

AGMA

HEALTH FUND PLAN B

**MEDICAL
REIMBURSEMENT
PROGRAM**

Summary Plan Description

AUGUST 2010

REVISED MAY 2012

AGMA HEALTH FUND PLAN B
1430 Broadway, Suite 1203
New York, NY 10018
(212) 765-3664

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Union Trustees

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Membership Supervisor
American Guild of Musical Artists
1430 Broadway, 14th floor
New York, NY 10018

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1st Vice-President
American Guild of Musical Artists
1430 Broadway, 14th Floor
New York, NY 10018

Mr. James L. Fayette
New York Area Dance Executive
American Guild of Musical Artists
1430 Broadway, 14th Floor
New York, NY 10018

Mr. Alan Gordon, Esq.
National Executive Director
American Guild of Musical Artists
1430 Broadway, 14th Floor
New York, NY 10018

Mr. James Odom
President
American Guild of Musical Artists
1430 Broadway, 14th Floor
New York, NY 10018

Management Trustees

Mr. Mark Weinstein
AGMA Health Fund
1430 Broadway, Suite 1203
New York, NY 10018

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Pacific Northwest Ballet
301 Mercer Street
Seattle, WA 98109

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AGMA Health Fund
1430 Broadway, Suite 1203
New York, NY 10018

Mr. Nicholas I. Martin
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Lyric Opera of Chicago
20 N Wacker Drive, Suite 860
Chicago, IL 60606

Mr. Brooks Parsons
Senior Director of Operations
New York City Ballet
David H. Koch Theater
20 Lincoln Center Plaza
New York, NY 10023

Mr. Matthew Shilvock
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San Francisco Opera
301 Van Ness Avenue
San Francisco, CA 94102-4509

Executive Director

Mr. Derek J. Davis

Legal Counsel
Spivak Lipton LLP

Auditor
Schultheis & Panettieri, LLP

Consultants
The Segal Company

Third-Party Administrator
Administrative Services Only, Inc.

AGMA HEALTH FUND PLAN B

August 2010
Updated May 2012

Dear Participant:

We are pleased to provide you with this booklet effective May 1, 2012, which describes how you can use your Individual Account in the AGMA Health Fund Plan B for your health care needs and that of your dependents. This booklet replaces and supersedes prior materials distributed to you describing your Individual Account in the AGMA Health Fund Plan B.

Please note that you can apply your Individual Account toward the premiums for health insurance that you may choose to purchase through various sources, including The Entertainment Industry Group Insurance Trust ("TEIGIT"). Furthermore, your account balance can be applied toward the reimbursement of an extensive list of medical expenses that are not covered by a health insurance policy or plan, or for the premiums or costs of other health plan coverage that you may have.

We suggest that you read this booklet and share it with your family. We believe this Plan has the flexibility to meet some of the health care needs of all Artists and their dependents.

Sincerely,

THE BOARD OF TRUSTEES

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1. OVERVIEW

Collective bargaining agreements between AGMA and certain opera, ballet and concert companies require contributions on behalf of the Artists they engage to help cover the cost of health insurance and medical benefits. The contribution rate is set by collective bargaining agreements. A complete list of current Contributors is available upon request from the Third-Party Administrator.

This Plan, called the AGMA Health Fund Plan B (“Plan B” or “Plan”), was established by the Board of Trustees of the AGMA Health Fund to receive such contributions on behalf of participating Artists. Plan B is intended to serve as a source of funds that Participants can apply to the purchase of health insurance and to the reimbursement of medical expenses that are not otherwise covered by a health insurance policy or plan. In view of the various engagement patterns of Artists, Plan B is structured for the maintenance of Individual Accounts where contributions are available for use in as broad and as equitable a manner as possible.

Briefly, the Individual Accounts are available to help defray premiums for health insurance that Participants may elect to purchase through three broad sources: (1) The AGMA Health Fund’s traditional benefit plan (Plan A); (2) TEIGIT, and (3) the premiums and cost of any other health insurance policy or plan that covers the Participant and his/her dependents, either directly or as a dependent.

TEIGIT was selected as a source of health insurance through the Fund because of its ability to make group premium rates available to people in the entertainment industry who voluntarily purchase insurance on an individual or family basis. The AGMA Health Fund Plan A (AGMA’s traditional plan) has group rates. It also has more eligibility requirements than are otherwise applicable to other benefits.

The Individual Accounts are also available for the reimbursement of medical expenses not covered by insurance when incurred by Participants and their dependents. This includes deductibles, co-payments, dental, optical, substance abuse programs and other benefits for which a complete listing appears in a later section of this booklet.

If you have any questions regarding the contents of this Summary Plan Description, or about Plan B generally, please contact the Third Party Administrator named in Section 3.

2. DEFINITIONS

Administrative Expenses: Expenses to operate the AGMA Health Fund Plan B, including, but not limited to, expenses for the maintenance of Individual Accounts, communications with Participants, professional and service fees and interaction with TEIGIT and other insurance companies on behalf of Participants, and costs in connection with processing of reimbursement of medical expenses. Allocation of these expenses to Individual Accounts is detailed in Section 8.B.

Artist - A Principal Artist as defined by collective bargaining agreements between AGMA and Contributors, as well as any other artist for whom Contributors are required to make contributions to the AGMA Health Fund Plan B.

Contributors: A contributing company or organization which is a signatory to a collective bargaining agreement with the Union or participation agreement with the Fund requiring contributions to the AGMA Health Fund Plan B on behalf of Artists.

Covered Engagement: Engagement as an Artist by a Contributor.

Fund: The assets of the AGMA Health Fund Plan B.

