PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

# HEALTH FUND
# SUMMARY PLAN DESCRIPTION

Effective March 31, 2024


**PWGA PENSION & HEALTH PLANS**
2900 W. Alameda Avenue, Suite 1100
Burbank, CA 91505-4267
(818) 846-1015 • (800) 227-7863
wgaplans.org

**PWGA PENSION & HEALTH PLANS**
2900 W. Alameda Avenue, Suite 1100
Burbank, CA 91505-4267
(818) 846-1015 • (800) 227-7863
*wgaplans.org*

# CONTENTS

# Contents

# Contents

# Contents

# INTRODUCTION

The Board of Trustees (Trustees) is pleased to provide you with this Summary Plan Description (SPD), which describes the benefits and eligibility rules under the Writers' Guild-Industry Health Fund (Fund) and the Producer-Writers Guild of America (PWGA) Health Plan (the Health Plan or the Plan) effective as of March 31, 2024. This SPD constitutes the Fund's Plan document and supersedes all prior SPDs, Plan rules and other notices for health coverage rendered or received on or after March 31, 2024. As such, this SPD along with the Summary of Benefits will serve as the primary guide and reference concerning all aspects of your health care benefits and how to use them as of such date. For health coverage rendered or received prior to March 31, 2024, please refer to the Fund's prior SPD, subsequent Summaries of Material Modifications (SMMs), notices, and other documents for the applicable period. The SPD (and prior SPD and correspondence about the Fund) is also available on the Fund's website at wgaplans.org.

PWGA encourages every Participant to review this SPD carefully so that you are aware of all the benefits to which you are entitled, as well as some important restrictions and responsibilities. Our goal is to present and explain your benefits in language that is easy to understand. However, sometimes, for legal reasons, we must use terms that are not used in everyday conversation. Terms and phrases that fall into this category are either explained in the context of their sections or are listed alphabetically in the Glossary starting on page 226 of this SPD.

Periodically, changes are made to the Health Plan. As a Participant, you are notified through an SMM letter or special mailing. Those SMMs become part of this SPD. For easy reference, we recommend that you keep copies of the SMMs and your Health Plan correspondence with your SPD.

If you access the online version of this SPD, you will see a "working copy" that incorporates all of the most recent SMM changes as they are implemented. You may also access older versions of the SPD, as needed.

The nature and extent of benefits provided by the Writers' Guild-Industry Health Fund and the rules governing eligibility are determined solely and exclusively by the Trustees of the Fund. Employees of the Fund Office are available to assist Participants, but they have no authority to alter benefits or eligibility rules. Any interpretations or opinions given by employees of the Fund Office are not binding upon the Trustees and cannot enlarge or change such benefits or eligibility rules.

The Trustees and the Benefits Committee are authorized and empowered to determine a Participant's entitlement to or application for benefits under the Health Plan, and any such decision by the Trustees or Benefits Committee is final and binding upon all affected parties. The Trustees and the Benefits Committee have ultimate authority to administer the Health Plan; they are empowered to execute all such agreements, adopt and promulgate all such reasonable rules and regulations, take all such proceedings, and exercise all such rights and privileges necessary to establish, maintain, and administer the Health Plan.

Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment. Receipt of this document does not guarantee eligibility for Plan benefits. No individual shall have accrued or vested rights to benefits under this Plan. A vested right refers to a benefit that an individual has earned a right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed.

Additional information about the Fund is available in other Plan documents including, without limitation, the Fund's Agreement and Declaration of Trust and insurance or service provider contracts (collectively referred to as "Official Plan Documents"). While we have made every effort to ensure that the SPD provides an accurate explanation of the Fund's Official Plan Documents, in the event that there is a conflict between this SPD and the Official Plan Documents, the Official Plan Documents will govern.

# Introduction

The benefits described in this SPD may be reduced, modified, or discontinued by action of the Trustees (or their authorized designee) at any time. These benefits and eligibility of any person (including, without limitation, an active Participant, Certified Retiree, or dependent) to receive these benefits are not vested or guaranteed and may be changed at any time.

If you have any questions about any terms of your coverage in general, please call the Fund Office: (818) 846-1015 or toll free outside the Los Angeles area at (800) 227-7863.

**NOTE:** Calls may be recorded for quality purposes.

**IMPORTANT NOTE:** The Fund and the Writers Guild of America, East, Inc. and the Writers Guild of America, West, Inc. are separate legal entities.

All benefits described in this SPD are provided by the Fund (and not the Writers Guild of America, East, Inc. or the Writers Guild of America, West, Inc. (collectively referred to as the "WGA"), which are separate legal entities). Accordingly, if you have a question regarding your benefits under the Fund, please do not contact the WGA. Instead, direct all questions concerning the Fund to the Fund's Administrative Office.

The Fund is what the law calls a "health and welfare" benefits program that is established and maintained in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Fund covers writers for whom contributions are made by contributing employers to the Fund pursuant to the terms of a collective bargaining or other written agreement with the WGA as well as employees of eligible Named Employers (e.g., Writers' Guild-Industry Health Fund, Producer-Writers Guild of America Pension Plan, Writers Guild of America East and West, Writers Guild Foundation, and certain temporary employees of Audacy, Inc. (Audacy Staff Group).

(Please note: The Audacy Staff Group includes both regular full-time staff and temporary employees of Audacy, Inc. who meet the requirements of Article II, Section 1(e)(2) of the Pension Plan and participate in the Fund. Audacy, Inc. is a "Named Employer" pursuant to a collective bargaining agreement.)

**NOTE:** For more detailed information about benefits for employees of the Named Employers listed above please refer to the addendum on pages 245-246.

The Fund makes no profit of any kind, and all assets are used for the sole and exclusive benefit of its Participants. The Fund is governed by a joint Board of Trustees that is made up of an equal number of Union and Employer Trustees who have equal voting power. Therefore, neither the Union nor the Employers may unilaterally determine the policies, benefits, or rules of the Fund. The Trustees of the Plan determine the form, nature, and amount of health and welfare benefits, the rules of eligibility for such benefits, and the effective dates of such benefits. The Trustees receive no compensation for their service to the Fund.

# Introduction

## NOTIFICACIÓN DE ASISTENCIA CON TRADUCCIONES AL ESPAÑOL

Este documento es un resumen del plan, el cual contiene un resumen en inglés de sus derechos y beneficios según el plan de salud de. Si tiene dificultades para entender cualquier parte de este documento, comuníquese con un representante de Writers' Guild-Industry Health Fund al (818) 846-1015, de 8:30 a.m. a 5 p.m. Hora estándar del Este, o visite una de las oficinas de Writers' Guild-Industry Health Fund:

PWGA Pension & Health Plans
Writers' Guild-Industry Health Fund
2900 W. Alameda Ave.
Suite 1100
Burbank, CA 91505-4267
8:30 a.m. a 5 p.m.
Hora estándar del Pacífico

# HANDBOOK SUMMARY

Health and life insurance benefits are an important part of the advantages of working in covered employment. To make the most of these benefits, you should understand how they work and how to use them.

That's where this handbook can help. It contains detailed information about the health and life insurance benefits provided by the Health Fund.

- Overview of Sections
- How to Use the SPD booklet
- How to Access and Navigate the Most Current SPD Online

## OVERVIEW OF SECTIONS

**SECTION 1** – Summary of Benefits
This section is a guide to the benefits available to eligible Participants in the Writers' Guild-Industry Health Fund and includes Plan contact information. Starting on page 1.

**SECTION 2** – Eligibility and Enrollment
This section explains how you become eligible for health and life benefits, which family members you can cover, what happens when you lose eligibility, and what benefits are available to you if you become ineligible. Starting on page 22.

**SECTION 3** – Medical Benefits
This section explains the hospital, medical, and mental health and substance use disorder benefits available for the PPO Plan and the Low Option Plan. The section is filled with tips to help you get the most from the Plan and provides a comprehensive listing of what's covered and what's not covered under the Health Plan. Starting page 60.

**SECTION 4** – Infertility Benefits
This section explains the infertility benefits available under the PPO Plan and the Low Option Plan. This section explains the process for obtaining infertility services, and provides a comprehensive list of what is covered and what is not. Starting on page 125.

**SECTION 5** – Paid Parental Leave Benefits
This section explains the benefits available under the PPO and the Low Option Plan. Learn how you obtain this benefit and how it can best be used to benefit your needs. Starting on page 131.

**SECTION 6** – Vision Benefits
This section explains the vision benefits available for the PPO Plan under the Vision Service Plan (VSP) Choice Plan. Learn what is covered and what is not, and learn how to get the most from your vision benefits under the Health Plan. Starting on page 135.

**SECTION 7** – Prescription Drug Benefits
This section explains the prescription drug benefits under the PPO Plan and the Low Option Plan. The section is filled with information to help you get the most from your prescription drug benefits, which are administered by Express Scripts (ESI). Learn what's covered and what's not covered, and learn how to maximize your prescription benefits under the Health Plan. Starting on page 139.

# Handbook Summary

**SECTION 8** – Dental Benefits
This section explains the dental benefits available under the Delta Dental PPO and HMO plans (the Dental HMO is available in California only), including which expenses are covered and which are not. Starting on page 152.

**SECTION 9** – What Else You Should Know About Your Health Plan
This section explains legal provisions describing certain rights you have to benefits under federal law. Starting on page 173.

**SECTION 10** – Protection Benefits
This section explains life insurance and accidental death and dismemberment coverage under the Health Plan. Starting on page 179.

**SECTION 11** – Administrative Information
This section explains claims and appeals regulations, your legal rights under the Plans, and how the Fund maintains your privacy. Starting on page 185.

**SECTION 12** – Other Resources
This section contains Fund contact information and answers to Frequently Asked Questions (FAQ). Starting on page 220.

**SECTION 13** – Glossary
This section contains the glossary of defined terms used throughout the SPD. Starting on page 226.

**SECTION 14** – Index
Starting on page 240.

**ADDITIONAL INFORMATION** – Starting on page 245.

## HOW TO USE THE SPD BOOKLET

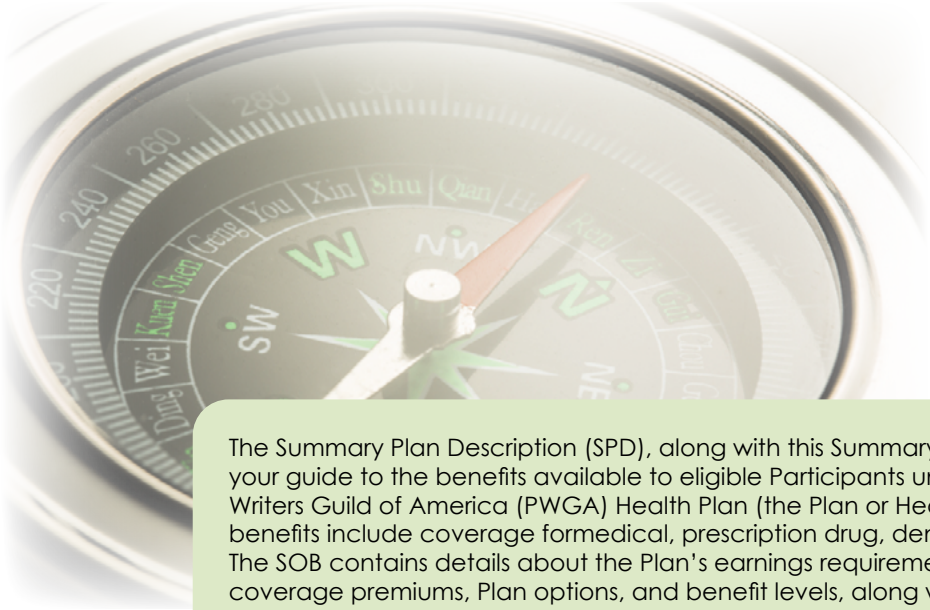
The SPD provides a summary of the benefit resources available to Participants. If a Participant wants to know if something is covered, the SPD is the place to look. In addition, we strongly suggest you use the online version of the SPD available at wgaplans.org. The online version will always have the most recent updates to benefits provided by the Health Fund (and the Pension Fund) as well as online tools to help Participants better understand their benefits.

## HOW TO ACCESS AND NAVIGATE THE MOST CURRENT SPD ONLINE

Visit wgaplans.org ("Health" | "Summary Plan Description") to access the online version of the SPD, which includes Plan amendments and updates. Save the SPD file to your computer or other mobile device, and then open the file.

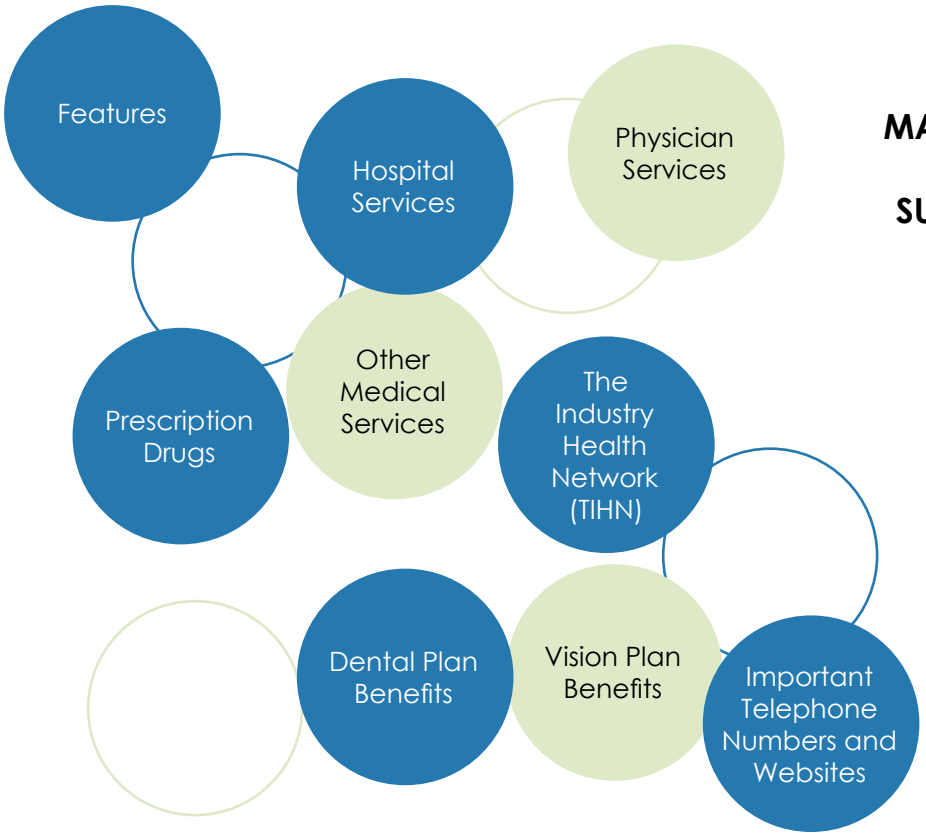
You may browse this version of the SPD like an online magazine by using a touch screen (on a tablet or smart phone) or trackpad/mouse (on a computer) to navigate the document. Use the Table of Contents to quickly navigate to different sections of the SPD. Wherever you see a URL for wgaplans.org or another website, simply touch or click the URL to open the web page in your default web browser.

And, wherever you see a reference to another page in the SPD, simply click the page number to navigate immediately to that page.



The Summary Plan Description (SPD), along with this Summary of Benefits (SOB), is your guide to the benefits available to eligible Participants under the Producer-Writers Guild of America (PWGA) Health Plan (the Plan or Health Plan). These benefits include coverage formedical, prescription drug, dental, and vision. The SOB contains details about the Plan's earnings requirements, dependent coverage premiums, Plan options, and benefit levels, along with PWGA contact information.

The SOB is not a guarantee of benefits. Covered services are subject to preauthorization or Medical Necessity review. The benefits outlined in the SOB may change from time to time. Terms not specifically defined in the SOB are defined in the SPD. The Trustees reserve the right to terminate or change all or any part of the Health Plan at any time. Between published updates to this SOB, the Fund Office will notify you of benefit changes by mail or email -- in the form of Plan change announcements (Summary Material Modifications, or SMMs) or newsletters – and online announcements at wgaplans.org.




**MAJOR TOPICS IN THE SUMMARY OF BENEFITS SECTION**

# PLAN FEATURES

| MEDICAL | | | | | |
|---|---|---|---|---|---|
| | **PPO PLAN** | | | **LOW OPTION PLAN (COBRA and Extended Coverage Participants only)** | |
| | **In-Network Provider** | **Out-of-Network Provider** | **Out-of-Area Provider** | **In-Network Provider** | **Out-of-Network Provider** |
| | Contracted rate applies | Allowed Charge applies | For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies. | Contracted rate applies | Allowed Charge applies |
| **Plan Features** | | | | | |
| **Calendar Year Deductible**<br>Applies to all benefits unless otherwise noted | $400/person; $1,200/family | $400/person; $1,200/family | $400/person; $1,200/family | $750/person; $2,250/family | $750/person; $2,250/family |
| **Coinsurance Out-of-Pocket (OOP) Limit** | $1,000/person (coinsurance only) | $20,000/person (coinsurance only) | $1,000/person (coinsurance only) | $4,500/person (coinsurance only) | $20,000/person (coinsurance only) |
| **ACA In-Network Out-of-Pocket (OOP) Limit**<br>Includes in-network deductible, coinsurance, and copays. | $9,100/person $18,200/family/yr. | Not applicable | Not applicable | $9,100/person $18,200/family/yr. | Not applicable |
| **Lifetime Maximum** | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited |

**IMPORTANT NOTES:**

- All services are subject to Medical Necessity review at the time of payment.
- Calendar-year deductible, office visit copays, hospital copays, and any other copays do not apply toward the Coinsurance Out-of-Pocket Limit. They do apply to the ACA In-Network Out-of-Pocket Limit if services are received in-network or if the out-of-network services are required to be applied toward your ACA In-Network Out-of-Pocket Limit under the No Surprises Act, defined in the Glossary.

- The Plan's out-of-pocket maximum (after deductible) for Medicare-eligible Certified Retirees who retired prior to March 1, 1997 and who are receiving a benefit from the Producer-Writers Guild of America Pension Plan of greater than $800 per month is $400 for in-network providers (with coverage at 85%) and $600 for out-of-network providers (with coverage at 70%).

The 2023 ACA out-of-pocket maximum of $9,100 per person and $18,200 per family per year applies to in-network services and out-of-network services required to be applied toward your ACA In-Network Out-of-Pocket Limit under the No Surprises Act and changes automatically each year to reflect the ACA permitted maximum. You can contact the Fund Office for the current limit.

## LEARN MORE IN THE SPD

- Contracted rate vs. Allowed Charge – Pages 62-65
- Out-of-pocket limits and the Affordable Care Act – Pages 66-67

## COVERED EARNINGS MINIMUM

| | |
|---|---|
| Eligibility Earnings Minimum (effective July 1, 2022): | $41,773 (One-hour network prime-time story and teleplay) |
| Eligibility Earnings Minimum (effective January 1, 2024 | $43,682 (One-hour network prime-time story and teleplay) |
| Eligibility Earnings Minimum (effective July 1, 2024): | $45,397 (One-hour network prime-time story and teleplay) |
| Eligibility Earnings Minimum (effective July 1, 2025): | $46,986 (One-hour network prime-time story and teleplay) |
| Premium for Dependent Coverage: | $50 per month, payable quarterly, in advance |
| Life Insurance Benefit for Active Participants and Certified Retirees: PPO Plan only | $5,000 |
| *Board may elect to divert minimum increases into pension and health fund contributions | |

# PHYSICIAN SERVICES

| MEDICAL | | | | | |
|---|---|---|---|---|---|
| | **PPO PLAN** | | | **LOW OPTION PLAN (COBRA and Extended Coverage Participants only)** | |
| | **In-Network Provider** | **Out-of-Network Provider** | **Out-of-Area Provider** | **In-Network Provider** | **Out-of-Network Provider** |
| | Contracted rate applies | Allowed Charge applies | For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies. | Contracted rate applies | Allowed Charge applies |
| **Physician Services** | | | | | |
| **Doctor's Office Visit** | 85% | 60% | 80% | 70% | 60% |
| **Periodic Health Assessment** | Covered under Wellness Benefits | Covered under Wellness Benefits | Covered under Wellness Benefits | Not covered | Not covered |
| **Well Baby Visits** | Covered under Preventive Care at 100% with no deductible | 60% | 80% | Covered under Preventive Care at 100% with no deductible | 60% |
| **Childhood Wellness Visits including Preventive Immunizations (e.g., Chickenpox, Hepatitis, Measles, etc.):** | | | | | |
| • Through age 6: | • Covered under Preventive Care at 100% with no deductible | • 60% | • 80% | • Covered under Preventive Care at 100% with no deductible | • 60% |
| • Age 7 and older: | • Covered under Preventive Care at 100% with no deductible | • Covered under Wellness Benefits | • Covered under Wellness Benefits | • Covered under Preventive Care at 100% with no deductible | • Not covered |

| MEDICAL | | | | | |
|---|---|---|---|---|---|
| | **PPO PLAN** | | | **LOW OPTION PLAN (COBRA and Extended Coverage Participants only)** | |
| | **In-Network Provider** | **Out-of-Network Provider** | **Out-of-Area Provider** | **In-Network Provider** | **Out-of-Network Provider** |
| | Contracted rate applies | Allowed Charge applies | For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies. | Contracted rate applies | Allowed Charge applies |
| **Physician Services** | | | | | |
| **Adult Preventive Immunizations (e.g., Chickenpox, Hepatitis, Measles, etc.):** | Covered under Preventive Care at 100% with no deductible | Covered under Wellness Benefits | Covered under Wellness Benefits | Covered under Preventive Care at 100% with no deductible | Not covered |
| **Maternity Care**<br><br>Includes prenatal care, delivery, and postnatal care of a physician-delivered baby | 85% | 60% | 80% | 70% | 60% |
| **Inpatient/ Outpatient Physician Services** | 85% | 60% | 80% | 70% | 60% |
| **Inpatient Routine Nursery Visits and Room and Board**<br><br>Inpatient hospital copay applies to the facility fees associated with the baby's facility charges | 85% | 60% | 80% | 70% | 60% |
| **Other Physician Services** | 85% | 60% | 80% | 70% | 60% |
| **Surgery** | 85% | 60% | 80% | 70% | 60% |

**IMPORTANT NOTES:**

- For non-emergency services received from out-of-network providers at in-network facilities, in-network coinsurance rates will apply as required under the No Surprises Act (unless you consent to out-of-network billing rates for those services, if applicable). Assistant surgeons will be considered at a reduced benefit level that is equal to 20% of the surgeon's contract or the Allowed Charge.
- If performed by an in-network provider, some or all of the services listed above may be covered at 100% with no deductible under the Preventive Care benefits described on pages 105-106. For services covered under Wellness Benefits, see page 115.

