ENTERTAINMENT INDUSTRY Flex Plan

2026

Summary of Benefits

California / CA

This Summary of Benefits provides a brief overview of benefits available under the different Insurance Carriers.

The monthly rates shown are effective through 12/31/2026.

For the sake of brevity and simplicity, many details have been omitted. In case of a conflict between this summary and insurance policies and/or rates, the provisions of the insurance policies will govern your rights and benefits. Some services are limited or not covered. Benefits are subject to change annually without prior notice. Please refer to the detailed Evidence of Coverage brochures and search for providers on our website:

www.flexplan.com/insurance

If you do not have internet access, you may request this information from our Member Services Department.

Anthem Blue Cross - Prudent Buyer EPO

This Plan offers comprehensive coverage with direct access to quality providers through the Anthem Blue Cross Prudent Buyer EPO / Blue Card provider network. Most employees will find that with the Anthem Blue Cross extensive provider network, their physician(s) are in-network ensuring a smooth transition and continuity of care. When accessing care through the Anthem Blue Cross provider network, the provider will submit the claim to Anthem on your behalf, eliminating the need for you to submit a claim form to Anthem. Once the provider submits the claim, Anthem will pay the provider directly minus member cost share if applicable. There is no coverage for the usage of out of network providers and Anthem Blue Card EPO — Plan 60 is the default option.

Network Participation: US Hospitals: 97% US Physicians: 95%

Additional Benefit Information: Generally, co-payment amounts are not subject to plan deductibles. Percentages shown are paid by Anthem Blue Cross AFTER deductible has been satisfied.
No exclusions on pre-existing conditions.

	Plan 60		Plan 80	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Out of Pocket Maximum	$6,000 per person $12,000 per family (including deductible, co-pay & co-insurance)	Not Covered	$6,000 per person $12,000 per family (including deductible, co-pay & co-insurance)	Not Covered
Deductible	$4,500 per person max $11,250 per family	Not Covered	$1,650 per person max $4,125 per family	Not Covered
Hospital	* 40%	Not Covered	* 20% after $100 fee	Not Covered
Emergency Care +	* 40% after $150 fee (fee waived if admitted)	Covered as In Network	* 20% after $200 fee (fee waived if admitted)	Covered as In Network
Preventive Care Services	No Charge	Not Covered	No Charge	Not Covered
Doctor Visits				
Office Visit	$40 co-pay	Not Covered	$30 co-pay / $50 Specialist	Not Covered
Video Doctor Visit	$20 co-pay (deductible waived)	Not Covered	$15 co-pay (deductible waived)	Not Covered
X-ray & Lab	$40 co-pay (deductible waived)	Not Covered	$30 co-pay (deductible waived)	Not Covered
Pregnancy & Maternity	Paid as any other condition	Not Covered	Paid as any other condition	Not Covered
Calendar Year Pharmacy Deductible	$250 per person max $500 per family (excluding Generic drugs)	Not Covered	$100 per person max $200 per family (excluding Generic drugs)	Not Covered
Pharmacy Out of Pocket Maximum	$1,600 per person max $3,200 per family (including deductible)	Not Covered	$1,000 per person max $2,000 per family (including deductible)	Not Covered
Prescriptions (30 day supply) Maintenance drugs subject to 90 day supply co-payments	Generic $10 (deductible waived) Preferred $25 Non-Preferred $50 Specialty 30% of prescription drug max allowed amount (max $150 co-pay per fill)	Generic Not Covered Preferred Not Covered Non-Preferred Not Covered Specialty Not Covered	Generic $10 (deductible waived) Preferred $25 Non-Preferred $50 Specialty 30% of prescription drug max allowed amount (max $150 co-pay per fill)	Generic Not Covered Preferred Not Covered Non-Preferred Not Covered Specialty Not Covered
Mail Order Prescriptions (90 day supply) **Available through Mail Order or at Walgreens** Maintenance drugs subject to 90 day supply co-payments	Generic $10 (deductible waived) Preferred $50 Non-Preferred $100 Specialty 30% of prescription drug max allowed amount (max $300 co-pay per fill)	N/A	Generic $10 (deductible waived) Preferred $50 Non-Preferred $100 Specialty 30% of prescription drug max allowed amount (max $300 co-pay per fill)	N/A

*** After deductible is satisfied** **U&C = Usual and Customary Charges** **+ Refer to Evidence of Coverage (EOC) for definition of emergency.**
 # Additional deductible for out of network hospital or residential treatment center if utilization review is not obtained

Single	$733.75
2-Party	$1,534.82
Mbr + Child(ren)	$1,381.91
Family	$2,190.24

Includes $2.50 administration fee

Single	$1,414.42
2-Party	$2,962.53
Mbr + Child(ren)	$2,667.03
Family	$4,229.19

Includes $2.50 administration fee

Kaiser HMO

Kaiser is a pre-paid plan. All services and prescriptions must be obtained at a Kaiser facility.