Individual Account: The accumulation of Contributor contributions on behalf of an Artist increased by Investment Return minus Administrative Expenses and minus transfers to TEIGIT and the AGMA Health Fund Plan A to cover the cost of a Participant's health insurance and minus reimbursement to the Participant for qualified medical expenses or premiums for other health insurance that covers the Participant, minus any funds forfeited pursuant to Section 7. Individual Accounts are updated quarterly, and maintained in accordance with Section 8.

Investment Return: The yield of the invested assets of the AGMA Health Fund Plan B. Investment Rate is attributed to Individual Accounts in accordance with Section 8.C.

Participant: An Artist with an Individual Account balance.

Union: American Guild of Musical Artists (AGMA)

Valuation Dates: February 28, May 31, August 31 and November 30 of each year.

Valuation Period: March 1 through May 31, or June 1 through August 31, or September 1 through November 30, or December 1 through February 28.

3. THE ROLE OF THE PLAN B TRUSTEES AND THE THIRD PARTY ADMINISTRATOR

The Board of Trustees is the named Plan Administrator of Plan B. The Board of Trustees has engaged the services of Administrative Services Only, Inc. ("Third Party Administrator") to perform many of the administrative functions outlined in this Summary Plan Description, including but not limited to: the payment of TEIGIT premiums and the reimbursement of claims for uninsured medical expenses and premiums for other health insurance, the collection and verification of contributions for Covered Individuals, communication with Participants about their Individual Account balances and how they can be applied to their health service needs, and the maintenance of Individual Accounts for Participants.

For Participants who purchase health insurance through TEIGIT, the Third Party Administrator must communicate with TEIGIT about Individual Account balances, and must make available to TEIGIT the appropriate portion of the Individual Account balance of a Participant who enrolls for health coverage. (Typically, premium payments are collected by TEIGIT on a quarterly basis, but in some cases the initial enrollment can cover one or two months).

The Third Party Administrator will also make initial claims decisions, provide you with Individual Account balance information, and general information regarding Plan B, and therefore, you may obtain claims forms from, and should submit all your claims for reimbursement to the Third Party Administrator at:

Administrative Services Only, Inc.
303 Merrick Road, Suite 300
Lynbrook, New York 11563-9010
Toll Free 1-866-263-1185
www.asonet.com

You may also contact the Third Party Administrator with general questions about Plan B. The service contract between the Third Party Administrator and the Board of Trustees is on file at the Fund Office. The Third Party Administrator is a fiduciary for many of the functions it performs (see Section 13 outlining your rights under ERISA).

For Participants who seek reimbursement for other health insurance premiums or medical expenses not covered by TEIGIT insurance, the Third Party Administrator must collect from the Participant valid documentation of the expense to be reimbursed. This will include collecting from the Participant proof that the outside insurance premium was paid by the Participant or, if applicable, by the Participant's spouse. Furthermore, the Third Party Administrator must obtain from the Participant a bona fide bill paid by the Participant from a medical provider for the reimbursement of uninsured medical expenses.

4. ELIGIBILITY AND PARTICIPATION

Artists as defined in Section 2 will have an Individual Account set up on their behalf upon the receipt of contributions. An Artist, or his/her eligible dependents, may participate in the Plan when he/she has funds in an Individual Account.

Plan B is available to Participants and their eligible dependents up to the amount currently in the Participant's Individual Account.

Your Eligible Dependents are:

- your legal spouse;
- your unmarried dependent children – *to the last day of the month in which they reach age 26.*
- your unmarried dependent children who are over the age of 26 and unable to support themselves because of mental illness, developmental disability, mental retardation (all as defined in the New York mental hygiene law) or physical handicap, provided the incapacitating condition started and initial proof of the condition is submitted to the Fund Office before the child reaches age 26, when coverage would otherwise end. Proof of continued disability must be submitted annually. The Fund will make the final determination of eligibility.

Unmarried dependent children include your: adopted children or children placed with you for adoption, your stepchildren if you claim them as dependents for income tax purposes, and any other children for whom a court has awarded you legal custody or guardianship and whom you claim as dependents for income tax purposes.

When evidence of tax dependency is required for stepchildren and children for whom a court has awarded you legal custody or guardianship (other than an adopted child or child placed for adoption) – that child's coverage will not become effective until you submit proof of tax dependency, such as a copy of your filed tax return).

You may also cover as your dependent a person who is your "Domestic Partner" as defined below.

Definition of Domestic Partner

AGMA Health Fund Plan B defines domestic partners as follows:

Two unmarried adults (both of whom are 18 years or older) of the same or opposite sex, neither of whom is married or legally separated who:

- have resided with each other for six months prior to the application for benefits and who intend to live continuously with each other indefinitely;

- are not related by blood closer than the law would permit by marriage;
- are financially dependent on each other;
- have an exclusive close and committed relationship with each other; and
- have not terminated the domestic partnership.

Procedures for Verifying Domestic Partner Status.

A participant who seeks domestic partner coverage will be required to submit an affidavit attesting to the domestic partner status and a declaration of financial interdependence with two items of proof (such as joint lease or mortgage, joint bank account). (A sample affidavit and declaration is available from the Third Party Administrator.)

Person who fraudulently, wrongfully (or negligently) obtain coverage for persons who are not entitled to such coverage, or who fail to timely notify the Executive Director of the termination of a domestic partnership, may be subject to civil action.

In addition, those who live in municipalities offering a domestic partner registry (such as New York City and San Francisco) will be required to show proof that they have registered as domestic partners.