# HOSPITAL SERVICES

| MEDICAL | | | | | |
|---|---|---|---|---|---|
| | **PPO PLAN** | | | **LOW OPTION PLAN (COBRA and Extended Coverage Participants only)** | |
| | **In-Network Provider** | **Out-of-Network Provider** | **Out-of-Area Provider** | **In-Network Provider** | **Out-of-Network Provider** |
| | Contracted rate applies | Allowed Charge applies | For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies. | Contracted rate applies | Allowed Charge applies |
| **Hospital Services** | | | | | |
| **Emergency Room**[1] | 85% after $50 copay (copay is waived if admitted; hospital admission copay applies) | 85% after $50 copay (copay is waived if admitted; hospital admission copay applies) | 85% after $50 copay (copay is waived if admitted; hospital admission copay applies) | 70% after $50 copay (copay is waived if admitted; hospital admission copay applies) | 70% after $50 copay (copay is waived if admitted; hospital admission copay applies) |
| **Inpatient Services**<br>Includes prenatal care, delivery, and postnatal care of a physician-delivered baby | 85% after $100 copay/ admission | 60% after $100 copay/ admission | 80% after $100 copay/admission | 70% after $100 copay/ admission | 60% after $100 copay/ admission |
| **Outpatient Services** | 85% | 60% | 80% | 70% | 60% |
| **Outpatient Lab Work and X-rays** | 85% | 60% | 80% | 70% | 60% |
| **Skilled Nursing Facility**<br>Ask your provider to contact Anthem Blue Cross to facilitate your care through Case Management | 85% after $100 copay/ admission | 60% after $100 copay/ admission | 80% after $100 copay/admission | 70% after $100 copay/ admission | 60% after $100 copay/ admission |

**IMPORTANT NOTES:**

- Inpatient services include semi-private room within Plan limits and ancillary services.

[1] Emergency services received at an out-of-network emergency health care facility will be treated as if received in-network and will be reimbursed based on the Allowed Charge for such services as set forth under Allowed Charge (Out-of-Network Services) on page 57 (unless you consent in writing to out-of-network billing rates for certain post-stabilization services) if the condition meets the definition of emergency care on page 75.

- If you fail to obtain the required preauthorization, the Trustees may, at their discretion, authorize a post-service Medical Necessity review (which does NOT waive the preauthorization requirement under the Plan). See pages 202-204 for complete information.
- If performed by an in-network provider, some or all of the services listed above may be covered at 100% with no deductible under the Preventive Care benefits described on pages 105-106.
- Inpatient, outpatient facility, home health, hospice, home infusion therapy, skilled nursing facility, and transplant services must be preauthorized through Anthem Blue Cross. If you fail to obtain the required preauthorization, the Trustees may, at their discretion, authorize a post-service Medical Necessity review (which does NOT waive the preauthorization requirement under the Plan). See pages 202-193 of the SPD for complete information.

# OTHER MEDICAL SERVICES

| MEDICAL | | | | | |
|---|---|---|---|---|---|
| | **PPO PLAN** | | | **LOW OPTION PLAN (COBRA and Extended Coverage Participants only)** | |
| | **In-Network Provider** | **Out-of-Network Provider** | **Out-of-Area Provider** | **In-Network Provider** | **Out-of-Network Provider** |
| | Contracted rate applies | Allowed Charge applies | For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies. | Contracted rate applies | Allowed Charge applies |
| **Alternative Medicine**<br>• Acupuncture[2]<br>• Biofeedback[3]<br>• Chiropractic[4]<br>• Hydrotherapy/ Aquatic Therapy[3]<br>• Lymphedema Therapy[3]<br>• Osteopathic Manipulative Treatment<br>• Orthoptic Training | 85% of $60 allowable per visit (one re-exam every 30 days to evaluate and monitor progress) | 60% of $60 allowable per visit (one re-exam every 30 days to evaluate and monitor progress) | 80% of $60 allowable per visit (one re-exam every 30 days to evaluate and monitor progress) | 70% of $60 allowable per visit (one re-exam every 30 days to evaluate and monitor progress) | 60% of $60 allowable per visit (one re-exam every 30 days to evaluate and monitor progress) |
| **Alternative Medicine**<br>Outpatient Occupational Therapy[3] and Outpatient Physical Therapy[3] | 85% of $90 allowable per visit (one re-exam every 30 days to evaluate and monitor progress) | 60% of $90 allowable per visit (one re-exam every 30 days to evaluate and monitor progress) | 80% of $90 allowable per visit (one re-exam every 30 days to evaluate and monitor progress) | 70% of $90 allowable per visit (one re-exam every 30 days to evaluate and monitor progress) | 60% of $90 allowable per visit (one re-exam every 30 days to evaluate and monitor progress) |
| **Ambulance** | 80% (emergency only) | 80% (emergency only) | 80% (emergency only) | 70% (emergency only) | 60%[1] (emergency only) |
| **Air Ambulance** | 85% (emergency only) | 85% (emergency only) | 85% (emergency only) | 70% (emergency only) | 70% (emergency only) |
| **Sea Ambulance** | 85% (emergency only) | 60% (emergency only) | 80% (emergency only) | 70% (emergency only) | 60%[1] (emergency only) |
| **Ambulatory Surgery Center** | 85% | 60% $1,500/ incident maximum | 80% $1,500/ incident maximum | 70% | 60% $1,500/ incident maximum |

[2] For chronic pain only.
[3] A referral is required from a doctor of medicine (MD).
[4] Manipulation of the musculoskeletal system.

| MEDICAL | | | | | |
|---|---|---|---|---|---|
| | **PPO PLAN** | | | **LOW OPTION PLAN (COBRA and Extended Coverage Participants only)** | |
| | **In-Network Provider** | **Out-of-Network Provider** | **Out-of-Area Provider** | **In-Network Provider** | **Out-of-Network Provider** |
| | Contracted rate applies | Allowed Charge applies | For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies. | Contracted rate applies | Allowed Charge applies |
| **Electro-Convulsive Therapy (ECT)** See SPD page 93 for details. | 85% | 60% | 80% | 70% | 60% |
| **Enhanced External Counterpulsation Therapy (EECP)** See SPD page 93 for details | 85% | 60% | 80% | 70% | 60% |
| **Hearing Aids**[5] | 50% | 50% | 50% | 50% | 50% |
| **Home Health**[6] **Care and Home Infusion Therapy** | Preauthorization Required - 85% | Preauthorization Required - 60% | Preauthorization Required - 80% | Preauthorization Required - 70% | Preauthorization Required - 60% |
| **Hospice Care**[6] | Preauthorization Required - 85% | Preauthorization Required - 60% | Preauthorization Required - 80% | Preauthorization Required - 70% | Preauthorization Required - 60% |
| **Infertility**[7] | 100% of certain infertility charges up to a lifetime maximum of $30,000 (combined limit for participant and covered spouse) | Not covered | Not covered | 100% of certain infertility charges up to a lifetime maximum of $30,000 (combined limit for participant and covered spouse) | Not covered |
| **Preventive Care Benefits** For services covered under Wellness Benefits, see page 115. | 100% of certain preventive charges as identified by federal law | Not covered | Not covered | 100% of certain preventive charges as identified by federal law | Not covered |

[5] Covers up to a maximum allowable charge of $2,000 per device. A prescription from a doctor of medicine (MD) is required. Benefit does not accumulate to the coinsurance or the out-of-pocket maximums.

[6] Please have your provider contact the Fund's Utilization Administrator (Anthem Blue Cross) to facilitate your care through Case Management Intervention. On the back of your Medical ID card, you will find the phone number for preauthorization, or pre-service, review.

[7] Effective 1/1/22, infertility benefits are administered through Carrot, see pages 126-130 for details.

| MEDICAL | | | | | |
|---|---|---|---|---|---|
| | **PPO PLAN** | | | **LOW OPTION PLAN (COBRA and Extended Coverage Participants only)** | |
| | **In-Network Provider** | **Out-of-Network Provider** | **Out-of-Area Provider** | **In-Network Provider** | **Out-of-Network Provider** |
| | Contracted rate applies | Allowed Charge applies | For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies. | Contracted rate applies | Allowed Charge applies |
| **Routine Mammograms**<br>• Under 35<br>• Ages 35-39<br>• Age 40 & Over | Covered under Preventive Care at 100% with no deductible (see pages 105-106)<br>• Not covered<br>• One every 5 years<br>• One every year | Covered under Wellness Benefits (see page 115)<br>• Not covered<br>• One every 5 years<br>• One every year | Covered under Wellness Benefits (see page 115)<br>• Not covered<br>• One every 5 years<br>• One every year | Covered under Preventive Care at 100% with no deductible (see pages 105-106)<br>• Not covered<br>• One every 5 years<br>• One every year | 60%<br>• Not covered<br>• One every 5 years<br>• One every year |
| **Speech Therapy[3]**<br>Subject to Plan restrictions and coordinated with speech therapy benefits provided through child's school. Any sessions covered through school program will reduce visits, on a one-for-one basis. | 85%<br>100 visits/ calendar year | 60%<br>100 visits/ calendar year | 80%<br>100 visits/ calendar year | 70%<br>100 visits/ calendar year | 60%<br>100 visits/ calendar year |
| **Telemedicine – LiveHealth Online (LHO) Medical** | 100% after $20 copay with no deductible | Not covered | Not covered | 100% after $20 copay with no deductible | Not covered |
| **Telemedicine – LiveHealth Online Psychology/ Psychiatry[8,9]** | 100% after $10 copay with no deductible | Not covered | Not covered | 100% after $10 copay with no deductible | Not covered |
| **Transplant Services[10]** | Preauthorization Required - 85% | Preauthorization Required - 60% | Preauthorization Required - 80% | Preauthorization Required - 70% | Preauthorization Required - 60% |

[8] Treats patients 10-17 and/or 18 years of age or older. For 18 years of age and older, the patient must have his/her own LHO account.

[9] The patient must be 18 years of age or older and must have his/her own LHO account. Prescriptions determined to be a controlled substance (as defined by the Controlled Substances Act under federal law) cannot be prescribed using LiveHealth Online. Psychiatrists on LHO will not offer counseling or talk therapy.

[10] Please have your provider contact the Fund's Utilization Administrator (Anthem Blue Cross) to facilitate your care through Case Management Intervention. On the back of your Medical ID card, you will find the phone number for preauthorization, or pre-service, review.

| MEDICAL | | | | | |
|---|---|---|---|---|---|
| | PPO PLAN | | | LOW OPTION PLAN (COBRA and Extended Coverage Participants only) | |
| | In-Network Provider | Out-of-Network Provider | Out-of-Area Provider | In-Network Provider | Out-of-Network Provider |
| | Contracted rate applies | Allowed Charge applies | For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies. | Contracted rate applies | Allowed Charge applies |
| **Treatment of TMJ Dysfunction** | 85% for X-rays and 6 physiotherapy visits | 60% for X-rays and 6 physiotherapy visits | 80% for X-rays and 6 physiotherapy visits | 70% for X-rays and 6 physiotherapy visits | 60% for X-rays and 6 physiotherapy visits |
| **Wellness Benefits**[11]<br><br>Ages 7 and older; refer to SPD page 115 for covered wellness services. | $500/person or $1,500/family/ calendar year for specific wellness care expenses covered at 100% up to this limit | $500/person or $1,500/family/ calendar year for specific wellness care expenses covered at 100% up to this limit | $500/person or $1,500/family/ calendar year for specific wellness care expenses covered at 100% up to this limit | Not covered (certain Wellness Benefits that qualify as Preventive Care under the ACA may be covered at 100% with no deductible under Preventive Care benefits described on pages105-106). | Not covered |

**IMPORTANT NOTES:**

- Telemedicine services are offered through Anthem Blue Cross only, available in all 50 states and the District of Columbia. Visit livehealthonline.com. (To accommodate the COVID-19 pandemic, between March 16, 2020 and May 11, 2023, any office visit (in-network or out-of-network) that is otherwise covered under the Plan and that can be conducted online will not be excluded solely because it is held online. These office visits will be covered, subject to normal Plan rules.)
- Services under the Wellness and Preventive Care benefits are not subject to a copay or annual deductible. All services are subject to review for Medical Necessity at the time of payment.
- All services are subject to review for Medical Necessity at the time of payment.
- In-network services that are considered preventive care services (including women's preventive care) as identified by the federal law are not subject to a copay or annual deductible. For additional details, see pages 105-106 or visit healthcare.gov/coverage/preventive-care-benefits.

[11] If the wellness benefit maximum is met, services will be considered under the Plan's medical benefits, subject to the annual deductible and Plan limitations. (This doesn't apply to the Low Option Plan, which does not have wellness benefits.) Preventive services defined as preventive benefits under the ACA (e.g., routine mammogram and pap smear for women of certain ages) and provided in-network are not subject to the deductible.

# PRESCRIPTION DRUGS

| MEDICAL | | | | | |
|---|---|---|---|---|---|
| | **PPO PLAN** | | | **LOW OPTION PLAN (COBRA and Extended Coverage Participants only)** | |
| | **In-Network Provider** | **Out-of-Network Provider** | **Out-of-Area Provider** | **In-Network Provider** | **Out-of-Network Provider** |
| | Contracted rate applies | Allowed Charge applies | For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies. | Contracted rate applies | Allowed Charge applies |
| **Participants and covered dependents will automatically be enrolled in the Pharmacy Program if you are enrolled in the PPO Plan only. The benefits are administered by Express Scripts.** | | | | | |
| **Prescription Drugs** (subject to coordination of benefits provision) | | | | | |
| **Retail** (up to a 30-day supply only) | | | | | |
| • Generic<br>• Preferred Brand<br>• Non-Preferred Brand[12] | $10 copay[13]<br>$25 copay[13]<br>$50 copay[13] | $10 copay[14]<br>$25 copay[14]<br>$50 copay[14] | $10 copay<br>$25 copay<br>$50 copay | Not covered[13] | Not covered |
| **Mail Order** (up to a 90-day supply)<br>Important: Using the mail-order service or Smart90 is mandatory for maintenance medications. | | | | | |
| • Generic<br>• Preferred Brand<br>• Non-Preferred Brand | $20 copay[13]<br>$50 copay[13]<br>$100 copay[13] | $20 copay[14]<br>$50 copay[14]<br>$100 copay[14] | $20 copay<br>$50 copay<br>$100 copay | Not covered[13] | Not covered |

**IMPORTANT NOTES:**

- Compounded medications will be subject to the preauthorization requirements. If any ingredient in a compounded medication is on Express Scripts' list of excluded ingredients, it will not be covered. However, ESI will work closely with the compounding pharmacy to replace or remove the non-covered ingredient.

[12] Brand-name copay applies only when a licensed health care provider acting within the scope of his/her license specifies "Dispense as Written" (DAW) on the prescription and no generic equivalent is available. If a generic equivalent is available, the patient pays the generic copay plus the cost difference between generic drug and brand-name drug even if a licensed health care provider acting within the scope of his/her license specifies DAW on the prescription. For non-covered drugs, visit Express Scripts' website express-scripts.com. Different rules apply for contraceptive drugs that are covered as ACA preventive services; see list of eligible preventive care benefits at page 105.

[13] Preventive care drugs allowed under the Affordable Care Act are administered by Express Scripts. See list of eligible preventive care benefits, pages 105-106.

[14] For out of network pharmacies, you must pay the full cost of the drug at the point of purchase. You will be reimbursed according to the Plan's schedule of benefits when you submit your claim to Express Scripts.

- Hepatitis C Medications will be subject to the preauthorization requirements.
- There are medications that are excluded from the Express Scripts formulary. These medications are not covered by the Plan.
- For specialty drugs eligible for the SaveonSP copayment assistance program, the copayment amount is higher than listed above. Your cost share will be $0 if you participate in the program (because the applicable copayment is covered by the copayment assistance). If you do not participate in the program, you will need to pay the full, higher copayment amount. You can obtain information about the specialty drugs eligible for this program and the amount of the copayment at www.saveonsp.com/wga or by calling the Administrative Office.

# THE INDUSTRY HEALTH NETWORK

Participants can take advantage of significant savings available to them when they use The UCLA Health/Motion Picture & Television Fund (MPTF) Health Centers (TIHN - The Industry Health Network), available only in Southern California. Initially, you must choose a primary care physician (PCP).Then, your TIHN PCP will treat you directly, coordinate your care, and, if necessary, refer you to a TIHN specialist. Without a PCP's referral, your standard Health Plan benefits will apply, including your deductible and coinsurance. No enrollment is required to use this benefit. You may change your PCP at any time, and you may choose other health care providers within The Industry Health Network.

All TIHN benefits are subject to the maximums and limitations listed in this Summary of Benefits and your Summary Plan Description. All claims from a TIHN specialist must be submitted with the referral number assigned by MPTF. The Preventive Care services (pages 105-106) rendered under TIHN are not subject to a $10 copay and will not be applied towards your wellness benefit maximum.

If the Health Center doctor treating you determines that a behavioral health provider should treat your condition, he/she will provide you with a medical order (a recommendation that requires self-referral to a behavioral health care provider) rather than a referral. At this time, behavioral health services will not be part of the TIHN referral program.

Referral from a primary care physician to a TIHN specialist does not guarantee payment. All services are subject to Medical Necessity and the maximums, and the limitations of the Plan.

| PLAN BENEFITS | WHEN YOU USE THE INDUSTRY HEALTH NETWORK |
|---|---|
| PCP Office Visit | $10 copay |
| Specialist Office Visit (requires a written referral from your PCP) | $10 copay<br>(Referrals to specialists who will provide alternative medicine services, such as physical/ occupational therapy, are subject to the Plan's alternative medicine $60 allowable per visit limitation. Outside services, such as specialty care, always requires a written referral authorization from your PCP. You and your dependents must obtain a referral for all services outside of the Health Centers, even if ordered by your specialist. Note: Under the alternative medicine benefit, the Fund allows up to $90 per visit, per provider for occupational and physical therapy services only.) |
| Periodic Physical Exam[15] | No copay |
| Pediatric Visit (excluding ACA well-baby and well-child visits)[16] | $10 copay |
| Lab Works/X-rays | 100% |
| Physical Therapy | $10 copay<br>(Subject to the Plan's alternative medicine $90 allowable per visit limitation.) |
| Hospitalization | 100% after $100 copay/admission |
| Surgery | 100% after $100 copay |
| Anesthesiology | 100% |

**IMPORTANT NOTES:**

- A medical order is a treatment recommendation that requires self-referral to a behavioral physician.

[15] Comprehensive Physical Exam (CPE) charges will be applied to your Wellness Benefit. Wellness Benefits are only available to those over age 7.

[16] Children 13 years and older may utilize pediatric services at any of the five TIHN Health Centers (see page 21). For children under 13 years of age, contact TIHN customer service at (800) 876-8320 for a list of pediatricians.

You have the right to designate any primary care provider who participates in the TIHN network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the in-network primary care providers, contact (800) 876-8320. Children 13 years and older may utilize services at any of the five Health Centers. For children under 13 years of age, you may designate a pediatrician as the primary care provider. You do not need prior authorization from TIHN or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the TIHN network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of TIHN health care professionals who specialize in obstetrics or gynecology, contact (800) 876-8320.

# DENTAL PLAN BENEFITS

If Participants (and their dependents) are enrolled in the PPO Plan, they will automatically be enrolled in the Delta Preferred Option (DPO). Participants who live in California may choose to enroll in the DeltaCare USA Dental HMO (DHMO), a managed dental plan, instead. Participants also have the option of enrolling their eligible dependent(s) in the DHMO.

| DELTA PREFERRED OPTION (DPO) | | | DELTACARE | |
|---|---|---|---|---|
| | **DPO Provider** | **Delta Dental Provider** (not part of DPO network) | **Out-of-Network Provider** | **DHMO**[15] (California only) |
| **Plan Features** | | | | |
| Calendar-Year Deductible | $75/person or $150/family (doesn't apply to diagnostic and preventive services) | $75/person or $150/family (doesn't apply to diagnostic and preventive services) | $75/person or $150/family (doesn't apply to diagnostic and preventive services | None |
| **Plan Maximums**<br>Important: All orthodontia benefits are limited to the lifetime maximum of $2,000 | | | | |
| Diagnostic, Preventive, Basic, and Major Services | $2,500/ calendar year | $2,500/ calendar year | $2,500/ calendar year | Unlimited |
| Orthodontia | Coverage for children up to the age 19 $2,000 Lifetime maximum | Coverage for children up to the age 19 $2,000 Lifetime maximum | Coverage for children up to the age 19 $2,000 Lifetime maximum | See Delta Dental's Evidence of Coverage (EOC) Schedule A for a description of benefits and copayments. |
| **Plan Benefits** | | | | |
| Diagnostic and Preventive | 100% of DPO-approved fee (no deductible applies) | 80% of Delta-approved fee (no deductible applies) | 80% of Delta-approved fee; you pay remaining 20% plus fees above approved amount | See Delta Dental's Evidence of Coverage[17] (EOC) Schedule A for a description of benefits and copayments |
| Basic and Major Services | 80% of DPO-approved fee | 70% of Delta-approved fee | 70% of Delta-approved fee | See Delta Dental's Evidence of Coverage[18] (EOC) Schedule A for a description of benefits and copayments |

[17] The Delta Dental EOC was distributed at the time of enrollment. If you need another copy, contact DeltaCare USA Customer Relations at (800) 422-4234 or visit wgaplans.org.

