSys Administrators
1050 Lakes Drive, Suite 120
West Covina, CA 91790
(855) 696-2909 or email staff@phbpbenefits.org

IMPORTANT NOTICES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. Refer to the Utilization Management in the next section for information on precertification.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

This Plan complies with the Women's Health and Cancer Rights Act (WHCRA) that indicates that for any Covered Person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and the treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Benefits for these services shall be subject to the same Deductible, Copayments and/or Coinsurance as for other services covered under this Plan.

CLAIMS AND APPEALS PROCEDURES

BENEFIT CLAIMS APPEALS

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. When the procedures require that you file a claim for benefits offered under this Plan, you must submit a completed claim form.

For an explanation of claims and appeals procedures under the plan, refer to the Benefit Documents listed in the Plan Benefits section.

ELIGIBILITY APPEALS

If you disagree with a decision that the PHBP Plan has made regarding your eligibility for coverage under the Plan, you may appeal to the Board of Trustees. Your appeal must be in writing and submitted to the address or email address provided below within 30 calendar days of your termination of coverage. Eligibility appeals must include all of the following:

1. A statement describing the specific issues which you are disputing.
2. A statement of the resolution you seek.
3. Any other information relevant to your appeal. This includes copies of the decision letter and all other documents you may have received from the Plan and any documents such as time cards, pay stubs, or other relevant materials to support your appeal.

To file an eligibility appeal, send the above documentation to:

BenSys Administrators at Producers' Health Benefit Plan
P.O. Box 2340
West Covina, CA 91793
staff@phbpbenefits.org

Eligibility Appeals will be reviewed by the PHBP Board of Trustees within 15 business days after your appeal is received, after which you will be notified in writing of the Board's decision regarding your appeal.

ADDITIONAL PLAN PROVISIONS

Important: Notwithstanding any provision in the Benefit Documents to the contrary, the following provisions will apply to this Plan:

Assignment of Claims. The rights and benefits under the Plan are not assignable by any Participant, and any such assignment shall be considered null and void.

Time Limit on Legal Actions. A legal action may be brought against the Plan only during the period which ends one year after the date when the cause of action accrued. A legal action on a claim may be made against the applicable insurance carrier only during the period specified by the insurance carrier in the Benefits Document. For purposes of these time limits, a claim is incurred on the date specified in the applicable Benefit Document.

COORDINATION OF BENEFITS WITH OTHER PLANS

You or your covered Dependents may have other insurance through another group health plan, governmental coverage, or individual insurance. If you have other insurance, the PHBP plan would be your primary or secondary coverage in conjunction with that other policy, depending on the Coordination of Benefit (COB) rules associated with each policy. The COB rules will be included in the insurance Evidence of Coverage for the Plan Option in which you are enrolled. We recommend that you clarify how your other insurance coverage will coordinate with or affect your coverage under this plan.

YOUR ERISA RIGHTS

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Fund Office all documents governing the Plan, summary plan descriptions and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. 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 may make a reasonable charge for the copies.

3. 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

1. Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event, as described in the COBRA chapter. You and/or your Dependents may have to pay for such coverage, if it is elected. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

2. Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under your group health plan if you have creditable coverage from another plan. You should be provided a HIPAA Certificate of Creditable Coverage, free of charge, from your group health plan or health insurer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

1. 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.

2. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

1. 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, as discussed in the Claims Filing and Appeals

Information sections of the Evidence of Coverage provided by your insurer for the Plan Option you have elected.

2. 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.

3. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. See the applicable Claims Filing and Appeal information in the Evidence of Coverage on the requirement to appeal a denied claim and exhaust the Plan's appeal process **before** filing a lawsuit.

4. 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.

5. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

1. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, 200 Constitution Avenue, N. W., Washington, DC 20210.

2. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration) at Toll-Free: 1.866.444.EBSA (3272).

PLAN AMENDMENTS OR TERMINATION OF PLAN

Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor reserves the right, without the consent of any participant or beneficiary, to:

1. make any modifications or amendments to the Plan as may be necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and

2. terminate, suspend, withdraw, amend or modify the Plan, in whole or in part and at any time and on a retroactive basis.

Any modification, amendment or termination action will be done in writing, and by resolution of the Plan Sponsor's Board of Trustees, adopted in accordance with the procedures set forth in the Plan's Agreement and Declaration of Trust Agreement as amended and restated from time to time. Employees will be provided with notice of the change within the time required by federal law.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate/designee, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder.

NO LIABILITY FOR PRACTICE OF MEDICINE

The Plan, Plan Administrator or any of their designees are **not** engaged in the practice of medicine, 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, Plan Administrator, 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.

RIGHT OF PLAN TO REQUIRE A PHYSICAL EXAMINATION

The Plan reserves the right to have the person, who is totally disabled or who has submitted a claim for benefits and is undergoing treatment under the care of a Physician, to be examined by a Physician selected by the Plan Administrator or its designee at any time during the period that benefits are extended under this Plan. The cost of such an examination will be paid by the Plan.

HEADINGS, FONT AND STYLE DO NOT MODIFY PLAN PROVISIONS

The headings of chapters and subchapters and text appearing in **bold** or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text for the **convenience** of the reader. The headings are **not** part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

OTHER NOTICES

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the PHBP health plan, maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

The term "Protected Health Information" (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

A complete description of your rights under HIPAA can be found in the Notice of Privacy Practices for your medical, dental, or vision plan, which was distributed to you upon enrollment in the Plan and is also available from the medical, dental, or vision plan.

GENERAL STATEMENT OF NONDISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)

PHBP complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PHBP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. PHBP's health plan providers will:

a) Provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

b) Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Civil Rights Coordinator identified in your health plan Certificate.