Taxation

Reimbursement for a domestic partner's medical expenses is taxable as wages unless the participant's domestic partner is financially dependent on the participant.

a) Financially Dependent Domestic Partners

If the Participant presents proof satisfactory to the Trustees that his or her domestic partner is a financial dependent within the meaning of Section 152 of the Internal Revenue Code, health benefits to such partners are not taxable. Section 152 defines a financial dependent as one who resides with you and for whom you provide more than 50% support. Adequate proof shall ordinarily mean copies of tax returns showing the partner as a financial dependent and a supporting affidavit.

b) Non-Dependent Domestic Partners

Except as provided above for financially dependent domestic partners, health insurance paid by the Employer for a participant's domestic partner is taxable as wages in the amount of the fair market value of the insurance. Fair market value shall ordinarily mean the amount reimbursed on behalf of the domestic partner. Such amount will be subject to federal and state taxes, including

withholding, social security and Medicare (FICA), and unemployment (FUTA).

For participants participating in Plan B's medical reimbursement program, the taxable amount shall be the amount paid for reimbursable expenses of the domestic partner. Taxes shall be deducted before reimbursement for such expenses is paid.

Modification and Interpretation

The Trustees reserve the right to amend or modify the eligibility requirements for domestic partner coverage and to amend, modify or terminate domestic partner coverage at any time for any reason. The Trustees reserve the right to interpret all plan documents concerning domestic partner coverage and to interpret the requirements for and extent of such coverage.

Enrollment of Dependents

You can enroll your dependents for coverage under Plan B at any time, provided you furnish the required proof of dependent status.

5. USE OF YOUR INDIVIDUAL ACCOUNT

Your individual account can be used in the following ways:

- to defray the cost of health insurance purchased from the AGMA Health Fund Plan A,
- to defray the cost of health insurance purchased through TEIGIT;
- to reimburse the cost of health insurance from any other source that covers you; and
- to reimburse qualified medical expenses not covered by insurance.

A. Purchasing Health and Dental Insurance through TEIGIT

The Entertainment Industry Group Insurance Trust (TEIGIT) administers health insurance plans for members of participating associations in the arts and entertainment industry throughout the country. Current health insurance programs are underwritten by **Oxford in New York and by CIGNA in New Jersey, Connecticut, California, the greater Chicago area, Northern Indiana, the greater Atlanta area and parts of Central & Southern Florida. Dental coverage is currently provided through CIGNA**

Upon request, TEIGIT will provide you with detailed benefit plan descriptions and premium information, process your application and enrollment and collect the premiums from you and from the AGMA Health Fund Plan B. If you decide to purchase insurance through TEIGIT, the premiums will automatically be deducted from your Individual Account. If the balance in your Individual Account is not

enough to cover the TEIGIT premiums, then you will be billed directly by TEIGIT for the balance of the premium.

To apply for health insurance coverage, please contact TEIGIT directly, either by phone, fax or mail. TEIGIT will be responsible for the administrative requirements relative to your application and enrollment for coverage and collection of your premium payments, less any AGMA Health Fund Plan B amounts available in your Individual Account for this purpose. TEIGIT, The Entertainment Industry Group Insurance Trust, is located at 632 Plank Road, Suite 203, Clifton Park, NY 12065. The telephone number is (518) 348-1270 or 1-800-886-7504, and the fax number is (518) 348-1273. You may also email them at teigit@teigit.com. Please notify the Third Party Administrator that you intend to purchase insurance through TEIGIT so that it may forward the premium payments to TEIGIT from your Individual Account.

B. Purchasing Traditional Health Insurance and Dental Insurance Through the AGMA Health Fund Plan A

If you meet the eligibility requirements stated below, you can use your Plan B Individual Account to purchase the traditional health insurance and/or dental insurance provided by the AGMA Health Fund Plan A.

Health Insurance

The AGMA Health Fund Plan A provides comprehensive hospital/medical benefits and optional dental benefits through a group insurance contract issued by Aetna, Inc. Plan A also includes prescription drug coverage through Envision. The Plan A hospital/medical coverage is in a Point of Service design, permitting enrollees to use any physician or provider. However, enrollees using Aetna's extensive physician and provider network can obtain more generous benefits.

In order for a Plan B account balance to be used to purchase this coverage starting on any September 1 (the beginning of the AGMA Health Fund's Plan Year), a participant must have a reasonable amount of employment that requires employer contributions to their Plan B Individual Account in a relatively recent period of time. Specifically, and for example, in order to be eligible to use a Plan B account balance to purchase Plan A Health Insurance coverage, starting September 1, 2012, an Artist must meet **ONE** of the following requirements.

- (1) Have a minimum of \$1,200 in employer contributions to his/her Plan B Account based on Covered Employment between July 1, 2010 and June 30, 2012,

OR

- (2) Have at least 32 weeks of Plan B Covered Employment in the period from July 1, 2010 and June 30, 2012.

A similar, rolling two-year covered employment test will determine eligibility to start Plan A Health Insurance on each succeeding September 1.

Dental Insurance

If you meet the eligibility requirements stated below you can also enroll in voluntary dental insurance through Plan A. You can elect dental coverage if you are also electing medical coverage. In addition, even if you do not qualify for traditional health coverage through Plan A, you can enroll in dental coverage, as a specific example starting September 1, 2012, provided you meet **ONE** of the following requirements.

- (1) Have a minimum of \$300 in employer contributions to his/her Plan B Account based on Covered Employment between July 1, 2010 and June 30, 2012,

OR

- (2) Have at least 8 weeks of Plan B Covered Employment in the 24-month period from July 1, 2010 and June 30, 2012.

A similar, rolling two-year covered employment test will determine eligibility to start Plan A Health Insurance on each succeeding September 1.