[18] Services received from out-of-network dentists are not covered, except in an emergency, and if your DeltaCare dentist is unavailable or cannot see you within 24 hours of making contact, or if you believe your condition makes it medically inappropriate to travel to your contracted dentist to receive emergency services. The Plan will reimburse up to $100 of out-of-network emergency dental care per emergency, per enrollee, less any applicable copayment.

| DELTA PREFERRED OPTION (DPO) | | | DELTACARE | |
|---|---|---|---|---|
| | **DPO Provider** | **Delta Dental Provider** (not part of DPO network) | **Out-of-Network Provider** | **DHMO**[15] (California only) |
| Orthodontia Benefits | 70% of DPO-approved fee (coverage for children up to age 19 with a $25 deductible)<br><br>Benefits are limited to a $2,000 lifetime maximum. 50% is payable at the time of banding and the remaining 50% 12 months later. | 70% of Delta-approved fee (coverage for children up to age 19 with a $25 deductible)<br><br>Benefits are limited to a $2,000 lifetime maximum. 50% is payable at the time of banding and the remaining 50% 12 months later. | 70% of Delta-approved fee (coverage for children up to age 19 with a $25 deductible)<br><br>Benefits are limited to a $2,000 lifetime maximum. 50% is payable at the time of banding and the remaining 50% 12 months later. | • Up to age 19: 100% after $350 start-up fee; $1,600 copay (for 24 months of standard orthodontia treatment; additional fee may apply after 24 months)<br><br>• Adults and dependents 19-26 years of age: 100% after $350 start-up fee; $1,800 copay (for 24 months of standard orthodontia treatment; additional fee may apply after 24 months) |
| Dental Work Performed by a Pedodontist<br><br>(a dentist who specializes in the growth and development of children's teeth) | | | | • Pedodontic referrals must be pre-authorized by DeltaCare.<br><br>• Up to age 7: 100% less applicable copayments following an attempt by the assigned contracted dentist to treat the child and upon prior authorization by DeltaCare USA. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis. |

**IMPORTANT NOTES:**

- Plan maximum annual dollar limit does not apply to dependent children under the age of 19. However, orthodontia benefits will be limited to the lifetime maximum of $2,000.

# VISION PLAN BENEFITS

All eligible Participants (excluding Participants covered under the Low Option Plan) will automatically be enrolled in vision coverage administered through VSP Vision Care (VSP).

| VSP IN-NETWORK BENEFITS | | | |
|---|---|---|---|
| **Benefit** | **Description** | **Copay** | **Frequency** |
| **Well Vision Exam** | Regular vision wellness exam | $30 | Once every calendar year |
| **Prescription Glasses** | | **$30** (materials copay) | **See frame and lenses** |
| **Frames** | • $150 allowance for a wide selection of frames<br>• $200 allowance for featured frame brands<br>• 20% savings on the amount over your allowance<br>• $80 Costco frame allowance | No additional copay required (included in prescription glasses) | Once every other calendar year |
| **Lenses** | • Single vision, lined bifocal, and lined trifocal lenses<br>• Polycarbonate lenses for adults<br>• Polycarbonate lenses for dependent children | Included with prescription glasses<br>$31 for single vision; $35 for multifocal<br>Included with prescription glasses | Once every calendar year |
| **Lens Enhancements** | • Standard progressive lenses<br>• Premium progressive lenses<br>• Custom progressive lenses<br>• Average savings of 20-25% on other lens enhancements | $0<br>$95 – $105<br>$150 – $175 | Once every calendar year |
| **Contacts** (elective; instead of glasses)<br>**Contact lenses** (Medically Necessary)[19] | • $150 allowance for elective contacts; copay does not apply<br>• Materials covered in full with prior approval (less a $30 materials copay) | Up to $60 for exam, fitting, and evaluation<br>$30 (for materials) | Once every calendar year |
| **Sun care** | $150 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contacts | $30 | Once every other calendar year |
| **Diabetic Eyecare Plus Program** | Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible Participants with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. | $20 | As needed |

[19] When VSP benefit criteria is met and verified by an in-network doctor for eye conditions that would prohibit the use of glasses, contact lenses are considered Medically Necessary. Covered conditions include aphakia, aniridia, anisometropia, corneal transplant, high ametropia, nystagmus, keratoconus, heredity corneal dystrophies, and other eye conditions that make contact lenses necessary.

## OUT-OF-NETWORK BENEFITS

A Participant may receive vision care services from an out-of-network health care provider. If a Participant chooses an out-of-network provider, he/she must pay the provider directly for all charges and then submit a claim for reimbursement to:

VSP
PO Box 385018
Birmingham, AL. 35238-5018

You can obtain a copy of the VSP Vision Claim Form at: wgaplans.org or online at: vsp.com.

Claims for out-of-network vision care must be filed with VSP no later than 12 months after the date of service.

The chart below outlines the VSP out-of-network benefit.

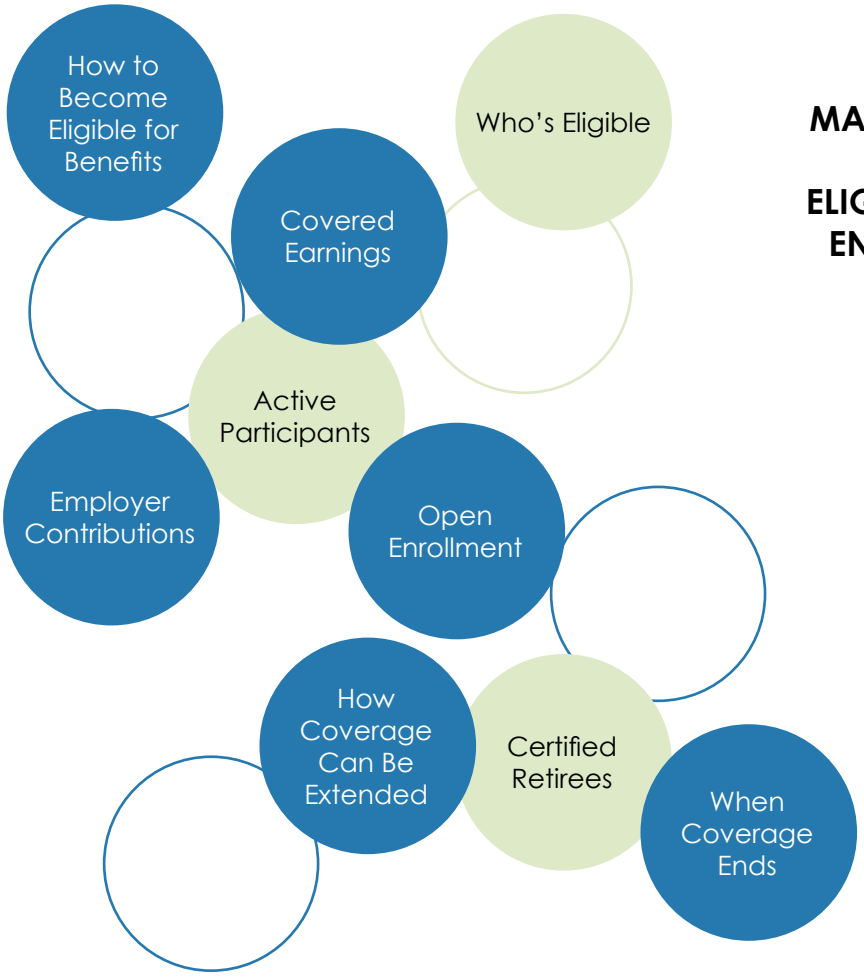
| OUT-OF-NETWORK BENEFITS<br>(Visit *vsp.com* for details if you plan to see a provider that is not in the VSP network.) | |
|---|---|
| **Description** | **Benefit** |
| Exam | Up to $76 |
| Frames | Up to $70 |
| Single Vision Lenses | Up to $33 |
| Lined Bifocal Lenses | Up to $50 |
| Lined Trifocal Lenses | Up to $65 |
| Progressive Lenses | Up to $50 |
| Contacts (instead of glasses) | Up to $115 for elective contacts |
| Contacts (Medically Necessary) | Up to $327 for Medically Necessary contacts |
| VSP will reimburse the patient according to each benefit's out-of-network schedule of allowances, not to exceed the actual exam fee and the cost of corrective eyewear. | |

# IMPORTANT TELEPHONE NUMBERS AND WEBSITES

| IMPORTANT TELEPHONE NUMBERS AND WEBSITES | | | |
|---|---|---|---|
| **For Questions Related To** | **Contact** | **Phone Number** | **Website Information** |
| Eligibility, Claims, General Benefits, and Life and AD&D Insurance | Writers' Guild-Industry Health Fund<br>2900 W. Alameda Ave.<br>Suite 1100<br>Burbank, CA 91505-4267 | (818) 846-1015<br>or<br>(800) 227-7863 | wgaplans.org |
| PPO Plan and Low Option Plan Providers | Physician and Hospital Network in California:<br>Anthem Blue Cross of California<br><br>Physician and Hospital Network Outside California:<br>BlueCross Blue Shield Global Core | (800) 810-BLUE (2583) | wgaplans.org |
| Prescription Drug Benefits | Prescription Drug Network Nationwide:<br>Express Scripts | (800) 987-6551 | express-scripts.com |
| The Industry Health Network | Motion Picture & Television Fund Customer Service (available in Southern California only) | (855) 760-6783 | mptf.com |
| DPO Dental Plan | Delta Preferred (DPO) Customer Relations | (800) 765-6003 | www1.deltadentalins.com/deltacare-usa.html |
| DeltaCare Dental HMO | DeltaCare USA Customer Relations<br><br>(available in Southern California only) | (800) 422-4234 | www1.deltadentalins.com/deltacare-usa.html |
| Vision Plan | VSP | (800) 877-7195 | vsp.com |
| Infertility Benefit | Carrot | | app.get-carrot.com |

| TIHN Health Centers | Location | Phone Number |
|---|---|---|
| Bob Hope Health Center | Los Angeles, Hollywood, Mid-City | (323) 634-3850 |
| Calabasas Health Center | Calabasas | (818) 876-1050 |
| Santa Clarita Health Center | Valencia | (661) 284-3100 |
| Toluca Lake Health Center | Toluca Lake | (818) 556-2700 |
| Westside Health Center | Los Angeles, West Los Angeles | (310) 996-9355 |

The medical, dental, vision, prescription drug, life insurance, and accidental death and dismemberment coverages are designed to help cover eligible Participants and dependents for the cost of routine care, as well as to provide some protection if catastrophic illness or injury strikes. In this section, Participants will learn how you become eligible for coverage, who's eligible, and what happens if you lose your eligibility.




**MAJOR TOPICS IN THE ELIGIBILITY AND ENROLLMENT SECTION**

# HOW TO BECOME ELIGIBLE FOR BENEFITS

To be eligible for coverage that your employer or employers have funded through contributions based on your earnings (called employer-paid coverage), you must not only earn income for writing services (called covered earnings) covered by the Writers' Guild of America Theatrical and Television Minimum Basic Agreement ("MBA" or "Basic Agreement"). Your employer is required to make contributions to the Fund, however;

- You must be paid enough to meet the covered earnings minimum for coverage within the appropriate time period;
- Your employer(s) must report your covered earnings to the Fund; and
- Your employer(s) must make full contributions to the Fund based on your covered earnings.

## VERIFY INFORMATION REPORTED ON YOUR HEALTH FUND EARNINGS STATEMENTS

Health Fund Earnings Statements (aka "Summary of Compensation and Contributions") are issued to Participants with current earned coverage approximately eight weeks prior to the end of the earnings cycle. Since reported earnings can affect your qualification for benefits under the Plan, it is very important that you review your Earnings Statements carefully as soon as you receive them. You should confirm that your Earnings Statements reflect all the covered services you performed during the applicable time period. If you believe that they do not, or if you did not receive an Earnings Statement, but think you had covered employment during the statement period, notify the Fund Office immediately to request an earnings review.

The eligibility rules in Section 2 of this SPD do not apply to employees of any of the following eligible Named Employers: Writers' Guild-Industry Health Fund, Producer-Writers Guild of America Pension Plan, Writers Guild of America East and West, Writers Guild Foundation and the CBS Staff Group. In general, an eligible employee of an eligible Named Employer would become eligible for coverage (month-to-month) on the first day of the month following a full month of staff employment and will generally continue until employment ends (subject to the payment of employee contributions, if any), assuming a 30 hour work week. For additional details and important exceptions, employees of Named Employers should review the "Addendum to the Writers' Guild-Industry Health Fund Summary Plan Description," which is incorporated by reference into this SPD.

**Note:** Participants' earnings are available online at wgaplans.org and updated daily. This is the best way to get the most current information about your earnings.

SUB-TOPICS


- Covered Earnings – Page 24
- Employer Contributions – Page 26

# COVERED EARNINGS

The accumulated covered earnings required to gain eligibility for benefits equal the Writers Guild of America minimum for a one-hour network prime-time story and teleplay. These covered earnings must be earned during four consecutive calendar quarters or less. For eligibility purposes, earnings will apply to the period in which the writing services were performed – not when the earnings were reported by employer(s). (See When Coverage Begins on page 34.) The covered earnings minimum will increase with any subsequent increase in the minimum as stipulated in the MBA. (See the Summary of Benefits section beginning on page 1 for the current covered earnings minimum.)

## EARNINGS QUALIFYING FOR EMPLOYER CONTRIBUTIONS AND ELIGIBILITY

The following types of earnings qualify for employer contributions and eligibility:

- Reportable compensation received when you are employed to perform writing services covered under Article 17 of the MBA;
- Purchases made from a "Professional Writer" (Article 1.B.1.b. of the MBA) if the Writer is also hired to perform writing services (rewrite, polish, etc.) on the same project; and
- Residual compensation, up to applicable ceilings, as specified in Article 17 of the MBA.

## EARNINGS NOT QUALIFYING FOR EMPLOYER CONTRIBUTIONS AND ELIGIBILITY

The following types of earnings are examples (but not the only examples) of those that do not qualify for employer contributions or eligibility:

- Compensation received where no employer/employee relationship (work-for-hire) existed or compensation received in excess of any applicable ceilings, as described in Article 17 of the MBA
- A purchase without an accompanying rewrite or polish
- Excerpts, theatrical residuals, options, royalties, character payments, separated rights, interest, late fees, expenses, or script publication fees

**IMPORTANT!**

Earnings are allocated to the quarter in which they were earned, not when they're paid by your employer. An advance is reportable when it is paid.

## MARRIED WRITING TEAM WAIVER

The Writers Guild of America (WGA) will consider waivers to allow an unequal earnings allocation, such as 70/30 or 80/20, in circumstances where a married writing team would not earn Health Fund coverage if their earnings were allocated 50/50. This waiver must be requested from the Writers Guild prior to employment. Please contact WGA for more information.

## 10% OWNERS

Writers cannot make contributions on their own behalf. If you are an owner or member, or an indirect owner/member of the company, or LLC reporting contributions on your behalf,

specific criteria must be met in order for the contributions to be accepted and count towards your eligibility. These are the 10% Owner Reporting Rules and rules of eligibility rules that determine whether the contributions paid on your behalf by a company owned by you can count towards your eligibility.

The rule is set forth here:
wgaplans.org/contributions/forms/10_Percent_Employer_Notice.pdf

The term "indirectly owns…the equity of the contributing employer," includes (a) equity ownership by the Writer's spouse or the Writer's (or spouse's) parent, sibling, or lineal descendant; or (b) funding of the employer by the Writer or the Writer's spouse or the Writer's (or spouse's) parent, sibling, or lineal descendant.

The reporting signatory must have unrelated third-party financing funding the project. The term "unrelated" means financing from a third party which is not directly or indirectly related to the owner/ member of the reporting for-profit signatory (or an officer, board member or director of a not-for-profit reporting signatory) or have interest in the reporting signatory.

In order for the Administrative Office of the Trusts to determine if contributions can be accepted, additional documentation, including but not limited to the following items, must be submitted to the PWGA for review:

- PROOF OF UNRELATED OUTSIDE FINANCING
  (check copies/wire transfers/bank statements)
- LICENSE AGREEMENT BETWEEN SIGNATORY AND FINANCIER
  (license agreement should contain an allocation for the writing services)
- EMPLOYMENT CONTRACT BETWEEN SIGNATORY AND WRITER
- BUDGET
  (with allocation for writing services and contributions)
- EVIDENCE OF PAYMENT TO WRITER
  (copy of canceled check, wire transfer or bank statement)
- SCRIPTS AND OTHER LITERARY MATERIAL

## NEW MEDIA – 100% SELF-FUNDED OWNER/WRITER

If the Owner/Writer does not receive any outside financing and is fully self-funded, contributions on the Owner/Writer's compensation will count towards the Owner/Writer's eligibility for benefits when there is a legitimate project produced and distributed. Contributions are payable upon first receipt of revenues and are deemed earned and due at that time. The writing fee reportable amount would be 10% for Dramatic programming or 5% for Non-Dramatic programming based on the actual production budget. Revenues are fees received from an unrelated third party for availability or exhibition of the project, i.e., program(s) or series, on New Media, including but not limited to, the internet and mobile devices (such as smartphones and PDAs).

**Note:** If the New Media Owner/Writer's project is not 100% self-funded, the 10% Owner Reporting Requirements and Other Reporting Requirements provided herein will apply.

If you are an owner or member of the reporting signatory, you may want to speak to Employer Compliance to make sure that you are following the 10% Reporting Rules correctly. These rules can be tricky and it is to your benefit to make sure your company complies with the rules.

Please note that if a project is strictly development, earnings may not be reportable. New projects that are created without a license agreement and/or budget may not be reportable. Proof of unrelated third-party financing does not guarantee acceptance of the contributions.

Please direct any questions regarding the 10% Owner Reporting Rules to the Employer Compliance Department at (818) 846-1015, ext. 603.

# EMPLOYER CONTRIBUTIONS

The Fund is financed primarily by participating employers that are signatories to the Writers Guild of America MBA and make contributions to the Fund. As of May 2, 2019, participating employers are required to contribute 11.5% of all "gross compensation" (as that term is defined in Article 17 of the MBA) earned, paid, or due to writers for guaranteed flat deal writing services covered under the terms of a WGA collective bargaining agreement, provided the writer's employment contract is dated on or after May 2, 2019, or the writer is employed on a week-to-week or term deal. Optional services are reportable at the rate and ceiling in effect on the date the optional service is exercised (default to pay date if unknown). This percentage will be periodically adjusted based on bargaining agreements. (See Earnings Qualifying for Employer Contributions and Eligibility on page 24.)

If your employer does not remit the required contributions, you may still be able to receive credit toward eligibility. Contact the Administrative Office at the Health Fund for information.

**IF ELIGIBILITY IS GRANTED IN ERROR**

Contributions an employer remits to the Fund may be paid in error. Examples include:

Services not covered by a WGA collective bargaining agreement;

Contributions paid in excess of the applicable ceilings; and

Contributions paid when no covered services are performed.

In these cases, the Health Fund will attempt to collect from your employer the cost of any benefits the Fund or the Fund's insurance carriers paid for the writer or covered dependents as a result of such error, plus audit costs and attorney fees the Fund spent to recover this amount. In certain circumstances, the Fund will seek repayment from the Participant and employer.

### TERMINATION OF HEALTH COVERAGE FOR CAUSE — INCLUDING FRAUD OR INTENTIONAL MISREPRESENTATION

As always, the Fund reserves the right to terminate coverage for Participants and/or their dependent(s) if the Participant and/or dependent(s) are otherwise determined to be ineligible for coverage. Pursuant to the Patient Protection and Affordable Care Act (PPACA), the coverage will not be rescinded (as defined by the PPACA) retroactively except in the circumstances permitted by law, such as failure to pay premiums, fraud or intentional misrepresentation. In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon 30 days' notice.

If a Participant fails to promptly inform the Fund Office that he/she (or a dependent or spouse) has become ineligible for coverage (e.g., following a divorce), enrolls an individual who does not meet the eligibility requirements or knowingly provides false information to obtain coverage for the Participant or an ineligible dependent, that is considered fraud or intentional misrepresentation. The Participant and any individual who obtains benefits from the Plan through misrepresentation or fraud will be jointly and severally liable for any overpayment.

**IMPORTANT!**

Fraud or intentional misrepresentation includes you, your covered dependent(s), or someone seeking coverage on your behalf knowingly submitting a false claim or appeal for benefits or providing incorrect information in enrollment materials or in response to a question from the Fund administrator or its delegates, or where not considered a rescission.

# WHO'S ELIGIBLE

Active Participants and their qualified dependents may be eligible for coverage. Once eligible, a Participant is automatically enrolled in the PPO Plan for medical coverage and the Dental PPO for dental coverage. Participants who live in California have the option to enroll in the Dental HMO plan instead of the Dental PPO. Once an election has been made, it may not be changed until the Fund's next Open Enrollment period, unless the Participant and/or their dependents qualify for Special Enrollment Rights outside the Open Enrollment period.

An eligible Participant will receive coverage at no cost. Participants who would like to cover their eligible dependents may enroll them; however, the Participant must pay a monthly dependent coverage premium before coverage becomes effective. Dependent coverage premiums are payable quarterly and due in advance. Dependent coverage premiums are not required for dependents of Certified Retirees if the dependent is age 65 or over and has not earned active coverage. The Trustees (in consultation with the Fund's benefit consultants and relevant service providers) are responsible for approving the amount of the dependent coverage premium, which is periodically reviewed and subject to change. Participants will be notified of any change to the dependent coverage premium or other premium amounts.