No exclusions on pre-existing conditions.

	Kaiser
Out of Pocket Max	15% coinsurance with out of pocket max of $3,000 per member $6,000 per family
Deductible	$500 per Individual $1,000 per family
Hospital	*15% Coinsurance
Emergency Care +	*15% Coinsurance
Preventive Care Services	No charge
Doctor Visits	
Office Visit	$30 co-pay
Specialist	$40 co-pay
Video Doctor Visit	$0 co-pay
X-ray & Lab	$15/encounter
Pregnancy & Maternity	
Office Visit	No charge (deductible does not apply)
Childbirth & Delivery	*15% Coinsurance
Calendar Year Pharmacy Deductible	N/A
Pharmacy Out of Pocket Maximum	N/A
Prescriptions	$15 Generic (30 day supply) $35 Non-generic (30 day supply) Specialty Items 20% Coinsurance (not to exceed $250) for up to a 30 day supply
Mail Order Prescriptions	$30 Generic (100 day supply) $70 Non-generic (100 day supply) Specialty Items 20% Coinsurance (not to exceed $250) for up to a 30 day supply

+ Refer to Evidence of Coverage (EOC) for definition of emergency
*** After deductible is satisfied**

	Northern California	Southern California
	Group No: 608124	Group No: 103150
Single	$1,340.49	$709.84
2-Party	$2,944.87	$1,557.45
Mbr + Child(ren)	$2,677.47	$1,416.18
Family	$3,787.17	$2,002.44

Includes $2.50 administration fee

Delta PPO **Delta Care USA (DHMO)**

Vision Service Plan

Delta PPO is an indemnity dental plan. This is Delta's most comprehensive dentist network, with about 3 out of 4 U.S. dentists participating. Patients have the option to use any dentist anywhere in the world. If you visit a Delta dentist, you'll enjoy the advantage of pre-negotiated fees and convenient claims handling.

There is a $50 per person calendar year deductible, $150 family maximum. The calendar year maximum benefit is $1,000 per person; Diagnostic and Preventive procedures do **not** apply towards the $1,000 per person maximum benefit.

Delta Care USA (DHMO) is Delta Dental's dental health maintenance organization (DHMO). When you enroll in Delta Care USA you must select one Delta Care USA dental office to provide primary care for you and your family.

VSP features a panel of over 39,000 doctors to provide professional vision care for persons covered under the Plan.

The Plan is designed to cover visual needs rather than cosmetic materials. This concept assures the finest quality professional care and materials at a uniform cost.

	Delta PPO	Delta Care USA
Preventive & Diagnostic (not subject to deductible)		
Oral Exams	# + 80%	No charge
X-rays	# + 80%	No charge
Prophylaxis: (teeth cleaning)	# + 80% 2 per calendar year	No charge 1 per 6 month period
# Diagnostic & Preventive procedures are not subject to the calendar year maximum.		
+ **Benefits paid at 100% if services are provided by a Delta EPO Dentist.**		
Restorative		
Amalgam one surface, permanent (filling)	80%	No charge
Tooth resin filling (posterior)	80%	$45.00
Tooth resin filling (anterior)	80%	No charge
Crown-porcelain/ceramic	50%	$195.00
Prosthetics		
Denture-complete upper or lower	* 50%	$100.00
Bridge-porcelain fused to metal, per unit	* 50%	$135.00
* Waiting Period: 12 months of continuous coverage		
Endodontics - Root Canal Therapy		
One Canal	80%	$45.00
Two Canals	80%	$90.00
Apicoectomy	80%	No charge
Periodontics		(per quadrant)
Subgingival Curettage	80%	No charge
Gingivectomy or Gingivoplasty	80%	$80.00
Orthodontics		
Pre-orthodontic treatment visit	N/A	$25.00
Co-payment	50%	Pre-treatment records $200.00 Child Fee $1,700.00 Adult Fee $1,900.00
Lifetime Maximum	$1,000.00	N/A
Orthodontic Retention	N/A	$275.00