If you are eligible to enroll in the AGMA Health Fund Plan A (either medical or dental insurance), you will be able to use contributions in your Plan B Individual Account to pay the premiums. Any premium costs above your Plan B account balance will then be billed to you directly.

If you enroll in Plan A, you will be subject to the rules of that Fund, including the special enrollment periods to add dependents, and COBRA continuation coverage if you lose coverage due to a qualifying event. Please consult the Summary Plan Description for Plan A, available from the Fund Office for further information.

If you would like additional information on this program and the coverage provided by AGMA Health Fund Plan A, please contact the Fund Office at 212-765-3664 or via Email at agmaretirement_health@yahoo.com.

C. Medical Reimbursement Program - Medical Expenses and the Cost of an "Outside" Health Insurance Policy or Plan

The AGMA Health Fund Plan B Medical Reimbursement Program lets you use the money in your Individual Account to obtain reimbursement for qualified medical expenses that are medically necessary and that have not otherwise been paid.

The Medical Reimbursement Program also reimburses premiums and costs for other qualified medical insurance plans (other than the AGMA Health Fund Plan A and those provided through TEIGIT) that cover you and your dependents. This applies to a medical insurance policy you purchase directly, or health insurance through your spouse's employer that requires an additional insurance premium to include you as a dependent.

Please note that the Executive Director will require that any individual seeking premium reimbursement for health insurance through his or her spouse's employer

that requires an additional insurance premium to include that individual as a dependent must certify that premiums or contributions made for that policy are made on a post-tax basis. If premiums or contributions are paid on a pre-tax basis, such reimbursements will be treated as taxable income for the Participant and the Fund Office will issue the Participant a W-2 for each pre-tax premium reimbursement payment.

1. What Outside Medical Insurance Premium Payments or Costs Qualify for Reimbursement?

First, the medical insurance policy or plan must provide you (and if applicable your dependents) with coverage for medical services such as hospitalization, surgery, x-rays, prescription drugs, etc. **Premiums for medical insurance that do not include the Artist in the coverage do not qualify for reimbursement.**

Premiums for **Long Term Care insurance** that meet the Internal Revenue Code requirements for qualified Long Term Care insurance contracts **are covered.**

Premiums for Life Insurance and accidental death and dismemberment insurance, loss of income insurance or automobile insurance **are not covered.**

In addition, the premium must meet **all** of the following requirements (please also see Section 7 regarding forfeitures of contributions):

- It covers a policy that is in effect at the time the reimbursement is to be paid,
- The Participant is covered by this policy,
- The claim for reimbursement must be filed no later than six months after the end of the calendar year in which the premiums were payable,
- It must be documented with proof of payment and a description of the medical coverage provided (*i.e.*, a premium billing statement and canceled check, and, in the case of coverage by your spouse's employer, proof that additional premium was paid for your coverage and a statement that premiums were made on a post-tax basis or a pre-tax basis.) (Please also see the Claims Procedure outlined in Section 6.B).

2. What Medical Expenses Qualify for Reimbursement?

In order to qualify for reimbursement, a medical expense must meet **all** of the following requirements (please also see Section 7 regarding forfeitures):

- It must appear in the list of **“Expenses That Can Qualify for Reimbursement,”**
- It must be medically necessary,

- It has not been, or will not be, reimbursed from another source,
- The claim for reimbursement must be filed no later than six months after the end of the fiscal year in which the medical expense was incurred. (If you can document to the satisfaction of the Trustees that the claim was filed beyond this deadline because of extenuating circumstances related to the health of the participant or an immediate family member, the claim will be paid to the extent of the Individual Account balance at the time of filing.)
- It must be documented by a detailed statement from the claimant including the name, address, telephone number and tax identification number of the provider, plus a written statement from the claimant that the medical expense has not been reimbursed and is not reimbursable under any other health insurance and a written statement from the provider that the medical expense has been incurred and the amount thereof (Please also see the Claims Procedure outlined in Section 6.B), and it must be rendered by a licensed provider as mandated by law.

3. Expenses That Can Qualify for Reimbursement include:

- Abortion (Only legal abortions),
- Acupuncture (Reimbursement limited to 14 visits per calendar year),
- Treatment for Alcoholism/Substance Abuse (Reimbursement limited to 30 days inpatient visits and 50 outpatient visits per calendar year),
- Ambulance (To and from hospital only),
- Ambulette (To and from a medical facility only),
- Annual Physical Exam (Reimbursement limited to one exam per calendar year),
- Artificial Limb,
- Artificial Teeth,
- Bandages,
- Birth Control Pills (Must be prescribed by a doctor),
- Breast Pumps and Supplies,
- Chiropractors (Reimbursement limited to 40 visits per calendar year),
- Christian Science Practice,

- Cosmetic Surgery (only if it is necessary to improve a deformity arising from, or directly attributable to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease),
 - Crutches (Reimbursement for rental fee will not exceed the purchase price),
 - Deductibles and Co-Insurance Payments,
 - Dental Treatment,
 - Diaper/Diaper Service (Must be three years of age or older and required to relieve the effects of a particular disease),
 - Diagnostic devices (e.g. diabetes blood sugar test kits),
 - Electronic Body Scans,
 - Fertility enhancement (e.g. in vitro fertilization),
 - Guide dogs or service animals to assist a visually-impaired or hearing-impaired person, or a person with other physical disabilities,
 - Hearing Aids (Maximum reimbursement of two exams and one hearing aid device per ear per calendar year),
 - Hospital Services (Expenses for telephone, television and extra meals are not covered),
 - Inhalation therapy devices and other prescribed mechanical, electronic and other devices for the treatment of medical conditions,
 - Insulin Syringes,
 - Laboratory Fees,
 - Laetrile (Must be prescribed by a doctor and legally used),
 - Lodging that is primarily for and essential to medical care (cannot exceed \$50 for each night, for each individual),
 - Medical Care and Services,
 - Medicine (Prescription drugs, medications, insulin and certain over the counter medication if prescribed by a doctor for a specific medical condition),
 - Nursing Services (Nursing expenses must be for services connected with caring for the patient's conditions, such as giving medication or changing dressings. Services must be rendered by an RN, LPN or a health aid who reports to a licensed or certified home health care agency. Benefits are not available for services

rendered by immediate family members or some one who ordinarily lives in your home),