SUB-TOPICS


- Active Participants – Page 28
- Certified Retirees – Page 36

# ACTIVE PARTICIPANTS

A writer is considered an active Participant the first time the Fund receives a contribution on their behalf; however, to become eligible for coverage, a writer must be paid enough to meet the covered earnings minimum within the appropriate time period, as well as meet other requirements. (See How to Become Eligible for Benefits on page 23.)

## ELIGIBLE DEPENDENTS

An eligible Participant may enroll:

- The Participant's legal spouse;
- The Participant's children younger than age 26, including:
  - A biological child or stepchild;
  - An adopted child or child placed for adoption with you (coverage begins on the date the child was placed for adoption or the date the adoption was final, whichever is earlier); and
  - Any other child who depends on the Participant for support and lives with the Participant in a parent-child relationship, provided the Participant provides proof of this relationship (legal guardianship or foster children — coverage for foster children will end on the last day of the month in which the foster relationship terminates);
- Coverage is available whether the dependent child is married or unmarried, regardless of student status, employment status, eligibility for or access to other health insurance coverage, financial dependency on the Participant (except as noted), or any other factor other than the relationship between the child and the Participant. If, however, the dependent child has other group health insurance — including coverage through an employer — the Fund will consider that other coverage to be primary and the Fund's coverage for the child will be secondary.
- Children age 26 or older who are incapable of self-sustaining employment because of a mental disability or a physical handicap, as long as:
  - The mental disability or physical disability existed while the child was covered by the Health Plan and began before the child reached age 26;
  - The child is primarily dependent on the Participant for support; and
  - The Participant provides evidence of incapacity to the Fund within 31 days after the child reaches age 26. (The Participant must also provide proof of continuing incapacity upon request of the Fund Office at other times during the child's coverage.)

**IMPORTANT NOTE:** If a Participant's dependent child is married, coverage will not be extended to the dependent child's spouse or children.

## ENROLLING DEPENDENTS

In order to enroll eligible dependents, a Participant must submit a completed dependent enrollment form to the Fund, along with the premium payment and all required documentation within 30 days of the date the Participant becomes eligible. If the Participant does not enroll his/her dependent(s) within this 30-day period, the Participant must wait until

the next Open Enrollment period unless the Participant experiences a Life Event that provides a special enrollment opportunity to add dependents as described on the following page. However, a newborn is covered for 31 days from birth.

| TO ENROLL… | YOU'LL NEED… |
|---|---|
| A spouse | A copy of the certified marriage certificate. |
| Dependent child (biological and/or step child) | A copy of the official birth certificate (since official birth certificates often are not available within 30 days of a birth, for newborns, the Fund will accept temporary documentation (such as a copy of an official hospital birth record or a certificate signed by the attending or supervising physician, or midwife) until the official birth certificate is received or 180 days passes from the date the dependent was added, whichever occurs first). |
| A foster child, adopted child, a child placed for adoption with you or a child for whom you're the legal guardian | A copy of the adoption/release, guardianship, or placement documents from the adoption agency or court of record. |
| All of the above | The Fund requires the Social Security Number for each dependent you are enrolling, unless they are not a citizen of the United States. When adding a newborn, the Participant must apply for the Social Security Number as soon as possible and provide it to the Fund Office once received. |

**IMPORTANT NOTE:** If a Participant submits a Dependent Enrollment Form with the required documentation but does not pay the required premium by the due date, the dependent will not be covered. In such a case, the Participant would have to wait until the next Open Enrollment Period to add the dependent.

If a Participant declines dependent coverage when first becoming eligible because the dependent has other health insurance coverage, and the dependent subsequently loses that coverage (or if the employer stops contributing toward the dependents' health coverage), the Participant then has special enrollment rights to enroll the dependent in Health Fund coverage outside of Open Enrollment. This does not apply where the dependent lost coverage due to failure to pay required premiums. For more information, please refer to the Life Events section on page 32.

If you are re-enrolling a dependent and meet all the conditions below, you only need to complete a Dependent Reinstatement Form and pay the dependent coverage premium (if applicable) to resume coverage for the dependent:

- You previously submitted the appropriate documentation for this dependent,
- You have not been asked to supply additional or modified information, and
- You have not been advised that the dependent(s) is not eligible to enroll.

## PAYING FOR DEPENDENT COVERAGE

In addition to meeting eligibility earnings requirements, you must pay a monthly premium if you wish to cover your dependents.

Your dependents include:

- Your spouse; and
- All eligible dependent children.

Newborns of Participants who have earned coverage or COBRA Continuation Coverage are covered for the first 31 days after birth, but lose coverage thereafter, unless:

- A completed Dependent Enrollment Form is received;
- The required documentation is provided; and
- The dependent premium is paid, if applicable.

**NOTE:** If the dependent premium has been paid for existing dependents, no additional premium is required to cover the newborn.

(See Eligible Dependents on page 28 for the definition of "eligible dependents.")

This premium covers all eligible dependents in your household who you enroll for benefits. The dependent premium amount is listed in the Summary of Benefits section.

Covered Participants (not including employees of "Named Employers") must pay dependent premiums on a quarterly basis. The premiums are due in advance (before the start of each quarter), based on invoices issued by the Fund. Only the dependents you have enrolled will be covered. When an invoice is received, the Participant can make payment through our website (registration is required), through the PWGA App, or by mailing a check, cashier's check, or money order to the Fund Office. If the Fund does not receive premium payment by the due date, dependent coverage will be terminated.

## PAY YOUR PREMIUM WITH AUTOPAY!

In order to avoid your dependents losing coverage as a result of a failure to timely pay the dependent premium, you can electronically enroll in AutoPay and set the dependent premium to be paid automatically. To enroll in AutoPay and set up automatic payments of the dependent premiums, sign in through our website or the PWGA App and select "AutoPay." This is a one-time process, and your dependent premiums will be paid automatically thereafter.

## LATE PAYMENT EXCEPTION – "ONE-IN-THREE RULE"

If a Participant fails to pay the required dependent coverage premium by the due date, dependent coverage will be terminated. However, the Participant may make a request to reinstate dependent coverage based on the One-in-Three rule, described below:

A Participant may submit a written request to the Fund Office, asking that an exception be made to allow a late payment and reinstate dependent coverage. The written request must be received no later than 45 days from the first day of the calendar quarter for which payment was due. The Fund Office will grant the request and no subsequent late payment exceptions will be allowed for three years (36 months) from the date the initial exception was made.

## DEPENDENT VERIFICATION AUDITS

As a covered Participant, you may be selected for an audit to verify the eligibility of your dependents under the Health Fund. Failure to comply with an audit request can lead to a loss of benefits for dependents. These audits are for the Participants' protection to assure that Health Fund benefits are reserved for eligible Participants and their eligible dependents.

Upon notification of an audit, by either the Fund or a company engaged by the Fund, a Participant must provide information or documents within the requested time period. For example, the Fund may request a copy of a recorded marriage certificate to verify a

spouse or a recorded birth certificate for a child. If a Participant cannot locate a requested document, he/she should immediately contact the Fund for assistance.

If the information or documents are not provided, the Fund may determine that the dependent(s) does not qualify for health coverage and will therefore lose coverage. The Participant will be held responsible for any overpayments made by the Fund as a result of the failure to provide such information or documentation.

If you are audited and have any questions, please contact the Eligibility Department at the Fund Office.

## HEALTH COVERAGE FOR CHILDREN AND FAMILIES

If you are eligible for health coverage from the Health Fund, but you are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or Children's Health Insurance Program (CHIP) to help those who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state that offers this program, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial 877-KIDSNOW, or go to insurekidsnow.gov to find out how to apply. If you think you may qualify, find out if your state has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined by state officials that you or your dependents are eligible for premium assistance under Medicaid or CHIP, the Health Plan permits you and your dependents to enroll — as long as you and your dependents are eligible, but not already enrolled in the Health Plan. This is called a "special enrollment" opportunity, and you must request coverage from the Plan within 60 days after you are determined eligible for such premium assistance.

If you would like to request such special enrollment from the Health Fund, please contact the Eligibility Department at (818) 846-1015 or (800) 227-7863 to request the necessary forms.

To determine which states have a premium assistance program or to obtain more information about your special enrollment rights, you can contact either of the agencies listed below:

U.S. Dept. of Labor Employee
Benefits Security Administration
dol.gov/ebsa
1 (866) 444-EBSA (3272), or

U.S. Dept. of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
1 (877) 267-2323, Ext. 61565

If your dependent's Medicaid or CHIP coverage is terminated due to a loss of eligibility, or if your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, then you may enroll your dependents in the Health Plan within 60 days of either event. Coverage will become effective the date after the Medicaid or CHIP coverage ends, or the date your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP. However, the request for enrollment, the required documentation, and the dependent premium (if applicable) must be received by the Administrative Office within 60 days of the eligibility determination for or the termination of (as applicable) Medicaid or CHIP coverage.

## GRANTING RETROACTIVE OR TERMINATING PROSPECTIVE COVERAGE

Sometimes employer compliance audits reveal cases in which a Participant gains or loses eligibility due to misreported earnings. The collection of any delinquent contributions may allow the Health Fund to provide the Participant with retroactive eligibility for coverage. Conversely, any refund of erroneous contributions may result in the termination of future coverage. The Fund will make the appropriate adjustments and notify Participants accordingly.

Retroactive eligibility will be granted for the period in which the Participant would have been eligible if earnings were accurately reported. Should retroactive eligibility be granted, the Fund Office will notify the Participant of the following:

- The new eligibility period;
- How to add eligible dependents (the Participant must pay dependent coverage premiums retroactively);
- The process for submitting receipts for reimbursement of health insurance premiums paid (to the Fund or to any other insurer) for the period of retroactive eligibility; and
- The process for submitting receipts for medical, dental, vision, wellness, and prescription expenses incurred during the period of retroactive eligibility. Coordination of benefits (COB) will occur if applicable. Please save your receipts!

If the Fund determines that the current coverage was granted in error, the coverage will be terminated prospectively (as opposed to retroactively, except as otherwise provided herein). Coverage will end on the last day of the month following the month in which our notice of termination is dated. For example, if our notice is dated March 15, the Participant's coverage will terminate on April 30. If eligibility is terminated, the Fund Office will notify the Participant of the following:

- The date coverage will be terminated; and
- The right to purchase COBRA Continuation Coverage.

## LIFE EVENTS

Any Participant who experiences one of the following Life Events will be granted a special enrollment opportunity or allowed to drop dependent coverage outside of Open Enrollment. However, the Participant must notify the Fund Office in writing (including copies of court records, adoption papers, or any other pertinent documentation) within 30 days of the life event.

Qualifying Life Events include:

- Marriage, divorce, or court-ordered legal separation(in the instance of a divorce, the Participant must notify the Fund within 60 days of the event);
- Divorce or court-ordered legal separation is a Life Event that results in disenrollment:
    - If notification is received after the 60-day window, the time limit to elect COBRA Continuation Coverage will be exhausted, and your qualified dependent(s) will lose his/ her/their right to elect COBRA Continuation Coverage;
- Birth or adoption of a dependent child, or placement of a child for foster care or adoption;

- Legal judgment or court order to cover a dependent child;
- Death of a spouse or dependent;
- Any change in a spouse's or dependent's employment status that results in a significant change to benefits, such as the start or end of employment, a change from full-time to part-time employment, or the start or end of an unpaid leave of absence;
- Becoming eligible for premium assistance under Medicaid or CHIP or termination of Medicaid or CHIP coverage (Participants must notify the Fund within 60 days);
- Loss of other health plan coverage as a result of exhaustion of coverage (e.g., the maximum COBRA duration has been reached), a loss of eligibility, or cessation of employer contributions to that other health plan coverage if:
    - The Participant declined or waived coverage for himself/herself and/or his/her eligible dependents when he/she were initially eligible to participate or during an Open Enrollment period because of other health plan coverage; and
- Change in work location or residence for the Participant (or a spouse or dependent, if that change affects benefits).

**NOTE:** If you request special enrollment in the Health Plan within the required time frame due to any Life Event listed above, coverage will become effective as of the date the life event occurred (dependent premiums must be paid). Please refer to Enrolling Dependents on page 25 to learn more.

**ALSO NOTE:** If a Participant newly acquires a dependent child through birth, adoption, placement for adoption, or marriage, the Participant's spouse and the newly acquired dependent child are all eligible for a special enrollment opportunity. Please note that the Participant's existing dependent children who are not enrolled in the Health Plan are not eligible for the special enrollment opportunity.

A Participant will not have to pay the entire quarterly dependent coverage premium if the Life Event takes place during the quarter and coverage is added. Instead, the premium will be prorated to the first day of the month in which the Life Event takes place. If premium payment is not made by the due date on the dependent premium invoice, or if the special enrollment request for a dependent is not made within 30 days (or 60 days, as applicable) of the life event, the Participant will not be able to enroll the dependent until the Fund's next annual Open Enrollment period.

If a Life Event results in the loss of dependent coverage, and the Participant has no other covered dependents, some or all of the quarterly dependent premiums previously paid will be refunded prospectively — as applicable.

If you recently (within 30 days or 60 days, as applicable) experienced one of the Life Events listed above and wish to add a dependent, a special enrollment request must be submitted to the PWGA with the following:

1. A completed Dependent Enrollment Form,
2. All required documentation, including a copy of the termination notice from the other health plan or the employer; and
3. The dependent premium, if applicable.

Special enrollment requests must be received by the Fund Office within 30 days (or 60 days as applicable) after the Life Event or other coverage ends (or after the employer stops contributing towards your dependent's other health coverage). If a special enrollment

request is due to marriage, the spouse's coverage will be backdated to the date of marriage. However, due to the fact that there is no daily proration of dependent premiums, the Participant may instruct the Fund to make the spouse's coverage effective on the first day of the month after the date of marriage.

Any dependent who qualifies for special enrollment must be added to the same coverage as the Participant. (For example, if a Participant who resides in California is enrolled in the Dental HMO Plan and gets married, the spouse must also be enrolled in the Dental HMO Plan).

Other status changes, such as a change in a family member's coverage, may apply. For example, if your spouse elects family coverage during his/her open enrollment period, a Participant may be allowed to drop dependent coverage. Please contact the Eligibility Department in the Fund's Administrative Office if you have questions about any of the life events described in this section.

## WHEN COVERAGE BEGINS

A Participant becomes eligible for 12 months of health coverage once the Plan reviews whether the Participant has met the earnings requirement for eligibility. Generally, this determination occurs approximately six weeks after the end of the quarter in which the Participant satisfies the earnings requirement for eligibility. (See the Summary of Benefits section for earnings requirement minimums.)

This six-week determination period is needed for employers to submit reports of your earnings and for the Plan to process these reports. Coverage begins on the first day of the calendar quarter after the end of this determination period. Coverage will continue for one year.

Once eligibility has been established, it is important that the Participant is aware of their earnings cycle (the period in which the Participant must meet the eligibility earnings requirement to continue uninterrupted coverage).

The chart below provides some examples:

| If You Satisfy the Eligibility Earnings Requirement During the Quarter[20] | Your Coverage Period Will Be | The Earnings Cycle for Continued Coverage Will Be |
|---|---|---|
| Oct. 1, 2022 – Dec. 31, 2022 | April 1, 2023 – Mar. 31, 2024 | Jan. 1, 2023 – Dec. 31, 2023 |
| Jan. 1, 2023 – March 31, 2023 | July 1, 2023 – Jun. 30, 2024 | April 1, 2023 – March 31, 2024 |
| April 1, 2023 – June 30, 2023 | Oct. 1, 2023 – Sep. 30, 2024 | July 1, 2023 – June 30, 2024 |
| July 1, 2023 – Sept. 30, 2023 | Jan. 1, 2024 – Dec. 31, 2024 | Oct. 1, 2023 – Sept. 30, 2024 |

[20] Not applicable to eligible Named Employers (i.e., Writer's Guild-Industry Health Fund, Producer-Writers Guild of America Pension Plan, Writers Guild of America East and West, Writers Guild Foundation and employees of the Audacy Staff Group).

## WHEN ELIGIBILITY BEGINS – EXAMPLE 1

| April 1, 2021 – June 30, 2021 | July 1, 2021 – Sept. 30, 2021 | Oct. 1, 2021 – Dec. 31, 2021 | Feb. 15, 2022 | April 1, 2022 – March 31, 2023 |
|---|---|---|---|---|
| Josh earned $18,000 in the second quarter of 2021 (April – June) | Josh earned $18,000 in the third quarter of 2021 (July – Sept.) | Josh earned $20,000 in the fourth quarter of 2021 (Oct. – Dec.) | This is the approximate date that the Plan determines whether Participants have satisfied the earnings requirements. This period provides the employer sufficient time to submit contribution reports and payments to the Fund Office. It also allows the PWGA time for internal processing. | Effective the first day of the second quarter of 2022 (Apr. 1, 2022), Josh's Health Fund coverage begins. His coverage will last for one year. |

## WHEN ELIGIBILITY BEGINS – EXAMPLE 2

| Oct. 1, 2022 – Dec. 31, 2022 | Jan. 1, 2023 – March 31, 2023 | April 1, 2023 – June 30, 2023 | Aug. 15, 2023 | Oct. 1, 2023 – Sept. 30, 2024 |
|---|---|---|---|---|
| Peggy earned $25,000 in the fourth quarter of 2022 (Oct. – Dec.) | Peggy had no earnings in the first quarter of 2023 (Jan. – Mar.) | Peggy earned $40,000 in the second quarter of 2023 (April – June) | This is the approximate date that the Plan determines whether Participants have satisfied the earnings requirements. This period provides the employer sufficient time to submit contribution reports and payments to the Fund Office. It also allows the PWGA time for internal processing. | Effective that first day of the fourth quarter of 2023 (Oct. 1, 2023), Peggy's Health Fund coverage begins. Her coverage will last for one year. |

# CERTIFIED RETIREES

## HOW TO QUALIFY FOR CERTIFIED RETIREE HEALTH FUND COVERAGE

Before you qualify for coverage as a Certified Retiree, you must:

- Satisfy certain employment minimums; and
- Submit a Certificate of Retirement to the Administrative Office of the PWGA Pension & Health Plans. You may request this certificate by contacting the Administrative Office.

If you retired before Jan. 1, 1997, you are considered a Certified Retiree if you:

- Retired under the PWGA Pension Plan on or after March 1, 1974; and
- Accumulated at least 20 Qualified Years or 80 Qualified Quarters before your retirement; or
- Accumulated at least 400 Credited Weeks before your retirement; and
- Accumulated at least three qualified years after Dec. 31, 1954.

If you retired on or after Jan. 1, 1997, you are considered a Certified Retiree if you:

- Are at least 60 years old; and
- Retired under the PWGA Pension Plan; and.
- Accumulated at least 68 quarters of earned eligibility before your retirement, calculated as follows:
  - A qualified year under the PWGA Pension Plan for each year before 1988 equals four quarters of eligibility for each year before 1988; and
  - Each year of eligibility earned under the Health Fund during 1988 and every year thereafter equals four quarters of eligibility.

**IMPORTANT!**

If your Health Fund coverage is Extended Coverage or COBRA Coverage, such coverage does not count toward your accumulated qualified quarters required for Certified Retiree Health Coverage.

**IMPORTANT!**

Certified Retiree Health Coverage and eligibility requirements for the coverage can be amended and terminated at any time both for actives and for those who are inactive or already retired. See When a Plan Changes or Ends on page 218.

*NOTE: For important information about Certified Retiree benefits for Participants covered under the Audacy Staff Group Employees and KNX Daily Rate Employees Agreement, refer to pages 245-246.*

## WHEN CERTIFIED RETIREE COVERAGE BEGINS

If a Participant has met all the qualifications for Certified Retiree coverage and still has active employer-paid coverage at the time of retirement, that active coverage will continue until the end of that employer-paid eligibility period. At that point, the Certified Retiree health coverage begins.

**Note:** GAP and ECP are considered active coverage. Therefore: If a Participant (is on ECP) during a quarter, (i.e., ECP from January – March) and they retire and start collecting a pension in the middle of the quarter (e.g., they start collecting their pension in February), then CRH will begin the first day of the following quarter, in this case, April 1st.

If the Participant is younger than 60 and has at least 68 qualified quarters at retirement, the Participant's Certified Retiree Health Coverage will begin on the first day of the month after he/she turns 60 (provided active employer-paid coverage is not in effect).

If a Participant returns to work after his/her Certified Retiree Health Coverage begins, and the Participant regains employer-paid coverage by meeting the eligibility earnings minimum requirement, the Participant will be considered an active Participant (on the first day of the quarter following the determination period, as described above). After that, if the Participant has dependents, the Participant must pay the premium for dependent coverage for as long as he/she has active coverage.

Generally, except for the very important rules that relate to Medicare (explained below), if you are a Certified Retiree, your health coverage includes the same benefits provided to Participants with employer-paid coverage. (For information about how your benefits will be coordinated, see Understanding Coordination of Benefits (COB) on page 81.

As a Certified Retiree, you are not required to pay a premium for dependent coverage if you:

- Are not eligible for active coverage under the Fund; and
- Are 65 or older.