In Network	
Co-payment	$10
Vision Exam	Every 12 Months
Lenses *	Every 12 Months
Frame ($170 Maximum Allowance)*	Every 24 Months
or	
Contacts ($170 Maximum Allowance) * +	Every 12 Months

Out of Network	
Co-payment	$10
Examination Maximum Payment	$50
Single Vision Lenses Maximum Payment	$50
Bifocal Lenses Maximum Payment	$75
Trifocal Lenses Maximum Payment	$100
Frame Maximum Payment	$70
Contact Lenses Maximum Payment	$105

* Only if needed

\+ When you choose contacts instead of glasses, your $150 allowance applies to the cost of your contacts and the co-pay for your fitting and evaluation exam will not exceed $60. This exam is in addition to your vision exam to ensure proper fit of your contacts. If you select contacts, you will be eligible for a frame 24 months from the date the contacts were obtained. Polycarbonate lenses will be covered in full for dependents up to age 26.

Single	$41.14
2-Party	$76.67
Mbr + Children	$89.78
Family	$128.25

Includes $1.00 administration fee

Single	$23.82
2-Party	$39.32
Mbr + Children	$41.57
Family	$56.17

Includes $1.00 administration fee

Single	$9.67
2-Party	$14.91
Mbr + Children	$15.17
Family	$23.86

Includes $0.50 administration fee

Group Term Life Insurance

Group Term Life and Accidental Death and Dismemberment (AD&D) insurance benefits are provided by Dearborn National for the member only. Two coverage options are available:

Option 1: $20,000 *

Life Benefit of $20,000 and an additional Accidental Death and Dismemberment (AD&D) Benefit of $20,000. **No health underwriting is required for initial enrollment. If coverage is waived or lapses, future enrollment will be subject to medical underwriting**.

Option 2: $50,000 *

Life Benefit of $50,000 and an additional Accidental Death and Dismemberment (AD&D) Benefit of $50,000. A brief health questionnaire must be completed. Carrier approval is required.

If you elect the $50,000 benefit, you will be enrolled under the $20,000 option (if not previously waived or lapsed) until approval is received from the Carrier.

If you are not approved for the $50,000 benefit level, you will remain at the $20,000 benefit level (if $20,000 coverage was not previously waived or lapsed).

* Life Benefits reduce 35% at age 65 and 50% at age 70.

Member Only ($20,000)	$7.62
Member Only ($50,000)	$16.80

Includes $0.50 administration fee

Disability Insurance

Disability Insurance benefits are provided by Dearborn National. Coverage is available for the member only. This benefit is required, subject to your eligibility. Please refer to the Summary Plan Description (SPD) for more information. In addition, if you are 65 or older, retired from full-time employment and are receiving a Social Security retirement benefit, you may waive coverage within 30 days of commencement of receipt of Social Security Benefits, during your initial or open enrollment period.

Standard Option: 50% of wages *
90 day waiting period

No health underwriting is required for initial enrollment. **If coverage is waived, future enrollment will be subject to medical underwriting.** In order to waive coverage, you must be able to certify you have another disability insurance contract in force.

High Option: 60% of wages *
60 day waiting period

A brief health questionnaire must be completed. Carrier approval is required. If you elect the High Option, you will be enrolled at the standard level (subject to your eligibility, see SPD) until approval is received from the Carrier. If you are not approved for the High Option, you will remain at the Standard benefit level (if coverage was not previously waived).

* Maximum Monthly Benefit: $5,000. Dearborn National will pay up to 50% or 60% (depending on option selected) of your pre-disability work earnings based upon wages earned by contributions made to the Flex Plan (examples follow):

	Monthly Benefit	
Annual Salary	**Standard Option**	**High Option**
$20,000	$833	$1,000
$60,000	$2,500	$3,000
$80,000	$3,334	$4,000
$100,000	$4,167	$5,000

Working Requirements: You must have worked in covered employment within 90 days of disability.

Benefit Payment Period: 60 months (reduced at age 65, minimum payment period 1 year).

Pre-existing Conditions: Are excluded for the first 12 months of coverage.

Deductible Income Sources: Your monthly benefit may be reduced by certain sources, e.g. Social Security, Worker's Compensation and State Disability Income.

Survivor Benefit: 3 times the monthly benefit without reduction by Deductible Income.

Individual Disability Policy: If you already have an individual Disability Policy, check with your carrier to see how this benefit would work with your policy.

Taxability: The earnings from this policy are taxable.

Member Only (Standard Option)	$17.09
Member Only (High Option)	$32.71

Includes $0.50 / $1.00 administration fee

ENTERTAINMENT INDUSTRY Flex Plan

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