- Operations (Expenses must be for legal operations),
- Oxygen,
- Pregnancy Test Kits,
- Psychiatric Care, Psychoanalysis and Psychologist visits (Reimbursement limited to 40 inpatient and 50 outpatient visits per calendar year),
- Sterilization,
- Therapy,
- Transplants,
- Transportation primarily for, and essential to, medical care,
- Vision Care including exams, Eyeglasses, contact lenses (No benefits are payable for lenses which are not prescribed by an ophthalmologist or an optometrist), cost of equipment and materials required for using contact lenses (such as saline solution and enzyme cleaner) and laser surgery,
- Well Baby Care (Reimbursement limited to 40 inpatient and 50 outpatient visits per calendar year),
- Wheelchair (Reimbursement for rental fee will not exceed purchase price),
- Wigs (purchased by patients, on advice of a physician, who lose hair due to disease),

and

- X-ray Fees (Including one routine mammogram per year),

6. CLAIMS & APPEALS PROCEDURES

This section describes the procedures for filing claims for benefits from the AGMA Health Fund Plan B (the Plan). It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

How to File a Claim

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. In order to file a claim for benefits offered under this Plan, you must submit a completed claim form. Simple inquiries about the plan's provisions that are unrelated to any specific benefit claim will not be

treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

A claim form may be obtained from the Third Party Administrator, Administrative Services Only, Inc., at the following number: 1-866-263-1185, or through its website, www.asonet.com, or from the Fund Office, 212-765-3664, or through its website http://www.agmaretirement-health.org/pdf_docs/planbform.pdf.

A. Filing Claims - Reimbursement of Insurance Premiums:

After your insurance premium has been paid (other than insurance provided through TEIGIT or the AGMA Health Fund Plan A), you may apply for reimbursement with the Third Party Administrator (see Section 3 for address). If you choose to purchase insurance through TEIGIT, the Third Party Administrator will automatically deduct the premium from your Individual Account, and therefore, there is no need to file a claim for reimbursement.

To file a claim: Attach copies of the premium statement and proof of payment (i.e. a copy of canceled check); and/or copies of pay stubs that show the payment of medical insurance premiums for your coverage and a statement that premiums were made on a post-tax basis or on a pre-tax basis. If the information you submit is insufficient to prove payment of a premium under a health insurance plan provided through an employer, it will be necessary to furnish a statement from the employer indicating that additional pay was taken out of a paycheck to include you in the employer's plan.

B. Filing Claims - With Individual Insurance Carriers:

Once you have incurred a medical expense that is covered by an insurance policy (including but not limited to insurance through TEIGIT and the AGMA Health Fund Plan A), you must file your claim for benefits directly with that insurance company. Plan B will not make claims determinations on expenses that are covered by an insurance policy.

For example, if you incur a medical expense that **is** covered by an insurance policy of which you are a beneficiary, you must file your claim for payment of that expense directly with the insurance company, not with Plan B or the Third Party Administrator. Plan B will only accept claims for the reimbursement of insurance premiums and uninsured or non-reimbursed medical expenses; not claims paid or payable under an insurance policy.

C. Filing Claims - Reimbursement of Uninsured Medical Expenses:

After you incur a qualifying medical expense and receive an Explanation of Benefits voucher from all medical insurance plans that you are covered under, you may apply for reimbursement of the unpaid balance of your expenses. Do *not file* a claim if your expense is paid in full by another source or if the incurred expense does not meet the requirements for qualified expenses.

To file a claim: Obtain a claim form from the Third Party Administrator or the Fund Office. Complete it in its entirety and sign the applicable statements, Attach copies of the itemized bills (e.g., a universal/CMS 1500 or UB 92 form) for the qualified expenses and the corresponding Explanation of Benefit vouchers to the claim form. All claims must meet the requirements to Qualify for Reimbursement as a medical expense as described in Section 5.3 to be considered eligible for reimbursement. *You must file separate completed, signed and dated forms for each family member.*

Reimbursements are payable only to you, the Participant, not to an insurance company or medical provider.

The following information must be completed in order for your request for benefits to be a claim, and for the Third Party Administrator to be able to decide your claim.

- Participant name
- Patient name
- Patient Date of Birth
- Date of Service
- CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association)
- ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services)
- Billed charge
- Number of Units (for anesthesia and certain other claims)
- Federal taxpayer identification number (TIN) of the provider
- Billing name and address
- If treatment is due to accident, accident details.

When Claims Must Be Filed

Claims should be filed as soon as possible after being incurred. However, there is a grace period that provides for the processing and consideration of claims that are filed by six months after the close of the Plan's fiscal year in which they are incurred. **The Plan's fiscal year is September 1 – August 31.**

For example, if you have a qualifying medical service on October 24, 2011, the grace period allows the claim to be filed as late as February 28, 2013. A second example would be for a qualifying medical service on May 2, 2012, the grace period allows the claim to be filed as late as February 28, 2013.