## CERTIFIED RETIREE COVERAGE – EXAMPLE 1

| Dec. 31, 2022 | | Jan. 1, 2023 |
|---|---|---|
| Joe's active employer-paid coverage is effective until Dec. 31, 2022. | Joe is 60 years old, has 68 qualified quarters. He is currently on active employer-paid coverage. He will start collecting his pension on Oct. 1, 2022. | Joe's Certified Retiree coverage will begin on Jan. 1, 2023. Since Joe is under 65, he will continue to pay the quarterly dependent premium for his family's coverage. |

## CERTIFIED RETIREE COVERAGE – EXAMPLE 2

| | Jan. 1, 2023 | |
|---|---|---|
| Jenn is 65 years old and has 72 qualified quarters. She had not had Health Fund coverage for 3 years. She will start collecting her pension on Jan. 1, 2023. | Jenn's Certified Retiree Health Fund coverage will begin on Jan. 1, 2023. | Jenn contacted the Fund Office several months prior to her retirement. She was informed that PWGA's plan will be secondary to Medicare.<br><br>Accordingly, Jenn enrolled in Medicare Parts A and B to ensure she receives optimum coverage through coordination of benefits. |

## CERTIFIED RETIREE COVERAGE – EXAMPLE 3

| April 1, 2023 – June 30, 2023 | July 1, 2023 – Sept. 30, 2023 | Oct. 1, 2023 – Sept. 30, 2024 | Oct. 1, 2023 |
|---|---|---|---|
| Jack is 67 years old and has been covered as a Certified Retiree for four years. Medicare is his primary insurance, the PWGA is secondary. He recently was hired to write on a theatrical project and he will earn $125,000. He will satisfy the earnings minimum requirement in the second quarter of 2023. | During this period Jack's Certified Retiree coverage will remain in place. The approximate date that the Plan will determine whether the earnings requirement was satisfied is Aug. 15, 2023 and his employer-paid coverage will not begin until the first day of the following quarter. | Jack's active employer-paid coverage period will be Oct. 1, 2023 to Sept. 30, 2024. Effective Oct. 1, 2023, PWGA becomes primary over Medicare. Jack has a covered dependent. He will have to resume paying the quarterly dependent premium during his employer-paid coverage period. | Jack did not satisfy the earnings minimum requirement during his four-quarter earnings cycle. Therefore, on Oct. 1, 2024, Jack's coverage will return to Certified Retiree.<br><br>Medicare will be primary once again and PWGA will be secondary. The quarterly dependent premium is no longer required. |

**Note:** This is only a brief summary of your benefits. All benefit descriptions contained herein are governed by the limitations and other information contained in your SPD.

**The Certified Retiree Health Fund program and all benefits associated with the program are subject to renewal by the Board of Trustees of the Writers' Guild-Industry Health Fund from time to time and may be revoked at any time with or without notice. Participants and their eligible dependents, spouses and/or children have no guaranteed or vested right to benefits.**

# OPEN ENROLLMENT

The PWGA's Annual Open Enrollment period begins Nov. 15 (or the first Monday thereafter) and continues through Dec. 31 of each year. During Open Enrollment, all covered Participants may add or reinstate dependent coverage or change dental coverage (if residing in California), and Participants enrolled in COBRA Continuation Coverage or the Extended Coverage Program may change their medical and/or dental coverage plan options. Open Enrollment changes are made online or through the PWGA App. All changes made during Open Enrollment will become effective on Jan. 1 the following year.

# WHEN COVERAGE ENDS

When Health Fund coverage ends, the Participant will be notified in writing, and, if applicable, that notification will include information about how to enroll and purchase COBRA Continuation Coverage (if, when coverage ends, the Participant is not eligible to extended coverage through other programs available through the Fund.)

A Participant's coverage will end on the last day of the Participant's 12-month coverage cycle if the Participant does not meet the eligibility earnings requirement during his/her personal four-quarter earnings cycle.

Other instances when a Participant's coverage will end are:

- The date the Participant dies (unless there are covered dependents on the Plan in which case they will continue to be covered for the duration of the Participant's earned coverage and any Extended Coverage to which the Participant was entitled);
    - If there is more than one surviving dependent, the dependent premium must be paid in order to continue coverage;
    - If there is only one surviving dependent then a dependent premium is not necessary as the sole surviving dependent is treated as the primary dependent
- The Participant exhausts his/her COBRA Continuation Coverage;
- The Participant exhausts his/her Extended Coverage Point balance and has not requalified for employer paid coverage;
- An employer compliance audit discovers that reported contributions which resulted in the Participant's current coverage were in fact, reported in error, and that coverage is then terminated prospectively;
- The Health Plan is modified to terminate coverage for a specific class of covered Participants;
- Coverage is terminated for other reasons permitted in this SPD, such as fraud or misrepresentation; or
- The Plan ends.

**Note:** The Fund's extended coverage programs (excluding the Fund's Disability Extension) are NOT applicable to covered employees of eligible Named Employers (e.g., Writer's Guild-Industry Health Fund, Producer-Writers Guild of America Pension Plan, Writers Guild of America East and West, Writers Guild Foundation, and employees of the Audacy Staff Group). For more information regarding the Disability Extension, please refer to the Addendum for Employees of Named Employers on page 52.

Dependent coverage generally ends when the Participant's coverage ends. Additionally, dependent coverage will end:

- The date the dependent dies;
- The first day of any period for which the dependent premium is not paid by the due date;
- On the last day of the month that a dependent child reaches age 26 (except for a totally disabled child to the extent provided in the next bullet below);
    - In the case of foster children, coverage ends on the last day of the month in which the foster relationship terminates;
- On the last day of the month that a totally disabled dependent child over the age of 26 is no longer totally disabled and no longer meets the eligibility requirements for coverage under the Plan, as defined in Eligible Dependents on page 28;
- The dependent child covered solely by virtue of a QMCSO, the last day of the month the child is no longer covered under the QMSCO;
- The date of or the date set forth in a court-ordered legal separation has been issued as applicable;
- The date a divorce has been finalized;
- The date the Health Plan is modified to terminate coverage for dependents or a class of dependents;
- The date the dependent exhausts his/her COBRA Continuation Coverage;
- The date the Plan ends; or
- The date coverage is terminated for other reasons permitted in this SPD, such as fraud or misrepresentation.

# HOW COVERAGE CAN BE EXTENDED

When Participants or dependents lose Health Fund coverage, they may be able to temporarily extend their coverage. The chart below lists the options for those qualified to extend coverage. Eligibility rules and benefits for each option are described in detail in this section.

| COBRA Continuation Coverage | Excess Earnings Extension (also referred to as the $250K Extension) | Total Disability Extension | Extended Coverage Program | Survivor Coverage |
|---|---|---|---|---|
| • Monthly premium payment required<br>• Choice of multiple Plan options | • Single Writer Coverage<br>• Two-Party Writing Team coverage | • Application required | • Points system<br>• Choice of multiple Plan options | • Active Survivor Coverage<br>• Certified Retiree Survivor Coverage |

The Extended Coverage Program and Excess Earnings Extension are not available to employees of eligible Named Employers (i.e., Writer's Guild-Industry Health Fund, Producer-Writers Guild of America Pension Plan, Writers Guild of America East and West, Writers Guild Foundation and employees of the Audacy Staff group).

## SUB-TOPICS

## COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created under federal law by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). COBRA Continuation Coverage can become available to a Participant or dependent when group health coverage would otherwise end.

**PLEASE NOTE:** If you are entitled to both Certified Retiree Health Coverage and COBRA Continuation Coverage at the time your Active Coverage ends, you (the Plan Participant) will be offered a choice of temporary continuation of your Active group health coverage under COBRA rather than the Certified Retiree Health Coverage. If you receive the Fund's Certified Retiree Health Coverage, you would have no further COBRA Continuation Coverage rights. However, your covered dependent(s) may experience a COBRA Qualifying Event as described in this section.

## OTHER HEALTH COVERAGE ALTERNATIVES TO COBRA

**Note:** You may have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplaces (the Marketplaces help people without health coverage find and enroll in a health plan, (for California residents see: coveredca.com. For non-California residents see your state Health Insurance Marketplace or visit healthcare.gov).

With coverage from one of the Health Insurance Marketplaces, 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 healthcare.gov.

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 other plan within 30 days of losing coverage under this Plan even if that other plan generally does not accept late enrollees.

## HOW COBRA CONTINUATION COVERAGE WORKS

COBRA premiums are based on single, two-party, or family coverage. The Participant and any eligible dependents will be notified of their individual right to purchase COBRA Continuation Coverage when the Participant (and/or covered dependents) lose eligibility for employer-paid coverage and is not eligible for any other form of extended coverage. The Fund Office is responsible for administering COBRA Continuation Coverage. Participants must elect COBRA within 60 days after the date that Health Fund coverage is terminated.

Generally, the premium for COBRA Continuation Coverage includes the full cost of coverage, plus an administrative fee of 2 percent. Covered benefits are based on the COBRA Plan option selected and can include medical (including preventive care), vision, dental, and prescription drug coverage. Life insurance and accidental death and dismemberment coverage are not available with any COBRA Plan.

COBRA Continuation Coverage requires payment of a monthly premium. Whatever COBRA Plan the Participant and/or dependent(s) chooses at enrollment, he/she/they must remain

covered under that Plan for the duration of the calendar year unless any of the following occurs:

- COBRA premiums change
- Annual Open Enrollment
- A qualifying life event

## FOR MONTHLY PAYMENTS, WHAT IF THE FULL COBRA PREMIUM PAYMENT IS NOT MADE WHEN DUE?

If the Fund Office receives a COBRA premium payment that is not for the full amount due, they will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be significantly short of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

If there is a significant shortfall, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.

If there is not a significant shortfall, the Fund Office will notify the Participant and/or dependent(s) of the deficient amount and allow a 30-day time period to pay the shortfall.

- If the shortfall is paid in the 30-day time period, then COBRA continuation coverage will continue for the month in which the shortfall occurred.
- If the shortfall is not paid in the 30-day time period, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made (which may result in a mid-month termination of COBRA coverage).

## WHO'S ELIGIBLE FOR COBRA

COBRA Continuation Coverage is available to:

- A Participant losing employer-paid coverage who is not eligible for any other form of extended coverage offered by Health Fund;
- Dependents who were covered under the Health Plan before the Participant's loss of coverage;
- A covered dependent who turns age 26 and is no longer eligible to be covered as a dependent child;
- A new spouse — if the Participant is married while covered under COBRA. The Participant must notify the Fund Office within 30 days of the marriage in order to add the spouse. If the Fund Office is not notified within 30 days of the marriage, the spouse will lose the right to COBRACoverage, and coverage cannot be added until Open Enrollment; and
- A child who is born to, adopted by, or placed for adoption or legal guardianship with the Participant while covered under COBRA . The Participant must notify the Fund Office within
- 30 days of the Life Event. If the Fund Office is not notified within 30 days of the qualifying event, the child will lose the right to COBRA coverage and coverage cannot be added until Open Enrollment.

**NOTE:** COBRA Enrollment documents and notification of any of the Life Events above can be submitted to the Fund Office via email, mail, or fax as directed below:

- For secure communication with the PWGA, please register with ZixMail by going to web1.zixmail.net. We will respond to your email with a Zix secure email. Once registered, you may upload your form and email it back to our office.
- Email Eligibility@wgaplans.org
- Fax (818) 526-3180
- PWGA Health Fund
  Attn: Eligibility Department
  2900 W. Alameda Ave., Suite 1100
  Burbank, CA 91505
  (8:30 a.m. – 5 p.m.)

## QUALIFYING EVENT AND DURATION CHART

The following chart shows under what circumstances a person is entitled to COBRA Continuation Coverage (also known as qualifying events), and how long COBRA Continuation Coverage will last. The Participant must notify the Fund Office of a divorce, a legal separation, or a child's loss of dependent status within 60 days after the later of the date of the qualifying event or the date of the loss of coverage. If you do not, the time limit to elect COBRA Continuation Coverage will be exhausted, and your qualified dependent(s) will lose his/ her/ their right to elect COBRA Continuation Coverage.

| QUALIFYING EVENT AND DURATION | | | |
|---|---|---|---|
| **Who** | **Qualifying Event** | **Who is Eligible for COBRA Continuation Coverage** | **Duration of COBRA Continuation Coverage** |
| **Participant** | A reduction in earnings below the level required for eligibility; or<br><br>Depletion of point balance under the Extended Coverage Program | The Participant and all covered dependents | Up to 18 months (if covered under the Fund for less than two years in the past 5-year period)<br><br>Up to 24 months (if covered under the Fund for two years or more in the past 5-year period) |
| | Is disabled at the time the Participant becomes eligible for COBRA or the Participant becomes disabled within the first 60 days after COBRA continuation coverage begins | The Participant and all covered dependents | Up to 29 months (if 18 months, entitled to additional 11 months. If 24 months, entitled to 5 additional months). Proof of eligibility for Social Security Disability Benefits must be provided to the Fund Office within 60 days after the later of the date of determination, the date of the qualifying event, or the date of the loss of coverage, but before the end of the 18-month (or 24-month) period of COBRA Continuation Coverage to receive this extension. |
| | Dies | Covered dependents | Up to 36 months |
| | Becomes entitled to Medicare | Covered dependents | Up to 36 months |
| **Covered Spouse and/or Dependent Child** | Is no longer an eligible dependent (due to age limit, divorce, or legal separation) | The covered spouse and/or dependent child(ren) | Up to 36 months |
| | Is no longer an eligible dependent because of the Participant's death (all eligible covered dependents will remain covered until the Participant's Employer Paid Coverage and/ or extended coverage that was in effect at the time of death ends. All required dependent premium payments must be continued.) | The covered spouse and/or dependent child(ren) | Up to 36 months |
| | Is disabled at the time COBRA Continuation Coverage begins or within the first 60 days after COBRA Continuation Coverage begins | The covered spouse and/or dependent child(ren) | Up to 29 months of COBRA Continuation Coverage (if 18 months, entitled to additional 11 months. If 24 months, entitled to five additional months). Proof of eligibility for Social Security Disability Benefits must be provided to the Fund Office within 60 days after the later of the date of determination, the date of the qualifying event, or the date of the loss of coverage, but before the end of the 18-month (or 24-month) period of COBRA Continuation Coverage to receive this extension. |

When a qualifying event occurs the Participant or covered dependent must provide notification to the Fund Office within 60 days of the event. The Fund will mail full details about how to elect COBRA Continuation Coverage, including the cost and duration of coverage, to the Participant and/or eligible dependent. You must submit a completed COBRA Election Form to the Eligibility Department (as detailed on page 48) within 60 days of the Fund's COBRA notice date or the date coverage ended, whichever is later. Once you elect COBRA Continuation Coverage, the initial premium payment is generally due no later than 45 days from the election date. Coverage is not in effect until payment is received. The initial premium payment must be retroactive to the date of the qualifying event. This 45-day grace period is required by law, and no extensions will be granted.

Premiums are billed monthly and due on the first day of the month. Failure to pay the premium within 30 days of the due date will result in termination of the COBRA Continuation Coverage, and coverage will not be reinstated. This 30-day grace period is required by law, and no extension will be granted. Premium rates are subject to an annual change.

If a Participant or dependent does not respond to the COBRA election notice within 60 days of the notice date or the date coverage ended, whichever is later, the affected Participant or dependent will no longer be eligible for COBRA Continuation Coverage, and no extension will be granted.

## DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION OF COVERAGE

If a Participant, covered spouse, or dependent child is determined to be "totally disabled" by the Social Security Administration, the Participant, the covered spouse or dependent child can receive up to an additional 11 months of COBRA Continuation Coverage, for a maximum total of 29 months. The disability must have started some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage.

The Participant and/or dependent must notify the Fund Office of the Social Security Administration's decision before the end of the 18-month period of COBRA Continuation Coverage, but not later than 60 days after the later of the date of the disability determination, the date of the qualifying event, or the date of the loss of coverage. If the Fund Office is not notified within this time frame, the Participant and/or dependent will not be eligible for the disability extension. Notification must be sent to the Fund Office, attention to the Eligibility Department. The Participant and/or dependent must continue to pay the monthly premium during the disability extension period if applicable.

The Participant and/or dependent must notify the Fund Office of any subsequent determination by the Social Security Administration that the disabled individual is no longer disabled within 30 days of the date of such determination.

**IMPORTANT!**

Life insurance and accidental death and dismemberment coverage are not included with COBRA Continuation Coverage.

## SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE[21]

If the initial qualifying event is the Participant's reduction in earnings below the level required for eligibility or depletion of point balance under the Extended Coverage Program, and

[21] Please note that certain deadlines were extended during the COVID-19 National Emergency. Contact the Fund Office to learn more.

a covered spouse, or dependent child experiences another qualifying event during the 18-month COBRA Continuation Coverage period, the Participant's spouse and dependent children can get up to 18 additional months of COBRA Continuation Coverage, up to a maximum of 36 months reduced by the number of months they were previously covered under the Participant's qualifying event. This extension is available to the Participant's spouse and dependent children if the Participant dies, divorces the covered spouse, legally separates from the covered spouse, or enrolls in Medicare (Part A, Part B, or both) or the covered dependent children ceases to be a dependent under the Plan during the initial 18-month COBRA Continuation Coverage period. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**NOTE:** In all of these cases, the Participant and/or covered dependent must make sure to notify the Administrative Office of the second qualifying event within 60 days of the event. If you do not provide the Administrative Office with notice of a second qualifying event within this 60-day period, coverage won't continue beyond the 18-month period.

## WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA Continuation Coverage takes effect on the date of your qualifying event and continues until the earliest of the following:

- You fail to pay the initial COBRA premium within 45 days of the date you enroll for COBRA Continuation Coverage;
- If you fail to pay subsequent premiums within 30 days of the due date, then the date for which the last full COBRA premium payment was made;
- The date the 18-month, 24-month, 29-month or 36-month continuation period ends;
- With respect to the extension for disability, the date the disability extension ends or the date the person is no longer "disabled" — whichever occurs first;
- After electing COBRA Continuation Coverage, the date you or your dependents become covered under another group health plan that does not contain any applicable exclusion or limitation for any pre-existing condition of the individual;
- After electing COBRA Continuation Coverage, the date you or your dependents enroll in Medicare (Part A, Part B or both);
- The date you qualify for Certified Retiree coverage;
- The date you requalify for Active coverage;
- The date your or your dependents' coverage is terminated for cause on the same basis that would apply to similarly situated non-COBRA Continuation Coverage beneficiaries (e.g., fraud or misrepresentation); or
- The date the Fund no longer provides group health coverage.

Please direct questions about your COBRA Continuation Coverage to PWGA's Eligibility Department, or the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Contact information for EBSA is available at dol.gov/ebsa.

In order to protect your rights to elect COBRA Continuation Coverage, inform the PWGA of any address changes for you or your covered dependents.

## EXTENDED COVERAGE PROGRAM

Not applicable to eligible Named Employers (e.g., Writer's Guild-Industry Health Fund, Producer-Writers Guild of America Pension Plan, Writers Guild of America East and West, Writers Guild Foundation and employees of the Audacy Staff group).

## WRITER'S POINT SYSTEM

The Extended Coverage Program awards points to Participants who meet the minimum earning requirement to qualify for eligibility in their four-quarter earnings cycle. (See Summary of Benefits for more details).

A Participant can accumulate up to 50 points to use toward future Fund coverage. A Participant cannot accrue more than 50 points at any given time, but if they have previously used points, they can once again accumulate points up to the maximum of 50.

When a Participant meets the minimum earning requirement for one year of employer-paid Health Fund coverage during any earnings cycle ending on or after Sept. 30, 1989, he/she:

- Gets 1 point; and
- Gets a second point by meeting the required earnings minimum shown below; and
- Gets a third point by meeting the required earnings minimum shown below.

The chart shows how the Plan awards points for each four-quarter earnings cycle.

| EXTENDED COVERAGE PROGRAM POINT THRESHOLD | | | | | | | |
|---|---|---|---|---|---|---|---|
| Earnings Minimum for Second Point | Earnings Minimum for Third Point | Earnings Cycle Effective Date | Earnings Cycle Effective Date | Earnings Cycle Effective Date | Earnings Cycle Effective Date | Earnings Cycle Effective Date | Earnings Cycle Effective Date |
| $100,000 | $200,000 | | April 1, 2000 | July 1, 2000 | Oct. 1, 2000 | | |
| $103,252 | $200,000 | Jan. 1, 2001 | April 1, 2001 | July 1, 2001 | Oct. 1, 2001 | | |
| $106,089 | $200,000 | Jan. 1, 2002 | April 1, 2002 | July 1, 2002 | Oct. 1, 2002 | | |
| $108,741 | $200,000 | Jan. 1, 2003 | April 1, 2003 | July 1, 2003 | Oct. 1, 2003 | | |
| $111,460 | $200,000 | Jan. 1, 2004 | April 1, 2004 | July 1, 2004 | Oct. 1, 2004 | | |
| $113,968 | $204,500 | Jan. 1, 2005 | April 1, 2005 | July 1, 2005 | Oct. 1, 2005 | | |
| $116,534 | $209,101 | Jan. 1, 2006 | April 1, 2006 | July 1, 2006 | Oct. 1, 2006 | | |
| $119,156 | $213,806 | Jan. 1, 2007 | April 1, 2007 | July 1, 2007 | Oct. 1, 2007 | Jan. 1, 2008 | April 1, 2008 |
| $122,731 | $220,220 | | April 1, 2008 | July 1, 2008 | Oct. 1, 2008 | Jan. 1, 2009 | April 1, 2009 |
| $126,413 | $226,827 | | | July 1, 2009 | Oct. 1, 2009 | Jan. 1, 2010 | April 1, 2010 |
| $130,205 | $233,631 | | | July 1, 2010 | Oct. 1, 2010 | Jan. 1, 2011 | April 1, 2011 |
| $132,809 | $238,304 | | | July 1, 2011 | Oct. 1, 2011 | Jan. 1, 2012 | April 1, 2012 |
| $135,133 | $242,474 | | | July 1, 2012 | Oct. 1, 2012 | Jan. 1, 2013 | April 1, 2013 |
| $137,498 | $246,717 | | | July 1, 2013 | Oct. 1, 2013 | Jan. 1, 2014 | April 1, 2014 |
| $125,000 | $250,000 | | | July 1, 2014 | And Beyond... | | |

**Note:** Effective July 1, 2014, the covered earnings minimum on which the second and third points are awarded will no longer be increased based on any increase in the MBA minimum.

A Participant must accumulate at least 10 points (one time during the course of their career) to qualify for extended coverage benefits. Once the 10-point minimum has been met, and the Participant subsequently loses employer-paid coverage, the PWGA will send notification that the Participant has been automatically placed in the Extended Coverage Program. The Fund will send a statement indicating the number of points accumulated, the number of points used, and the number of available points remaining.

Coverage will be extended based on the rules below:

- 10 points for four quarters of coverage under the PPO Plan (total points reduced by 2½ points per quarter). Coverage includes medical, hospital, prescription, vision, wellness, dental, life insurance, and accidental death and dismemberment benefits; or
- 6 points for four quarters of coverage under Low Option Plan (total points reduced by 1½ points per quarter). Coverage includes medical, ACA-required preventive drugs, and hospital benefits only, with higher out-of-pocket costs.

(See the Summary of Benefits for specific information about your medical coverage options.)

Applicable points will be deducted per quarter until the Participant:

- Once again qualifies for Active Health Fund coverage;
- Becomes eligible for Certified Retiree Health Coverage (see definition of "Certified Retiree"); or
- Has exhausted all of his/her Extended Coverage points, or the point balance does not meet the following point subsidy requirements:
  - If a Participant with PPO Plan coverage has 1½ points remaining, the PWGA will subsidize one point to provide one additional quarter of coverage.
  - If a Participant with Low Option Plan coverage has ½ a point remaining, the PWGA will subsidize one point to provide an additional quarter of coverage.

**Note:** If eligible, the Participant is automatically placed in the Extended Coverage Program even if he/she qualifies for other coverage. Participation in the Extended Coverage Program cannot be waived.

If a Participant dies, the surviving spouse and/or covered dependent child(ren) may use the remaining points to extend their coverage, provided any applicable dependent premium is paid. (The spouse and/or dependent(s) must be covered by the Fund at the time of death.)

If a Participant becomes covered as a Certified Retiree, he/she will forfeit any remaining Extended Coverage points. For more information on Certified Retiree health coverage, please see the Certified Retiree section on page 36.

If a Participant has exhausted his/her points under the Extended Coverage Program, this will be considered a Qualifying Event, and he/she will be offered the option of purchasing COBRA Continuation Coverage. (For information about COBRA, see COBRA Continuation Coverage on page 42).

## EXTENDED COVERAGE PROGRAM – EXAMPLE 1

| Sept. 30, 2022 | | Oct. 1, 2022 – Dec. 31, 2022 | Jan. 1, 2023 – March 31, 2023 | April 1, 2023 – March 31, 2024 |
|---|---|---|---|---|
| Mary's Active Employer-paid Coverage ended on Sept. 30, 2022. Mary had 15 Extended Coverage Program (ECP) points banked | Mary did not satisfy the earnings minimum during her designated Four-quarter earnings cycle which was (July 1, 2021 to June 30, 2022).Since Mary had 15 ECP points, the Fund Office sent her a notice stating that effective Oct. 1, 2022 her coverage would be extended using her ECP points. The notice included an election form with two coverage plans to choose from, the PPO Plan and the Low Option Plan. Mary chose to stay on the PPO Plan. | Fourth quarter 2022 (October through December), Mary's coverage was extended using 2.5 ECP points, reducing her point balance to 12.5 points. | First quarter 2023 (January to March), Mary's coverage was extended once more using 2.5 ECP points. This left her with a balance of 10 ECP points. Good news! Mary's employer just submitted contributions for $48,000 for writing services she performed in the fourth quarter of 2022! Since the earnings were in the fourth quarter, the approximate date that the Plan will determine whether the earnings requirement was satisfied is Feb. 15, 2023 and her employer-paid coverage will begin on the first day of the following quarter. | Effective the first day of the second quarter 2023 (April 1, 2023), Mary's Active Employer-paid Coverage begins! Her coverage will last for one year. Mary's earnings of $48,000 resulted in 1 ECP point being added to her ECP point bank, bringing her total to 11 ECP points. |

## EXTENDED COVERAGE PROGRAM – EXAMPLE 2

| March 31, 2023 | | April 1, 2023 – June 30, 2023 | July 1, 2023 – June 30, 2024 | |
|---|---|---|---|---|
| Brian's Active Employer-paid Coverage ended on March 31, 2023. Brian had 8 Extended Coverage Program points. | Brian did not satisfy the earnings minimum during his designated four-quarter earning cycle which was (Jan. 1, 2022 to Dec. 31, 2022). Brian does not qualify to extend his coverage under the ECP, because he has not yet reached the one-time minimum required point balance of 10 points. Brian received a notice of termination and a notice of his right to purchase COBRA Continuation Coverage effective April 1, 2023. | Brian elected to purchase COBRA Continuation Coverage for one quarter (April to June). He knows that he earned $165,000 in the first quarter of 2023, which means the approximate date that the Plan will determine whether the earnings requirement was satisfied is May 15, 2023. As such, his employer-paid coverage will begin on the first day of the following quarter. | Effective the first day of the third quarter (July 1, 2023), Brian's active employer paid coverage begins! His coverage will last for one year. Brian's earnings of $165,000 resulted in 2 ECP points being added to his ECP point bank, bringing his total to 10 ECP points. | Brian takes comfort in knowing that he now has 10 ECP points. Should he lose coverage in the future, he will be able to extend his coverage under the Extended Coverage Program. |

## EXTENDED COVERAGE PROGRAM – EXAMPLE 3

| June 30, 2023 | July 1, 2023 – Sept. 30, 2023 | Oct. 1, 2023 – Dec. 31, 2024 | Oct. 1, 2024 – June 30, 2025 | |
|---|---|---|---|---|
| Leslie did not satisfy the earnings minimum during her four-quarter earnings cycle (April 1, 2022 to March 31, 2023). Her coverage will end on June 30, 2023. Leslie has 10 ECP points. Leslie satisfied the earnings minimum during the second quarter (April through June). This means the approximate date that the Plan will determine whether the earnings requirement was satisfied is Aug. 15, 2023, and her employer-paid coverage will begin on the first day of the following quarter. | Leslie elected the Low Option Plan and under the ECP, 1.5 points are deducted from her point balance to extend her coverage for one quarter (July through Sept.).Leslie now has 8.5 points in her ECP bank. | Effective the first day of the fourth quarter (Oct. 1, 2023), Leslie's active employer paid coverage begins! Her coverage will last for one year. Leslie does not satisfy the earnings minimum during her next four-quarter earnings cycle (July 1, 2023 to June 30, 2024). | Since a Participant must only reach the ECP 10-point minimum requirement once, Leslie is able to extend her coverage using her ECP points. This time, Leslie elects the PPO Plan. Beginning Oct. 1, 2024, Leslie's coverage is extended using 2.5 ECP points per quarter. Leslie is able to extend her coverage for a total of three quarters (Oct. 1, 2024 to June 30, 2025). Leslie has 1 point remaining in her ECP point bank. | Leslie's coverage under the ECP ends on June 30, 2025. Leslie has not yet satisfied the earnings minimum requirement. The Fund Office notifies Leslie that her coverage will end and provides her with an option to purchase COBRA Continuation Coverage. |

## EXCESS EARNINGS EXTENSION (ALSO KNOWN AS THE $250K EXTENSION) FOR INDIVIDUAL WRITERS

If you earn at least $250,000 in gross covered earnings in one earnings cycle, but you do not earn enough in your next personal earnings cycle to be eligible for Fund coverage, the Fund will provide coverage for another year by dividing the $250,000 covered earnings minimum equally between the two consecutive earnings cycles. If you do earn enough during the second earnings cycle to qualify for regular employer-paid coverage, you won't require the $250,000 extension. The extension cannot be held in reserve for future use. The Fund automatically provides this extension, so you do not need to take any action.

The $250,000 eligibility extension will be coordinated with the points awarded under the Extended Coverage Program. First, you will be granted an eligibility extension based on the $250,000 extension. Then, if necessary and if you have accumulated the required points, you will be granted eligibility based on your accumulated points.

## EXCESS EARNINGS EXTENSION FOR BONA FIDE TWO-PERSON TEAMS

Effective September 25, 2023, notwithstanding other provisions of this Basic Agreement in which writing teams are treated as a "single writer" for the purposes of Article 17, each individual in a writing team shall receive contributions up to 100% of the ceiling as if he or she is a sole writer.

## EXCESS EARNINGS EXTENSION (INDIVIDUAL) – EXAMPLE 1

| Oct. 1, 2022 – Sept. 30, 2023 | | Oct. 1, 2023 – Sept. 30, 2024 |
|---|---|---|
| Jules has Active Employer-paid Coverage from Oct. 1, 2022 to Sept. 30, 2023. The covered gross compensation which earned this coverage came from two signatory employers and totaled $265,000.For the first project, he earned $15,000; for the second project, he earned $250,000, and he earned three Extended Coverage Points. | Jules did not satisfy the earnings minimum during his next four-quarter earnings cycle (July 1, 2022 to June 30, 2023). Based on the MBA, the project ceiling for his second project was $250,000. Jules is still working on that project. Since his employer already reported $250,000 in his last earnings cycle, they are unable to make any additional contributions reports on his behalf. | Jules qualifies for the Fund's Excess Earnings Extension. Coverage is automatically extended for another year (Oct. 1, 2023 to Sept. 30, 2024), and he earned one Extended Coverage Point. |

## TOTAL DISABILITY EXTENSION

If, at the time earned coverage ends, you or a dependent are totally disabled, that person may receive extended benefits through the total disability extension offered by the Fund discussed below or through COBRA.

The Total Disability Application and Attending Licensed Health Care Provider Statement must be submitted within 30 days after coverage would otherwise end.

## A DISABLED PARTICIPANT

If you are totally disabled and deemed eligible for a disability extension of coverage, the totally disabled Participant and his/her covered dependents are entitled to full medical,

prescription, vision, and dental benefits for six months from the date earned coverage would otherwise end.

- If approved, a totally disabled Participant may receive up to a 6-month extension of coverage. Dependents may be covered during this period provided the dependent premium continues to be paid.
- If the Participant remains totally disabled beyond the 6-month period, he/she will be entitled to apply for an additional 12 months of "comprehensive medical coverage" as described below:
  - This includes only medical, dental, vision, and prescription drug benefits.
  - If the Participant elects the 12-month comprehensive medical coverage extension, he/she will not be offered COBRA at the termination of the extension.
  - If the Participant elects the 12 months of comprehensive medical coverage, his/her dependents will not be eligible for comprehensive medical coverage. Covered dependents will be offered COBRA Continuation Coverage. The duration of COBRA Continuation Coverage will be offset by the six months of disability extension previously received.
- After receiving the initial 6-month extension, if the Participant declines the 12-month comprehensive medical coverage and instead elects COBRA Continuation Coverage, the COBRA coverage will be for a period up to 12 months (not to exceed 18 months of combined coverage — six months total disability, and up to 12 months of COBRA) unless the Participant is entitled to a disability extension of COBRA continuation coverage pursuant to COBRA (in which case, the COBRA coverage will be for a period of up to 23 months (not to exceed 29 months of combined coverage – six month total disability and up to 23 months of COBRA)).

**Special Rule:** If at the time a Participant's Earned coverage ends, the Participant has been covered under the Health Fund for two years or more in the past five-year period, the Participant is entitled to up to 24 months of COBRA Continuation Coverage. Accordingly, if the Participant receives the entire 18-month Total Disability Extension, the Participant will be offered COBRA Continuation coverage for a maximum of 6 months at the end of the 18-month disability extension period.

## A DISABLED SPOUSE

If, at the time coverage would otherwise end (when the Participant's earned coverage ends), the covered spouse is totally disabled and deemed eligible for a disability extension of coverage, the spouse will be entitled to elect 12 months of comprehensive medical coverage or COBRA Continuation Coverage. If the 12-month comprehensive medical coverage extension is elected, COBRA will not be offered at the termination of the 12-month extension.

## A DISABLED CHILD

## TOTALLY DISABLED CHILD (UNDER AGE 26) – TEMPORARY DISABILITY EXTENSION

If, at the time coverage would otherwise end (when the Participant's earned coverage ends or the dependent child turns 26, whichever occurs first), and the dependent child is totally disabled, the totally disabled dependent child may be eligible for a temporary disability extension of coverage. Such a totally disabled dependent child may elect 12 months of

comprehensive medical coverage or COBRA Continuation Coverage. If the 12-month comprehensive medical coverage extension is elected, COBRA will not be offered at the termination of the 12-month extension.

***Example:*** The Participant loses earned coverage and the totally disabled dependent child is 24. The totally disabled dependent child may elect 12 months of comprehensive medical coverage or COBRA continuation coverage. If the 12-month comprehensive medical coverage extension is elected, COBRA will not be offered at the termination of the 12-month extension.

If the Participant regains earned coverage prior to the totally disabled dependent child turning age 26, the totally disabled dependent child is initially eligible for coverage as a dependent child under age 26. Assuming that the Participant continues with earned coverage and the totally disabled dependent child is covered on the day before his/her 26th birthday, the totally disabled dependent child is eligible for continued coverage as a totally disabled dependent child over age 26, provided that he/she remains totally disabled and meets the eligibility requirements for coverage under the Plan, as defined in Eligible Dependents on page 28.

## TOTALLY DISABLED CHILD (OVER AGE 26)

If a covered dependent child reaches age 26, is totally disabled, and meets the eligibility requirements for coverage under the Plan, as defined in Eligible Dependents on page 28, the totally disabled dependent child may be eligible for coverage as long as the Participant is covered under the Fund. If the Participant loses eligibility for Fund coverage, the totally disabled dependent child's coverage will also end. Should the Participant regain earned coverage at a later date, the totally disabled dependent child's coverage would resume, provided the totally disabled dependent child meets the eligibility requirements for coverage under the Plan, as defined in Eligible Dependents, and the dependent premium is paid (if applicable). Recertification of the dependent's total disability and eligibility for coverage under the Plan (as defined in Eligible Dependents) is periodically required.

**Note:** A dependent child whose coverage terminated under the Plan due to reaching age 26 and who subsequently becomes totally disabled after turning age 26 is not eligible to enroll as a totally disabled dependent child

**Note:** The Total Disability Application and Licensed Health Care Provider Statement form is available at wgaplans.org or by contacting the Eligibility Department at the Fund Office. If the Fund Office does not receive these forms within 30 days before coverage would otherwise end, coverage under this extension may not be granted.

## SURVIVOR COVERAGE

When a Participant dies their surviving dependents may be entitled to Survivor Coverage Benefits. There are two types of Survivor benefits available under the Fund: 1) Active Survivor Coverage; and 2) Certified Retiree Survivor Coverage.

## ACTIVE SURVIVOR COVERAGE

If a Participant dies with active coverage under the Fund, their covered surviving dependent(s) may be entitled to one of two kinds of Active Survivor coverage, if at the time of death:

- The Participant was under age 60; and

- Had accumulated at least 68 quarters of Health Fund coverage; and
- Was married for at least two years.

The surviving dependent(s) (child(ren) or qualified spouse — married more than two years) may elect either of the following Active Survivor Coverage plans (Please note: If there is a spouse involved with a child, then the spouse will elect. If it is just the child, then the child can make the election. If there are multiple child dependents, only one can elect for the all dependent children on the Plan.)

- Five years of full Health Fund coverage, beginning the day after the deceased Participant's Earned Coverage ends; or
- Subject to the applicable rules under the Fund, Certified Retiree Survivor coverage starting the first day of the month after the date the Participant would have turned age 60.

**Note**: Whichever plan is elected, the surviving dependents will first be covered under any remaining Employer Paid Coverage, Excess Earnings Coverage and Extended Coverage Points to which the Participant was entitled. Dependent premiums must be paid, if applicable.

## OPTION 1 - 5-YEAR SURVIVOR COVERAGE

If elected, 5-year Survivor Coverage will extend coverage for all eligible surviving dependents for a period of five years from the date the coverage begins. Annual verification of eligibility for this coverage will be required every year before coverage is extended. If more than one dependent is covered, payment of the quarterly dependent premium is required.

This coverage will end for the impacted individual if:

- Any surviving dependents become(s) eligible for Medicare or any other group health plan.
- If the surviving spouse remarries.
    - Should this occur all eligible surviving dependent children would remain covered until they turn age 26 or the 5-year period is completed, whichever occurs first, provided the quarterly dependent premium is paid.

## OPTION 2 - CERTIFIED RETIREE SURVIVOR COVERAGE

If elected, this coverage will commence on the first day of the month after the Participant would have turned age 60. If the Participant's remaining coverage (Active or Extended) will not provide coverage for the surviving dependents until the Participant's 60th birthday, COBRA Continuation Coverage will be offered for a maximum of 36 months.

Once commenced, Certified Retiree Survivor Coverage will remain in effect for each covered dependent until such covered dependents become ineligible or they die, whichever occurs first. If more than one dependent is covered, payment of the quarterly dependent premium will be required until the surviving spouse turns age 65. If no spouse is covered but there are dependent children, the dependent premium will be required for the duration of coverage if more than one dependent is on the Plan, unless a dependent becomes eligible for Medicare (at which point the dependent will have Medicare as their primary provider).

**Additional information regarding Certified Retiree Survivor Coverage**

If any surviving dependent becomes eligible for Medicare, the Plan's coverage will be secondary to Medicare.

(Please note: If the spouse becomes eligible for Medicare, then Medicare will be primary and children will still be covered as primary, if the child is under survivor coverage.)
(See Understanding Coordination of Benefits (COB) on page 81).

If any surviving dependent becomes eligible for any other group health plan, the Fund must be notified immediately so coordination of benefits can be properly applied.

This coverage will end for the impacted individual if:

- The surviving spouse remarries (the Fund must be notified immediately within 30 days of the marriage); or
- The surviving dependent children turn age 26 (unless they are totally disabled and meet the eligibility requirements for coverage under the Plan, as defined in Eligible Dependents on page 28.

Important – a surviving spouse must immediately (within 30 days of the marriage) notify the Fund Office if he/she remarries. They will be notified that their Health Fund Coverage will end, and that they have the right to enroll in and purchase COBRA Continuation Coverage. (For information about COBRA, see COBRA Continuation Coverage beginning on page 42.)

To learn more about Active Survivor Coverage options, please see the examples below and on the following page

## POP-UP ACTIVE SURVIVOR COVERAGE - OPTION 1

| Jan. 1, 2022 – Dec. 31, 2022 | Dec. 1, 2022 | Jan. 1, 2023 – Dec. 31, 2023 | Jan. 1, 2024 – Dec. 31, 2028 |
|---|---|---|---|
| Joe passed away at 52 years old. He had 68 qualified quarters but had not yet retired under the Pension Plan. He was on Active Employer-paid Coverage until Dec. 31, 2022 and he covered his wife, age 48 and two dependent children. He was married for seven years. He had 10 Extended Coverage Points. | The Fund Office sent Joe's surviving spouse a letter informing her of the two options for Active Survivor Coverage. She chose Option 1, which means the family will receive Active Survivor Coverage for five years from the date Joe's Active Employer-paid Coverage ends. | Since Joe had 10 Extended Coverage Points, the family's Health Fund coverage continued through Dec. 31, 2023 (quarterly dependent premiums were required during this time). On Dec. 1, 2023, the spouse received a request from the Fund Office to validate their eligibility for the Active Survivor Coverage they previously elected. The request also contained an invoice for the quarterly dependent premium for the upcoming quarter. She returned the form and paid required dependent premium promptly, and the family's Active Survivor Coverage began on Jan. 1, 2024. | Joe's surviving spouse will receive an annual request to verify eligibility to receive Active Survivor Coverage every year for the duration of five years. Joe's family will remain eligible for Active Survivor Coverage from Jan. 1, 2024 to Dec. 31, 2028. In Nov. 2028, the Fund Office will send Joe's surviving family a notice of termination and an option to enroll in COBRA Continuation Coverage. |

## POP-UP ACTIVE SURVIVOR COVERAGE - OPTION 2

| July 1, 2022 – June 30, 2023 | June 1, 2023 | July 1, 2023 – Feb. 29, 2024 | March 1, 2024 |
|---|---|---|---|
| Jenn passed away at 58 years old. She had 72 qualified quarters. She had not yet retired under the Pension Plan. She was on Active Employer-paid Coverage through June 30, 2023. She had a husband, age 60 and they were married for 20 years. She had 30 Extended Coverage Points. | The Fund Office sent Jenn's surviving husband a letter informing him that Jenn had 30 Extended Coverage Points remaining that the family was entitled to use. Additionally, the Fund's letter informed him of the two Surviving Spouse options available. Jenn's surviving husband selected Option 2 (Active Certified Retiree Coverage). | Because Jenn had 30 Extended Coverage Points, her spouse's coverage was continued under the Extended Coverage Program until Feb. 29, 2024. (Jenn would have turned 60 on Feb. 12, 2024.) | The unused Extended Coverage Points are forfeited (because Jenn would have reached age 60) and the Active Certified Retiree Survivor Coverage began on March 1, 2024. Her husband was under 65, so the Fund's coverage remained primary. Once he turns 65, Medicare will become primary and the Fund will be secondary. |

## CERTIFIED RETIREE SURVIVOR COVERAGE

If a Participant is at least 60 years old when he/she dies, and the Participant has accumulated at least 68 qualified quarters of Health Fund coverage, one of two survivor coverages will be offered to the surviving dependents depending on the circumstances:

- If a Participant had been married for at least two years at the time of death, his/her surviving dependents will receive the same Certified Retiree health benefits he/she/they would have received had the Participant retired and died immediately thereafter; or
- If a Participant had been married for less than two years at the time of death, the surviving spouse will be entitled to receive Certified Retiree Survivor Coverage for six months. Thirty days before coverage ends, the surviving spouse will be notified of his/her right to enroll in and purchase COBRA Continuation Coverage (for up to 36 months). For information about COBRA, see COBRA Continuation Coverage beginning on page 42.
- All eligible dependent children will continue to be covered under the Certified Retiree Survivor Coverage benefit until the dependent child turns age 26 (unless the dependent child is totally disabled and meets the eligibility requirements for coverage under the Plan, as defined in Eligible Dependents on page 28).

Certified Retiree Survivor Coverage will end for the impacted individual if:

- The surviving spouse remarries (the Fund must be notified immediately within 30 days of the marriage date); or
- The surviving dependent children turn age 26 (unless they are totally disabled and meet the eligibility requirements for coverage under the Plan, as defined in Eligible Dependents on page 28).