If a claim is filed beyond the deadline provided by the above noted grace period, the Trustees may consider any evidence of extenuating circumstances related to the health of the participant or an immediate family member. If the Trustees then determine that an extension is warranted, the claim will be processed and considered for payment to the extent of the Individual Account balance at the time it is filed.

Where To File Claims

Your claim will be considered to have been filed as soon as the Third Party Administrator receives it. Claims should be filed with the Third Party Administrator at the following address:

Administrative Services Only, Inc.
303 Merrick Road, Suite 300
Lynbrook, NY 11563-9010

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from either the Third Party Administrator or the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

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

You do not have to submit an additional claim form if your bills are for a continuing disability and you have filed a claim within the past calendar year period. Mail any further bills or statements for any Medical or Hospital services covered by the Plan to the Third Party Administrator as soon as you receive them.

Ordinarily, you will be notified of the decision on your claim within 30 days from The Third Party Administrator's receipt of the claim. The Third Party Administrator may extend this period one time up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Third Party Administrator expects to render a decision.

If an extension is needed because the Third Party Administrator needs additional information from you, the extension notice will specify the information needed. In that case you will have 60 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 60 days or until the date you respond to the request (whichever is earlier). The Third Party Administrator will then have 15 days to make a decision on a **claim** and notify you of the determination.

D. Your Rights to Review and Appeal

This section applies to all claims filed pursuant to this Plan. A claim for an expense covered under an individual insurance policy is not reviewed by the Third Party Administrator, and thus this section does not apply (See Section 6.C).

If your claim for reimbursement (either under the Reimbursement of Insurance Premiums or Individual Insurance Carriers or Reimbursement of Uninsured Medical Expenses) is denied because there are insufficient funds in the Individual Account at the time the claim is processed, you may resubmit the claim once there are adequate funds in your Individual Account, provided that your renewed claim meets all time restrictions set out in Sections 5, 6, and 7. However, no claims will be honored for times when you are not eligible for benefits under the Eligibility rules of this Plan.

Benefits under the Plan may be denied, in whole or in part, in instances where a claim is filed improperly, a claim is not covered under the Plan or the individual is not eligible to receive the benefit claimed.

Notice of Decision

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

- The specific reason(s) for the determination
- Reference to the specific Plan provision(s) on which the determination is based
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that is available upon request at no charge.

REQUEST FOR REVIEW OF DENIED CLAIM

If your claim for benefits is denied, in whole or in part, the Third Party Administrator will provide you with a written explanation of the reasons for the denial within 90 days from the date your claim is received. In addition to a description of the reason for the denial, you will be advised of the specific provisions of the Plan on which the

denial is based. You will be instructed as to exactly what, if any, additional information or material is needed to process your claim and why it is needed. Finally, you will be advised of the steps which should be taken to appeal the denial of benefits to the Board of Trustees of the AGMA Health Fund Plan B.

Review Process

The review process works as follows:

You have the right to review documents relevant to your claim. A document, record, or other information is relevant if it was relied upon by the Third Party Administrator in making the decision; if it was submitted, considered or generated (regardless of whether it was relied upon); or if it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Third Party Administrator on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as determination that the treatment or service was not medically necessary, or was investigational or Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Timing of Notice of Decision on Appeal

The Third Party Administrator will send you a notice of decision on review within 60 days of receipt of the appeal

Notice of Decision on Review

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

- The specific reason(s) for the determination
- Reference to the specific plan provision(s) on which determination was based
- A Statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review

- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that is available upon request at no charge
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that is available upon request at no charge.

Limitation on When a Lawsuit may be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under Section 502 (a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than 3 years after the end of the year in which medical or dental services were provided, or if the claim is for short-term disability benefits, more than 3 years after the start of the disability.

7. FORFEITURES

The AGMA Health Fund Plan B Medical Reimbursement Program has a Forfeiture Provision that is applied each year against infrequently used Individual Accounts. The Plan requires employer contributions to be used within three fiscal years of receipt. Any contributions in an Individual Account that are not used for services covered by this Plan -- the reimbursement of qualified medical expenses or premiums for health insurance that includes the participant, or applied to the payment of premiums for health insurance you may purchase from the AGMA Health Fund Plan A or through TEIGIT - for a period of three consecutive fiscal years will be forfeited by the participant. However, the maximum amount that can be forfeited from an Individual Account in any one year is \$500.

For example, contributions received and deposited in a Participants' Individual Account by August 31, 2008, if not used to reimburse expenses incurred by August 31, 2011, and if not submitted to the Third Party Administrator by February 28, 2012, will be forfeited up to \$500 and used to offset the Administrative Expenses of the Health Fund (Plans A and B). Thus, if you incur no expenses in the Fiscal Years ending August 31, 2009, 2010, or 2011 and have \$800 contributed to your Individual Account between September 1, 2007 and August 31, 2008, \$500 will be forfeited on March 1, 2012 and used to offset Administrative Expenses for all Fund participants.

Any amount subject to forfeiture above the \$500 limit is carried over for another fiscal year. In the above example, the \$300 remaining would be available for expenses incurred by August 31, 2012 and submitted by February 28, 2013 or subject to forfeiture on March 1, 2013.

Any participant who can demonstrate with evidence satisfactory to the Trustees that he or she was unaware of the forfeiture because the Third Party Administrator had an incorrect address on file may apply within 24 months of the forfeiture for reinstatement of any amounts forfeited. The Trustees had previously amended the Plan to extend the time you have to use your contributions from one year to three years.

Upon the death of a Participant with an Individual Account, any remaining balance may be used for eligible expenses of the Participant prior to his or her death, provided they are submitted timely. Any amounts remaining after the time to submit expenses for the Participant has passed shall be forfeited.