**PLEASE NOTE:** If you are entitled to both Certified Retiree Health Coverage and COBRA Continuation Coverage at the time your Active Coverage ends, you (the Plan Participant) will be offered a choice of temporary continuation of your Active group health coverage under COBRA rather than the Retiree health coverage. If you receive the Fund's Retiree health coverage, you would have no further COBRA continuation rights. However, your covered dependent(s) may experience a COBRA Qualifying Event.

## ADDITIONAL INFORMATION REGARDING CERTIFIED RETIREE SURVIVOR COVERAGE

If any surviving dependent becomes eligible for Medicare, the Plan's coverage will be secondary to Medicare. (Please note: If the Spouse becomes eligible for Medicare, then Fund will pay secondary. If there are dependent children, Medicare would not be involved, and Fund will pay primary for children.)

(See Understanding Coordination of Benefits (COB) on page 81.)

If any surviving dependent becomes eligible for any other group health plan, the Fund must be notified immediately so Coordination of Benefits can be properly applied.

## POP-UP CERTIFIED RETIREE SURVIVOR COVERAGE -BENEFIT PLAN 1 (MARRIED LESS THAN TWO YEARS)

| May 31, 2023 | June 1, 2023 – Dec. 31, 2023 | Oct. 1, 2023 |
|---|---|---|
| Bill was 82 years old and he was covered as a Certified Retiree for 20 years. Medicare was his primary insurance, the Plan was secondary. Bill met the love of his life and got married. Sadly, Bill passed away on May 10, 2023, just four months shy of his second wedding anniversary. | The Fund Office sent Bill's surviving spouse a letter informing him of the Surviving Spouse benefit. The letter stated that since they had been married less than two years when he passed, he would be entitled to six months of Certified Retiree Survivor Coverage beginning on June 1, 2023. | On Oct. 1, 2023 (60 days before the 6-month Survivor Coverage ends) the Fund Office will send Bill's surviving spouse a notice of termination and option to enroll in COBRA Continuation Coverage. |

## POP-UP CERTIFIED RETIREE SURVIVOR COVERAGE -BENEFIT PLAN 2 (MARRIED TWO YEARS OR MORE)

| Oct. 1, 2022 – Sept. 30, 2023 | Oct. 1, 2023 | Additional Information |
|---|---|---|
| Jane was 68 when she passed. She had 118 qualified quarters, was still covered under Active employer paid coverage and had not yet retired from the Pension Plan. She had four Extended Coverage Points. She had been married for 15 years and covers her husband (age 66) and dependent child (age 24). Jane is required to pay the quarterly dependent premium because she is still on Active coverage until Sept. 30, 2023. Jane passed on July 28, 2023. | The four Extended Coverage Points are forfeited (because Jane was already over 65 years old, therefore, Certified Retiree coverage supersedes all other types of coverage) and the Certified Retiree Survivor Coverage began on Oct. 1, 2023. Her husband was over 65 which means Medicare became the primary insurance and the Fund is secondary. | Jane's surviving husband does not have to pay the quarterly dependent premium because he is over 65, covered, and has Certified Retiree Survivor coverage. Thirty days before the dependents 26th birthday, the Fund Office will send a notice of termination with an option to enroll in and purchase COBRA Continuation coverage for a maximum of 36 months. |

## NEW YORK STATE CONTINUATION ASSISTANCE PROGRAM (NEW YORK RESIDENTS ONLY)

This program assists eligible entertainment industry employees who reside in the state of New York to maintain health insurance coverage through COBRA Continuation Coverage. Eligible applicants shall receive COBRA premium assistance equal to 75% of their monthly COBRA premiums for up to 12 months of assistance in a five-year period.

In order to qualify for the New York State Continuation Assistance Program, your household income must fall within the limits established for the program. Even if your COBRA Continuation Coverage has already begun, you may still qualify for this Premium Assistance Program. For more information about the program, please contact the New York State Department of Financial Services at (518) 486-7815 or COBRA.application@dfs.ny.gov or visit one of the following:

NYSDFS: NYS Continuation Assistance Program - Application for Entertainment Industry Employees

Health Insurance - COBRA: Continuation Assistance Demonstration Program for Entertainment Industry Employees | Department of Financial Services (ny.gov)

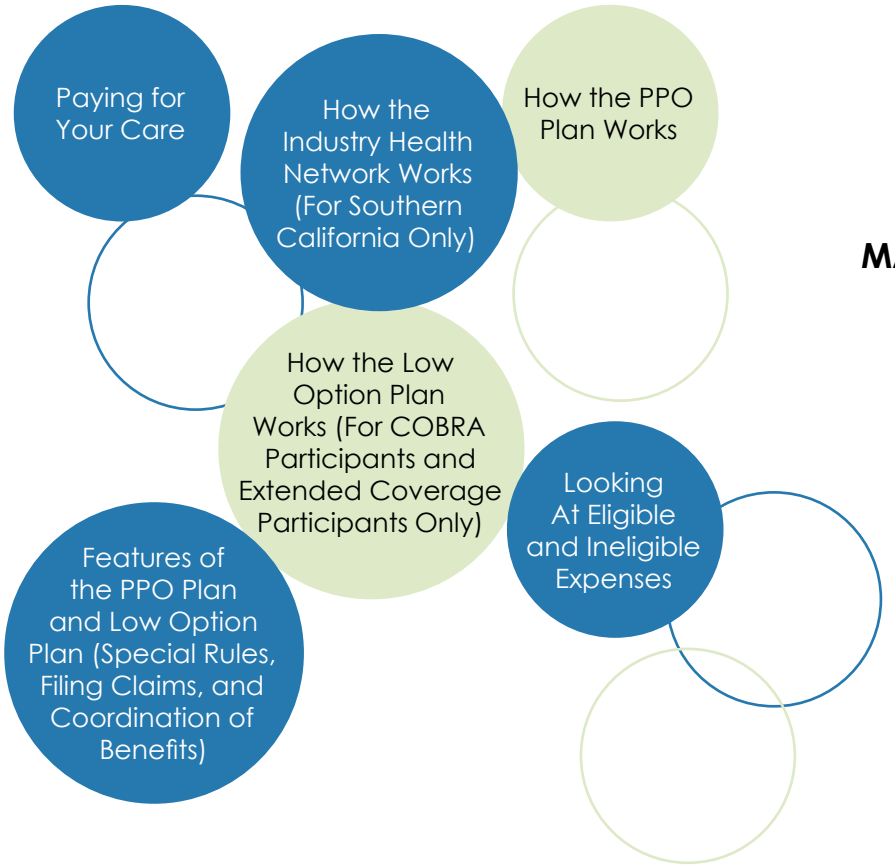
Health Insurance - COBRA: Coverage for Eligible Entertainment Industry Employees - FAQs | Department of Financial Services (ny.gov)

You have health care benefits that allow you to receive health care depending on where you live and whether you're a Participant with Active Coverage, COBRA Continuation Coverage, or coverage under the Extended Coverage Program.

In the following pages, you will find detailed descriptions about:

**IMPORTANT!**

If you live, or if you are visiting or working, in Southern California, you can get medical care at one of the local area health centers established especially for members of the entertainment industry. By using The Industry Health Network (TIHN), you could pay less out-of-pocket for care than you would by using other providers. (See Summary of Benefits, page 15. For additional details on TIHN, see pages 72-73.)




## MAJOR TOPICS IN THE MEDICAL BENEFITS SECTION

# PAYING FOR YOUR CARE

The Plan provides an extensive package of benefits that help you pay for everyday medical costs, preventive care, wellness, and mental health and substance use disorder benefits. The Plan pays toward covered physician charges, hospital and surgical expenses, laboratory and radiology charges, and prescription drugs, among other medical expenses. The Plan's benefits are subject to the exclusions and limitations described throughout this SPD. Services also must be Medically Necessary in order to be covered. As such, the Plan's benefits may not cover all treatment prescribed by your treating provider.

## ELIGIBLE EXPENSES

Any Allowed Charge for Medically Necessary services or supplies which is covered in full or in part by the Plan is considered an eligible expense.

For services to be considered eligible expenses, the health care provider must possess valid licensure or certification appropriate to the scope of his/her practice and provide services within the scope of that license. Any facility that provides health services also must possess a license, state accreditation, or Medicare recognition appropriate to the services it provides within the scope of that license.

## CALENDAR YEAR DEDUCTIBLE

A "calendar year deductible" is the portion of eligible expenses you are responsible for paying each calendar year before the Fund begins to pay certain benefits. Prescription drug benefits, preventive care, and wellness benefits are not subject to the calendar year deductible, though many prescription drug and wellness benefits require copays. Deductibles apply to all Plan options except when you receive services from TIHN.

Here is the breakdown of deductibles under the Health Plan:

- Individual deductible - Each covered person pays a specific amount each calendar year toward eligible expenses before the Fund begins paying a portion of those expenses.
- Family deductible - If you cover your dependents, any medical expense that counts toward an individual's deductible automatically counts toward the family deductible.
- Once three or more covered family members have met the combined family deductible, all enrolled family members are considered to have met their deductibles for the calendar year, and benefits will be paid accordingly.
- Multiple family member accident - If two or more covered family members are injured in the same accident, only one individual deductible will be applied to the eligible expenses for all affected family members. The deductible will be applied only to those accident-related medical expenses incurred during the calendar year in which the accident occurs.
- Deductible carryover - This is a special provision that applies to every covered family member. It allows you to carryover eligible expenses that were applied to your deductible from one year to the next under certain circumstances. Any portion of your calendar year deductible satisfied in the fourth quarter (i.e., October, November, and December) of each year will be carried over and applied to the next calendar year deductible.

## SAVINGS SYNOPSIS

If you use an out-of-network provider, the Plan pays a lower percentage of covered expenses (which means you pay more), and you're responsible for any amount over the Allowed Charge. To minimize your out-of-pocket expenses, use in-network providers whenever possible.

## COPAYMENTS

A copayment, or "copay", is a fixed-dollar amount that you pay for an eligible expense at the time the service is provided. Some network services require a copay for each visit or service. After you pay the copay and any applicable coinsurance, the Fund pays the rest of the cost of your care, up to certain maximums and limitations. Copays are required for specific benefits for all Plan options. Copays do not count toward your deductible.

**IMPORTANT!**

Check out the Summary of Benefits for specific individual and family deductible amounts, as well as for specific copay and coinsurance amounts. Separate copays apply to:

- Prescription drug purchases
- Hospital admissions (copay applies in addition to the deductible)
  - A "hospital admission" implies an over-night stay in the main hospital facility.
  - If, after you are discharged, you are re-admitted within 30 days for the same injury or illness, that admittance is considered the same as the initial hospital admission and you won't have to pay an additional copay.
- Visits to an emergency room or urgent care facility (copays apply in addition to the deductible).

NOTE: If you're subsequently admitted to the hospital, the emergency room copay will be waived. However, you will have to pay the hospital admission copay.

## COINSURANCE

"Coinsurance" is the percentage of eligible expenses that you must pay after the calendar year deductible has been met and after any copayment.

## IN-NETWORK AND OUT-OF-NETWORK PROVIDERS

In-network health care providers are doctors and hospitals that have agreed to be part of a Preferred Provider Organization (PPO) and to charge a reduced rate when used by Health Plan Participants. When you use an in-network provider, the provider should not "balance bill" — i.e., charge more than the contracted rate. Out-of-network providers are doctors and hospitals not affiliated with the Health Plan's PPO, which means they can charge whatever they deem appropriate. You are responsible for the non-covered expenses, any copays, the deductible, and the coinsurance amount, unless you see an out-of-network provider under the following circumstances:

- You receive emergency services at an out-of-network health care facility (unless you consent to out-of-network billing rates for certain post-stabilization services)
- You receive non-emergency services from an out-of-network provider at an in-network health care facility (unless you consent to out-of-network billing rates, if applicable)
- You receive out-of-network air ambulance services.

If you visit an out-of-network provider or facility in the situations described above, the out-of-network provider or facility may not bill you for any Eligible Expenses in excess of the Fund's Allowed Charge. In addition, your cost-sharing will be the same as if you had visited an in-network provider or facility, meaning that once you have met your deductible, your cost-

sharing amounts will be applied to your ACA In-Network Out-of-Pocket Limit and Coinsurance Network Out-of-Pocket Limit. For more information on the items and services covered during your visit, please see page 64.

Your health care provider may collect fees at the time services are rendered. Refer to page 65 for additional information.

## PROVIDER DIRECTORY

To help you find care from in-network providers and facilities, Anthem maintains a provider directory. Anthem updates its provider directory every ninety (90) days and will respond to your inquiry about the network status of a provider or facility within one business day. If you receive inaccurate information from Anthem or the Fund office about a provider or facility's network status, you will be liable only for in-network coinsurance for the services underlying your inquiry. It is your responsibility to confirm that the provider or facility that you have selected is in-network at the time you receive services.

To find an in-network provider, call the Fund Office at (818) 846-1015 or (800) 227-7863 or Anthem Blue Cross at (800) 810-BLUE (2583) or view the network's provider listings at wgaplans.org ("Health/Find a Participating Provider").

## CONTINUITY OF COVERAGE

The Fund provides continuity of coverage in situations where a termination of a contractual arrangement changes the in-network status of a provider or facility to out-of-network (except in the case of a termination of the contract for failure to meet applicable quality standards or for fraud).

If you are a "Continuing Care Patient," you will be notified of the contract termination and your right to elect continued transitional care from the provider or facility; and, you will be allowed ninety (90) days of continued coverage from the provider or facility at in-network cost-sharing to allow you time to transition to a new in-network provider or facility.

A Continuing Care Patient is an individual, who, with respect to a provider or facility, is undergoing:

- A course of treatment for an acute illness (serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm) or chronic illness or condition (life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time);
- Is undergoing a course of institutional or inpatient care from the provider or facility;
- Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility;
- Is pregnant or undergoing a course of treatment for the pregnancy from the provider or facility; or,
- Is or was determined to be terminally ill (under SSA § 1862(dd)(3)(A)) and is receiving treatment for such illness from such provider or facility.

## ALLOWED CHARGE (OUT-OF-NETWORK SERVICES)

Anthem Blue Cross negotiates rates with doctors and other health care providers to help you save money. We refer to these health care providers as "in-network" providers.

The Fund also pays for services from health care providers who are not in the network. Many plans pay for out-of-network services based on what is called the Allowed Charge.

The Allowed Charge (sometimes also referred to as the Allowed Amount or Allowable Charge) is the maximum dollar amount of a charge that the Fund will consider (prior to applying a deductible, coinsurance, or maximum) when determining benefits payable by the Fund. The Fund determines the Allowed Charge as the lowest of the following:

**IMPORTANT!**

If you are contemplating incurring a major medical expense from an out-of-network health care provider, you may want to find out whether the provider's charges fall within Allowed Charge limits for that service. Before you receive care, call the Fund Office for assistance. Allowed Charge limits are re-evaluated and adjusted periodically.

- With respect to an in-network health care provider or facility, the negotiated fee or rate set forth in the agreement between the network and the Fund; or
- With respect to an out-of-network health care provider or facility, the amount the Fund has determined it will allow for eligible, Medically Necessary covered services or supplies from out-of-network providers or facilities, except in the case of certain out-of-network services protected by the No Surprises Act, as explained below.
- With respect to services protected by the No Surprises Act, which are: (1) emergency services at an out-of-network health care facility (unless you consent to out-of-network billing rates for certain post-stabilization services), (2) non-emergency services by an out-of-network provider at an in-network health care facility (unless you consent to out-of-network billing rates, if applicable), and (3) out-of-network air ambulance services, the Allowed Charge is the "Qualifying Payment Amount," which is defined on page 238 of the Glossary; in general, it may be similar to the contracted rate with an in-network provider; or
- With respect to an in-network health care provider or facility whose network contract stipulates that the provider does not have to accept the network negotiated fee or rate for claims involving a third-party payer (including, but not limited to, auto insurance, workers' compensation or other individual insurance), or where the Fund may be a secondary payer, the negotiated fee or rate that would have been payable by the Fund had the claim been processed as an in-network claim; or
- The negotiated discounted amount that an out-of-network provider or facility agreed to, reducing the provider's original billed charges to a lower, discounted amount; or
- The provider's or facility's actual billed charge.

The Fund will not always pay benefits equal to or based on the provider's actual charge for health care services or supplies, even after you have paid the applicable deductible, copay, and/or coinsurance. This is because the Fund covers only the Allowed Charge for health care services or supplies.

The Allowed Charge is not necessarily reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary, and reasonable charge (UCR), prevailing, or any similar term. The Fund reserves the right to have the billed

amount of a claim reviewed by an independent medical review firm or provider to assist in determining the amount the Fund will allow for the submitted claim.

Any amount in excess of the Allowed Charge does not count toward the annual Coinsurance Out-of-Pocket Limit or ACA Out-of-Pocket Limit. Participants are responsible for amounts that exceed the "Allowed Charge" by the Fund.

The Plan reserves the right to negotiate with an out-of-network provider to reduce the billed charges to a lower, discounted amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a utilization management company, claims administrator, attorney, medical claim repricing firm, discount negotiation firm, or wrap/secondary PPO. This negotiated discounted amount will become the Allowed Charge amount upon which the Plan will base its payment for covered services for the out-of-network provider considering the Plan's cost-sharing provisions, Plan design, and any special reimbursement provisions adopted by the Plan.

In accordance with federal law, with respect to out-of-network emergency services that meet the definition of emergency services on page 231, the Fund's Allowed Charge for emergency room (E/R) visit facility fees and E/R professional fees is the lesser of the Qualifying Payment Amount or the billed charge.

**NOTE:** Balance billing occurs when a health care provider bills a patient for charges (other than copays, coinsurance, or deductibles) that exceed the Fund's payment for a covered service. If you use an out-of-network health care provider, and the services are not protected by the No Surprises Act, you may be balance billed by that provider. A list of out-of-network services protected by the No Surprises Act may be found on page 236.

Here are examples of an in-network and out-of-network office visit due to urinary tract infection (UTI). The Participant pays less when service is rendered by an in-network provider, $13.72, in comparison to service rendered by an out-of-network provider, $170.

| **Example - In-network v. Out-of-network Office Visits** | |
|---|---|
| **In-network cost sharing, yearly deductible of $400 met** | |
| Office visit charge | $350.00 |
| Anthem contractual discount, patient is not responsible | $258.51 |
| Eligible expense | $91.49 |
| Plan pays 85% of eligible expense | $77.77 |
| Participant pays 15% of eligible expense | $13.72 |
| **Out-of-network cost sharing, yearly deductible of $400 met** | |
| Office visit charge | $350.00 |
| Amount greater than the Allowed Charge (patient is responsible) | $50.00 |
| Allowed Charge | $300.00 |
| Plan pays 60% of Allowed Charge | $180.00 |
| Participant pays 40% of Allowed Charge plus the amount greater than Allowed Charge ($120 + $50) | $170.00 |

## OUT-OF-POCKET LIMITS

Under the Plan, there are two separate limits for the out-of-pocket eligible expenses you are responsible for paying each year — the Coinsurance Out-of-Pocket Limits and the ACA Network Out-of-Pocket Limit.

Out-of-pocket (OOP) limits mean there are limits for what you will pay for covered services. The Plan has separate Coinsurance OOP Limits for individuals. Keep in mind that in-network and out-of-network eligible expenses each count toward their respective out-of-pocket limits.

These Coinsurance OOP Limits limit the total amount of coinsurance you will pay before the Plan begins paying 100 percent of most eligible expenses.

Even if you reach the Coinsurance Out-Of-Pocket Limit(s), you must still pay copays for:

- Prescription drugs, hospital admissions, and emergency room or facility visits under the PPO Plan;
- Hospital admissions and emergency room or facility visits under the Low Option Plan; and
- The Industry Health Network (TIHN).

**Note:** Once you reach the Coinsurance OOP Limit(s), you only pay copays for the above bulleted items until you reach ACA Network OOP Limit (as explained below).The Plan complies with the ACA Network OOP Limit (family and individual). The ACA Network OOP Limit limits the total amount you will pay for in-network deductible, copays, and coinsurance for eligible expenses each year before the Plan begins paying 100 percent of most eligible expenses.

However, keep in mind that the Coinsurance OOP Limits and the ACA Network OOP Limit never include amounts you must pay for your dependent premiums (if any), any balance-billed charges over the Allowable Charge, or health care services that the Plan doesn't cover.

See the Summary of Benefits section on page 2 for more details about the Coinsurance OOP Limit and the ACA Network OOP Limit.

**IMPORTANT!**

Check out the Summary of Benefits section on page 2 for specific out-of-pocket limit amounts. Some Medicare-eligible Certified Retirees and their Medicare-eligible spouses and/or other dependents have lower out-of-pocket limits than Participants with active coverage.

## EXPENSES THAT DO NOT ACCUMULATE TO THE ACA IN-NETWORK OUT-OF-POCKET LIMIT

Under the Plan, each year, you are responsible for paying the following expenses out of your own pocket. These expenses do not accumulate towards the ACA Network OOP Limit or the Coinsurance OOP Limit:

- All expenses for medical services or supplies that are not covered by the Plan;
- All charges in excess of the Allowed Charge determined by the Plan;
- All charges in excess of the Plan's maximum benefits, or in excess of any other limitation of the Plan;
- All expenses for medical services or supplies in excess of Plan benefits;
- The cost of drugs included in the SaveonSP program, including the applicable cost share amounts, whether or not you choose to participate in the program; and
- In the case of the ACA OOP Limit, all expenses for medical services or supplies obtained from out-of-network providers, excluding:
    - Emergency services at an out-of-network health care facility (unless, in the case of certain post-stabilization services, you consent to out-of-network billing rates)
    - Non-emergency services received from an out-of-network provider at an in-network health care facility (unless you consented to out-of-network billing rates) Out-of-network air ambulance services.