A portion of the forfeited contributions are applied against this Plan's administrative expenses, thus reducing such charges to participants who actively draw benefits from the Fund. Another portion is applied to the AGMA Health Fund Plan A's administrative expenses thus reducing its cost to everyone it covers, including the Plan B participants who buy it. The Fund will apply 90% of the amounts forfeited to the expenses of Plan A and Plan B in proportion to each Plan's administrative expenses in the prior fiscal year. Ten percent of the amounts forfeited each Fiscal Year will be held as a reserve for one year against reclaimed individual account assets.

You are urged to use your account balances to cover reimbursable expenses without delay. This will help you receive the most benefit from the Plan and avoid or limit the possibility of forfeiture.

If you have any questions regarding the Forfeiture Provisions, your Individual Account, or the Medical Reimbursement Program, please contact the Third Party Administrator:

Administrative Services Only, Inc.
303 Merrick Road, Suite 300
Lynbrook, NY 11563
Toll Free 1-866-263-1185

8. INDIVIDUAL ACCOUNTS

A. Determination of Amount in Individual Accounts

As soon as practicable after each Valuation Date, the Trustees shall calculate and determine the amount in each Participant's Individual Account. The amount in each Individual Account as of the most recent Valuation Date shall be the total of the following:

- (1) The amount in the Individual Account as of the last previous Valuation Date, **plus**
- (2) The contributions made on behalf of the Participant during the relevant Valuation Period less any transfers to TEIGIT or the AGMA Health Fund

Plan A made since the last preceding Valuation Date and less any reimbursements for medical expenses or outside insurance premiums, **minus**

(3) An administrative charge of \$5, or the balance of the Individual Account if less, plus/minus

(4) The investment return/loss of Plan B allocable to the Individual Account in accordance with Section 8.C if there remains a positive balance after the adjustments set forth in (1) through (3) above, **minus**

(5) The administrative expense charge as established by the Trustees to be charged to each Individual Account in accordance with Section 8.B, **minus**

(6) Any contributions forfeited pursuant to Section 7.

B. Allocation of Administrative Expenses

At each Valuation Date, the Board of Trustees shall first apply the total amount of administrative charges deducted under Subsection 8(A)(3), above, to pay the Administrative Expenses of Plan B for the preceding quarter. If all the administrative charges deducted under 8(A)(3) are insufficient to pay the Administrative Expenses of Plan B for the preceding quarter, the Board of Trustees shall next deduct a pro rata share of the remaining Administrative Expenses of Plan B for the preceding quarter.

C. Investment Return

At each Valuation Date, the Board of Trustees shall add to/subtract from each Individual Account with a positive balance a pro rata share of the investment return/losses derived from the change in Fund assets in the preceding quarter. Investment Return consists of the net change in the market value of the Fund assets, including interest and dividends.

D. Right to Individual Accounts

The fact that Individual Accounts are established and valued as of each Valuation Date shall not vest in any Participant or others any right, title or interest in the Fund, or in the Individual Account, except to defray the cost of health insurance that a Participant elects to purchase through TEIGIT or the AGMA Health Fund Plan A, or qualified medical expense reimbursements, including premiums for other health insurance that covers the Participant.

9. PLAN AMENDMENT, MODIFICATION AND TERMINATION

The Board of Trustees reserves the right, within its sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of this Plan (including any related documents and underlying policies), at any time and for any reason, by action of the Board of Trustees, or any duly authorized agent(s) of

the Board of Trustees, in such manner as may be duly authorized by the Board of Trustees.

Without limiting any other Plan provisions for the discontinuance of coverage, your coverage shall terminate when the Board of Trustees terminates the Plan or when the Plan is terminated for any reason, or when you are no longer eligible to receive benefits under the Plan, whichever occurs first.

Neither you, your beneficiaries, nor any other person have or will have a vested or nonforfeitable right to receive benefits under the Plan.

If the Plan is terminated for any reason, any money remaining in the Fund will be used

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

No money will revert to the Contributors.

10. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

According to Federal law, you might be required to enroll your children in the Plan due to a Qualified Medical Child Support Order (QMSCO) or a National Medical Support Order (NMSO) – a support order of a court or state administrative agency that usually results from a divorce or legal separation. The Board of Trustees must honor any “qualified medical child support order” issued by a court or administrative agency which obligates you to pay medical child support and which allocates some portion of your Plan B Individual Account to meet these obligations. Plan B will pay such obligations up to the amount in your Individual Account. The procedures used to determine if a medical child support order is qualified are on file at the Third Party Administrators office. The procedures are available upon request from the Fund Office.

11. FAMILY AND MEDICAL LEAVES OF ABSENCE

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

- the birth, adoption, or placement with you for adoption of a child;
- to provide care for a spouse, child, or parent who is seriously ill; or
- your own serious illness.

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

- have worked for a covered employer for at least 12 months;

- have worked at least 1,250 hours over the previous 12 months; and
- work at a location where at least 50 employees are employed by the employer within 75 miles.

The Fund will maintain the employee's eligibility status until the end of the leave, provided the Contributor properly grants the leave under the FMLA and the Contributor makes the required notification and payment to the Fund. Of course, any changes in this Plan's terms, rules or practices that go into effect while you are away on leave apply to you and your dependents. the same as to active employees and their dependents. Call your Employer to determine whether you are eligible for FMLA leave. Call the Fund Office regarding coverage during FMLA leave.

12. BOARD OF TRUSTEES HIPAA STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and privacy rules issued under that law, gives you certain rights with respect to your health information, and requires that the American Guild of Musical Artists ("AGMA") Health Fund's health plan (referred to below as the "Plan") to protect the privacy of your personal health information. A complete description of your rights under HIPAA will be found in the Plan's Notice of Privacy Practices, which must be distributed to all Plan participants by April 14, 2004 (or when you enroll in the Plan, if you enroll after April 14, 2004) and which will be available to anyone upon request from the Office of the AGMA Health Fund (referred to below as the "Fund") or on the website www.agmaretirement-health.org. The statement that follows is not intended and cannot be considered to be the Plan's Notice of Privacy Practices.

Since the Plan is required to keep your health information confidential, before the Plan can disclose any of your health information to the Board of Trustees, which acts as the sponsor of the Plan, the Trustees must also agree to keep your health information confidential. In addition, the Trustees must agree to handle your health information in a way that enables the Plan to follow the rules in HIPAA. The health information about you that the Board of Trustees receives from the Plan (except for any information that is received in connection with the Supplemental Workers' Compensation benefit) is referred to below as "protected health information." Before the Plan provides your protected health information to the Board of Trustees, the Trustees must certify that the Plan documents have been changed to include the following language.

The Board of Trustees agrees to the following rules in connection with your protected health information:

- The Board of Trustees understands that the Plan will disclose protected health information to the Board of Trustees only for the Trustees' use in plan administration functions.
- Unless it has your written permission, the Board of Trustees will use or disclose that protected health information only for plan administration, as otherwise permitted by this Summary Plan Description, or as required by law.

- The Board of Trustees will not disclose your protected health information to any of its agents or subcontractors unless the agents and subcontractors agree to handle your protected health information and keep it confidential to the same extent as is required of the Board of Trustees in this Summary Plan Description.
- The Board of Trustees will not use or disclose your protected health information for any employment-related actions or decisions, or with respect to any other benefit or other employee benefit plan sponsored by the Board of Trustees without your specific written permission.
- The Board of Trustees will report to the Plan's Privacy Officer if the Trustees become aware of any use or disclosure of protected health information that is inconsistent with the provisions set forth in this Summary Plan Description.
- The Board of Trustees will allow you, through the Plan, to inspect and photocopy your protected health information, to the extent, and in the manner, required by HIPAA.
- The Board of Trustees will make available to the Plan your protected health information for amendment and incorporation of any such amendments to the extent, and in the manner required by HIPAA.
- The Board of Trustees will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of protected health information received from the Plan in order to allow the Secretary to determine the Plan's compliance with HIPAA.
- The Board of Trustees will keep a written record of certain types of disclosures it may make of protected health information, so that it may make available to the Plan the information required for the Plan to provide an accounting of certain types of disclosures of protected health information.
- The following categories of employees under the control of the Board of Trustees are the only employees who may obtain protected health information in the course of performing the duties of their job with or on behalf the Board of Trustees: the Executive Director, the Assistant to Executive Director, the Fund's IT personnel, and all other Fund claims staff routinely responsible for administration of Plan claims for the Fund. Additionally, the individual Trustees may receive health information from the Plan in the course of hearing appeals or handling other Plan administration functions. These employees and the individual Trustees will be permitted to have access to and use the protected health information only to perform the Plan administration functions that the Board of Trustees provides for the Plan.
- The employees listed above will be subject to disciplinary action and sanctions for any use or disclosure of protected health information that violates the rules set forth in this Summary Plan Description. If the Board of Trustees becomes aware of any such violations, the Board of Trustees will promptly report the violation to the Plan's Privacy Officer and will cooperate with the Plan to correct

the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the individual(s) whose privacy has been violated.

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

13. ADMINISTRATIVE INFORMATION

Plan Name: AGMA Health Fund Plan B

Employer Identification Number: 13-6701211

Plan Number: 501

Fiscal Year End: August 31st

Plan Year: September 1 - August 31

The Plan is a health and welfare plan. A joint Board of Trustees, consisting of an equal number of Contributors and AGMA representatives is the "Plan Administrator." The Board of Trustees has been designated as the agent for the service of legal process. Service of legal process may be made upon the Executive Director, on behalf of the Board of Trustees, at the Fund Office address:

AGMA Health Fund Plan B
1430 Broadway, Suite 1203
New York, NY 10018

All contributions to the Plan are made in accordance with collective bargaining agreements with AGMA. The Third Party Administrator will provide you, upon written request, with information as to whether a particular company or organization is a contributor to this Plan on behalf of Participants working under the collective bargaining agreement. If you request in writing, the Third Party Administrator will also provide you with a copy of the collective bargaining agreements or make it available for examination by participants. Benefits are provided from the Plan's assets, which consist of contributions paid under the provisions of the collective bargaining agreements and investment earnings thereon, and are held in a trust fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses of Plan B.

The Plan's assets consist of U.S. Fixed Income Securities and U.S. Equity Investments that are managed and held in custody by a professional investment firm.

The Plan shall be administered and operated by the Plan Administrator, in its sole and absolute discretion. The Plan Administrator, and any duly authorized representative thereof, shall have the complete authority to administer, apply and interpret the Plan (and any related documents) and to decide all matters arising in connection with the operation or administration of the Plan. All determinations made by the Plan Administrator with respect to any matter arising under the Plan (and any other Plan document) shall be final, conclusive and binding on all parties.

As a participant in the AGMA Health Fund Plan B, 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 Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit 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.

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 (AGMA), 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 and Appeals Procedures section of this document.
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 Plan's Claims and Appeals section on the requirement to appeal a denied claim 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).

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AGMA HEALTH FUND PLAN B

Administered by:

Administrative Services Only, Inc.
PO Box 9010
303 Merrick Road, Suite 300
Lynbrook, New York 11563-9010

1-866-263-1185

www.asonet.com