**IMPORTANT!**

The out-of-pocket limits do include any expenses related to covered in-network preventive care services or wellness benefits as those benefits are covered at 100% with no deductible.

# HOW THE PPO PLAN WORKS

The Preferred Provider Organization (PPO) Plan is network-based medical coverage that gives you more choices when choosing health care providers. The PPO Plan is available nationwide, and it is the default plan in which you are automatically enrolled when you become eligible for the Fund's health care benefits.

This is how it works: The PPO network contracts with physicians, hospitals, and other health care providers to provide services at a contracted rate. (See the Summary of Benefits section beginning on page 1 for benefit information.) Neither you nor the Fund is required to pay any amount over the contracted rate.

Each time you need medical care, you have the option of seeing:

- Any in-network provider and paying the required coinsurance. This means less money out of your pocket; or
- Any out-of-network provider and paying a higher coinsurance percentage of the Allowed Charge, plus any amount over the Allowed Charge. This means your out-of-pocket costs will be higher.

Through its contract with Anthem Blue Cross, the Fund uses a single nationwide hospital and major medical network — the BlueCross Blue Shield Global Core PPO network — for all PPO Plan and Low Option Plan Participants, no matter where they may live or travel. (For specific claim submission for services rendered, see the Filing Claims in General section on page 194 for medical claims.)

**IMPORTANT!**

**Patient Protection Disclosure:** If the non-grandfathered (as defined by the ACA) group health plan benefit option in which you are enrolled requires or provides for the designation of a primary care provider, you have the right to designate any participating primary care provider who is available to accept you or your family members. (For children, you may designate a pediatrician as the primary care provider.)

Whether you see an in-network health care provider or an out-of-network provider, the PPO Plan covers a broad range of medical services and supplies, including wellness benefits, hospital treatment, and prescription drug benefits.

For The Industry Health Network (TIHN), you can contact TIHN's Customer Service department at (800) 876-8320. For Anthem Blue Cross and nationwide BlueCard PPO in-network providers, call the Fund Office at (818) 846-1015 or (800) 227-7863 or Anthem Blue Cross at (800) 810-BLUE (2583) for information or view the network's provider listings at wgaplans.org ("Health" | "Find a Participating Provider").

You do not need prior authorization from the Health Plan or from any other person, including your primary care provider, in order to obtain access to obstetrical or gynecological care from a health care professional. However, you may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the TIHN and Anthem Blue Cross and nationwide BlueCard networks as described above.

## IF YOU LIVE OUTSIDE THE PPO NETWORK AREA

Participants who live more than 25 miles from a minimum of two health care providers (any type) who participate in the hospital/major medical PPO network, may be considered for out-of-area benefits. The PPO Plan's out-of-area benefit pays a percentage of the cost of eligible expenses, up to the Allowed Charge limit, after you meet your calendar year deductible. (See the Summary of Benefits for specific percentages.)

If you're traveling in an area where there are PPO in-network providers, you can use them. If you live close enough to a PPO provider, and you want to travel to that provider for care, you may do so.

That way, you can receive the advantage of network negotiated fees and reimbursement of eligible expenses without Allowed Charge limits.

If a Participant who lives in a network area is being treated for a serious condition and there are no in-network specialists in his/her area, the Participant may be considered for out-of-area benefits for services rendered by a non-contracted specialist in his/her network area. A serious condition includes conditions such as cancer and cardiac surgery. It does not include situations of a non-serious nature, such as claims for chiropractic or acupuncture.

The PPO Plan's out-of-area benefit covers the same medical services and supplies that are otherwise covered under the Health Plan, including prescription drugs. You are responsible for contacting the Fund Office to determine if your provider would qualify for out-of-area benefits.

## SUB-TOPICS


- Getting The Most From Your Plan – Page 70
- Looking At Eligible And Ineligible Expenses – Page 88
- Filing Claims in General – Page 194
- Understanding Coordination of Benefits (COB) – Page 81

## GETTING THE MOST FROM YOUR PLAN

The Health Plan's PPO option gives you choices when managing your medical care. You may choose to seek care from either in-network or out-of-network health care providers. However, if you choose in-network providers, you will pay less and spend less time filing claims.

## WHAT DOES ALL THIS MEAN IF I GO TO THE DOCTOR?

When you visit an in-network health care provider:

- If you have not met your calendar-year deductible, you will pay the full amount of the health care provider's charge, up to the contracted rate. That amount will be credited toward your deductible.
- If you have met your calendar-year deductible, you will pay only the coinsurance based on the contracted rate, and a copay, if applicable. In-network providers are contractually prohibited from "balance billing" you — that is, charging you for any amount above the contracted rate.

When you visit an out-of-network health care provider, the following principles generally apply:

- If you have not met your calendar-year deductible, you will pay the full amount.
- If you have met your calendar-year deductible, you will pay the out-of-network coinsurance (which is a higher percentage than the in-network coinsurance) of the Allowed Charge, and a copay, if applicable.
- If the physician charges more than the Allowed Charge, or allowed amount, you are also responsible for any charges above this amount.

Important Exception: If you receive emergency services at an out-of-network health care facility (unless you consent to out-of-network billing rates for certain post-stabilization services), receive non-emergency services from an out-of-network provider at an in-network health care facility (and do not consent to out-of-network billing rates, if applicable), or need out-of-network air ambulance services, out-of-network providers or facilities may not bill you for any amounts in excess of the Allowed Charge. In addition, your cost-sharing will be the same as if you had seen an in-network provider; and, once you have met your deductible, will be applied to your ACA Network OOP Limit and your Coinsurance OOP Limit

***Claim Example:*** A Participant's spouse has bronchitis and goes to an in-network doctor. He knows that for doctor's visits, he does not have to pay a copay, but he does have to pay the coinsurance. Let us assume that the spouse has already met his individual calendar year deductible of $400. Let's also assume that the Fund pays 85% of the contracted rate for in-network services, which makes his coinsurance 15%. The spouse's doctor sends a bill for $300, but because the doctor's contracted rate is $90 for that service, the spouse's share of that cost is $13.50 (15% of $90 contract rate).

The Participant also needs to go to the doctor. Let's assume that she has already met her individual calendar year deductible of $400. She always lets her business manager worry about bills, so she doesn't try to find an in-network provider. Instead, she goes to a new doctor, who is out-of-network. The doctor charges $300 for the visit, which she has to pay up-front. The Allowed Charge for this service is $170. The Fund will pay 60% of the Allowed Charge for out-of-network services, and she is responsible for paying the balance. The Participant's share of that cost is $68 (40% of $170) plus $130 (the amount of the office visit cost above the Allowed Charge), totaling $198.

| Patients | Physician's Charge | Allowed Charge | Percentage of Allowed Charge the Fund Pays | Amount the Fund Pays | Amount the Patient Pays (deductible already met) |
|---|---|---|---|---|---|
| Spouse (goes to an in-network provider) | $300 | $90 | 85%[22] | $76.50 | $13.50 |
| Participant (goes to an out-of-network provider) | $300 | $170 | 60%[23] | $102 | $198 ($68 coinsuance plus $130 over the Allowed Charge) |

[22] The Fund's reimbursement for in-network providers is considered at 85% of the Allowed Charge/contracted rate.
[23] The Fund's reimbursement for out-of-network providers is considered at 60% of the Allowed Charge.

# HOW THE INDUSTRY HEALTH NETWORK WORKS

## (FOR SOUTHERN CALIFORNIA AREA ONLY)

It is recommended you confirm with TIHN the referral by your specialist has been approved for ordered services.

If you live, are visiting, or are working in Southern California, the Plan contracts with The Industry Health Network (TIHN), which was acquired by the University of California Los Angeles (UCLA). TIHN offers a wide-ranging set of resources, including a network that includes more than 200 physicians, access to a hospital, and the ability to use the five UCLA Health/Motion Picture & Television Health Centers — all at substantial savings to what Health Fund Participants would normally have to pay. If you're not using TIHN, you may be missing out on significant savings.

- No enrollment is required to use this benefit. You can change your Primary Care Provider (PCP) at any time, as well as use other health care providers within The Industry Health Network.
- The UCLA Health/Motion Picture & Television Health Centers are set up for the exclusive use of entertainment industry members and Health Fund Participants. These centers are conveniently located in Burbank, Los Angeles (two sites), Valencia, and Woodland Hills. (See locations on the following page.)
- Benefits include hospitalization, surgery, anesthesia, primary care visits, laboratory, and radiology services.
- Children 13 years and older may utilize pediatric services at any of the five Health Centers listed on the following page. For children under 13, contact TIHN customer service at (800) 876-8320 for a list of pediatricians.
- You need to call for an appointment to see a Primary Care Physician (PCP) at one of the TIHN Health Centers. Outside services, such as specialty care, always requires a written referral authorization from your PCP. You and your dependents are required to obtain a referral for all services outside of the Health Centers, even if ordered by your specialist.
    - Without obtaining a written referral, your standard benefits for the PPO Plan (including deductible and coinsurance) will apply.
    - As a Participant, it is your responsibility to make sure that any referral you receive from a TIHN provider is in the TIHN network.
    - Referral from a primary care physician (TIHN) does not guarantee payment. All TIHN benefits are subject to Medical Necessity, Plan maximums and limitations, and Plan exclusions. See Summary of Benefits, page 15.
- You pay no deductible when you use TIHN health care providers and facilities. However, copays do apply. TIHN copays do not apply to the calender year deductible or the Coinsurance OOP Limit. (See page 15 of the Summary of Benefits section or visit wgaplans.org.)
- Physical therapy is subject to the Plan's Alternative Medicine $60 allowable per visit limitation. Effective Jan. 1, 2019 and dates of services thereafter, the Fund will allow $90 per visit limitation. See Summary of Benefits, page 9.

- The Preventive Care services rendered under the TIHN network are not subject to a $10 copay and will not be applied towards your Wellness Benefit maximum.

If the Health Center doctor treating you determines a mental health provider should treat your condition, the doctor will provide you with a medical order rather than a referral. At this time, mental health services will not be part of the TIHN referral.

| UCLA ORTHOPAEDIC SURGERY – Office Visit Charge | | | | |
|---|---|---|---|---|
| **Network** | **Billed Amount** | **Allowed Amount** | **Deductible** | **Patient Responsibility** |
| TIHN | $945.00 | $472.65 | None | $10.00 |
| Anthem Blue Cross | $945.00 | $472.65 | $400.00 | $425.90 |

| UCLA MEDICAL CENTER – Inpatient Hospital Charge | | | | |
|---|---|---|---|---|
| **Network** | **Billed Amount** | **Allowed Amount** | **Deductible** | **Patient Responsibility** |
| TIHN | $123,698.83 | $44,079.48 | None | $100.00 |
| Anthem Blue Cross | $123,698.83 | $122,398.83 | $400.00 | $1,400.00 |

## UCLA HEALTH/MP&T HEALTH CENTERS

Bob Hope Health Center
335 North La Brea Avenue
Los Angeles, CA 90036-2584
(323) 634-3850
Monday – Friday: 8:30 a.m. – 5 p.m.

Calabasas Health Center
26585 W. Agoura Road, Suite 330
Calabasas, CA 91302
(800) 876-8320
(818) 876-1050
Monday - Friday: 8 a.m. - 5 p.m.
Saturday: 8 a.m. - 4 p.m.
Sunday: Closed

Santa Clarita Health Center
23861 McBean Parkway, Suite E-24
Valencia, CA 91355
(661) 284-3100
Monday – Saturday: 8:30 a.m. – 5 p.m.

Toluca Lake Health Center
4323 Riverside Drive
Burbank, CA 91505
(818) 556-2700
Monday – Thursday: 7 a.m. – 7 p.m.
Friday: 7 a.m. – 6 p.m.
Saturday: 8:30 a.m. – 5 p.m.

Westside Health Center
1950 Sawtelle Boulevard, Suite 130
Los Angeles, CA 90025-7014
(310) 996-9355
Monday – Friday 8:30 a.m. – 5 p.m.
Saturday: 9 a.m. – 1 p.m.

To find out specific Plan benefits, refer to the Summary of Benefits section beginning on page 1 or go to wgaplans.org ("Health" | "Find a Participating Provider") to link to TIHN's website.

# HOW THE LOW OPTION PLAN WORKS

Only COBRA and Extended Coverage Program Participants are eligible to enroll in the Low Option Plan. The network organization, which varies by location, contracts with physicians, hospitals, and other health care providers to provide services at contracted rates.

(See the Summary of Benefits section beginning on page 1 or at wgaplans.org for benefit information.)

The Low Plan option covers a range of medical services, including hospital treatment. However, to keep costs down, the benefits are not as comprehensive as those offered by the Fund's PPO Plan. Although preventive services required by the ACA are provided, the Low Option Plan does not include benefits for wellness, vision, prescription drugs (except as otherwise required under the ACA), dental care, life insurance, or accidental death and dismemberment insurance, and it covers in-network services at a lower benefit level.

## GETTING THE MOST FROM YOUR PLAN

The Low Option Plan is designed to give you a choice when it comes to getting medical care. This option has additional limits on what the Fund pays in order to keep costs low. Since you pay a higher or lower coinsurance depending on whether you seek treatment from in-network or out-of-network providers, it's important to know how to reduce your costs as much as possible.

Also keep in mind that separate out-of-pocket maximum Coinsurance OOP Limits apply to eligible expenses from in-network and out-of-network health care providers.

***Claim Example:*** The Participant and the dependent spouse are enrolled in the Low Option Plan as an Extended Coverage Program. The spouse has bunions and goes to an in-network doctor. He knows that for doctor visits, he has to pay the coinsurance. Let us assume that the spouse has met the individual calendar year deductible of $750. Let us also assume that the Fund pays 70% for in-network services, and that the spouse pays 30%. If his doctor's negotiated fee is $90, the dependent's share of that cost is $27 (30% of $90 negotiated fee).

The Participant wants to see a doctor about a knee problem. She does not look for an in-network provider. She goes to an out-of-network provider. The doctor's visit sets her back $300, which she pays at the time, even though she's met her calendar year deductible. When she sends in the bill for reimbursement, the Fund pays a smaller percentage, 60% of Allowed Charges for out-of-network services. The Participant's share of that cost is $68 (40% of $170) plus $130 (over the Allowed Charge amount), totaling $198.

| Patients | Calendar Year Deductible | Physician's Charge | Negotiated Fee | Allowed Charge | Percentage of Allowed Charge the Fund Pays | Amount Fund Pays | Amount the Patient Pays (after deductible) |
|---|---|---|---|---|---|---|---|
| Spouse (goes to an in-network provider) | $750 | $300 | $90* | N/A | 70% | $63 | $27 |
| Participant (goes to an out-of-network provider) | $750 | $300 | N/A | $170 | 60% | $102 | $198 ($68 coinsurance plus $130 over the Allowed Charge) |

*This is the negotiated fee (contracted rate).

The spouse is responsible for paying just $27, and the Participant has to pay $198.

## EMERGENCY CARE

No matter where you are, if you have an emergency medical condition — that is, a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the covered person (or, with respect to a pregnant person, the health of the person or their unborn child) in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of a body part -- you should always go to the nearest hospital's emergency room (E/R) or other emergency care facility to get the care you need. Examples of emergencies include, but are not limited to:

- Broken bones;
- Burns;
- Chest pains or severe squeezing sensations in the chest;
- Major cuts;
- Seizures or loss of consciousness;
- Shortness of breath;
- Sudden paralysis or slurred speech;
- Suspected medication overdose or poisoning; and
- Uncontrolled bleeding.

Emergency services means, with respect to an emergency medical condition:

- An appropriate medical screening examination that is within the capability of an emergency room of a hospital or independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Such further medical examination and treatment as are required to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable (regardless of the department of the hospital in which such further examination or treatment is furnished); and
- Post-stabilization services, which are services furnished by out-of-network providers or out-of-network facilities after the patient is stabilized as part of outpatient observation or an inpatient/outpatient stay related to the emergency medical condition (regardless of the department of the hospital in which such further examination or treatment is furnished), until:
    - The treating provider or facility determines that the individual is able to travel using non-medical transportation or non-emergency medical transportation; and
    - The individual is provided with appropriate written notice to consent to out-of-network treatment and gives informed consent to such out-of-network treatment.

The Fund will charge you the same copayment or coinsurance for emergency services when you obtain those services from an in-network health care facility or from an out-of-network health care facility. Accordingly, emergency services by an out-of-network health care facility will be considered at the in-network coinsurance level, or 85% for the PPO Plan and 70% for the Low Option Plan, subject to the Plan's $50 copay and the annual deductible.

However, if you obtain emergency services from an out-of-network health care facility, that facility may not bill you separately if the hospital's charges exceed the Plan's allowances for the services.

Notwithstanding any exclusion in the Plan to the contrary, please note the Fund will cover any complication of a dependent pregnancy that meets the definition of emergency services, subject to applicable Fund rules.

## URGENT CARE

If you have a situation that is not life-threatening, but does require immediate medical care, it may be considered an urgent condition. Here are some examples:

- Back pain;
- Cold- or flu-like symptoms;
- Ear infections;
- Fever;
- Minor burns;
- Rash;
- Simple bone breaks (e.g., toe, finger);
- Twisting type orthopedic injuries ; and
- Urinary tract infections.

If you're in a PPO network area and want to receive the higher, in-network level of benefits, you must seek urgent care from an in-network provider. Otherwise, you will receive the lower, out-of-network level of benefits. If you utilize the E/R for a condition that can be seen at an urgent care facility, you do not qualify for the higher in-network level of benefits, so you will pay more in coinsurance.

# FEATURES OF THE PPO PLAN AND LOW OPTION PLAN (SPECIAL RULES, FILING CLAIMS, AND COORDINATION OF BENEFITS)

## SPECIAL RULES FOR USING CERTAIN OUT-OF-NETWORK PROVIDERS AT IN-NETWORK FACILITIES

If you receive non-emergency services from an out-of-network provider at an in-network health care facility, the out-of-network provider may not bill you separately if their charges exceed the Fund's Allowed Charge for such service; and, once you have met the deductible, you will be responsible for the in-network coinsurance for the service (unless you consent to out-of-network billing rates, if applicable).

A "visit" to an in-network health care facility includes the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is physically located at the facility.

However, if you go to an out-of-network facility (except in the case of emergency services at an out-of-network health care facility), you may not take advantage of this special rule. That means you will be responsible for a higher percentage of the cost (the out-of-network coinsurance) and any amount over the Allowed Charge. Also, please see page 75 and page 92 to find out what expenses and charges are covered for emergency care.

## FILING CLAIMS

Prescription drug, dental benefits, and vision care are administered by Express Scripts, Delta Dental, and VSP. (You will find the contact information for the Fund's Claims Administrators in the Summary of Benefits section.)

Other than standard CMS-1500 (HCFA) forms or superbills, claims must be presented with your health care provider's signature and an itemized statement from your provider with the following information to be considered a valid claim:

- Plan Participant's name and address;
- Plan Participant's 12-character Participant ID No. (WRXA########);
- Patient's name and address (if different from the Participant's);
- Patient's date of birth;
- Provider's name and address;
- Provider's Federal Tax ID No.;
- Itemized provider bill, preferably in a standardized CMS-1500 or UB-04 format (non-standard billing formats can delay claim processing);
- Amount paid (if any);
- CPT (Current Procedural Terminology) procedure code(s);
- ICD-10 (International Classification of Diseases, Tenth Revision) diagnosis code(s);

- Date(s) of service; and
- Other information or proof reasonably required by the Fund.

If your claim is the result of injuries suffered in an accident, you must submit details concerning the accident with the accident-related claim. (See The Fund's Right of Reimbursement and Subrogation Section starting on page 215.)

**IMPORTANT!**

If you use an out-of-network provider, the Fund pays a lower percentage of eligible expenses (which means you pay more), and you are responsible for any amount over the Allowed Charge. To keep your out-of-pocket expenses to a minimum, use in-network providers whenever possible.

## PROVIDER CLAIM SUBMISSION

If you use an in-network health care provider, you are not responsible to submit the claim. Your in-network doctor, hospital, or other provider will automatically submit the claim on your behalf. The provider has the right to collect the applicable coinsurance, copay, and any amount remaining on your deductible at the time of service.

In-network claims (facility and professional claims) are subject to BlueCross BlueShield Global Core's time limit for filing claims. Out-of-network claims (facility and professional claims) not filed within two years of the date of service will be denied.

If you use an out-of-network health care provider and the provider does not bill on your behalf, see the Participant Direct Claim Submission section that follows. You may designate an authorized representative, such as your business manager, to submit claims on your behalf. Call the Fund Office for details about what you need to do to designate a representative.

Claims from health care providers must be submitted as directed below:

Paper claims for services from California health care providers should be mailed to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060

Electronic claims from California providers should be submitted using Anthem's electronic claim submitter number: 47198

For all claims (paper or electronic) from non-California health care providers visit wgaplans.org and click the "Health" menu; then the "Claim Submission" tab; then choose "Hospital Claim" or "Professional Claim" to locate the local BlueCross BlueShield plan in your area.

## PARTICIPANT DIRECT CLAIM SUBMISSION

If you are filing your own claim, you must submit your claim directly to Anthem Blue Cross (or your local Blue Cross and Blue Shield plan through the nationwide BlueCross Blue Shield Global Core program), using a Participant direct submission claim form. You can obtain a copy from the forms section of wgaplans.org. You should retain copies of all claims you submit.

All California Participant direct claim submissions, with the exception of the claims noted below, must be sent to Anthem Blue Cross using a Participant direct submission claim form.

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060

All non-California Participant direct claim submissions, with the exception of the claims noted below, must be sent to your local BlueCard office using a Participant direct submission claim form. Visit wgaplans.org to locate the address of the local Blue Cross and Blue Shield plan in your area.

To receive Plan benefits for out-of-network claims, you must submit the claims to your local Blue Cross and Blue Shield plan within the two-year filing limit from the date you incurred the service. Any claims received later than two years after that date will be denied.

The claims noted below from California and non-California providers may be submitted directly to the Administrative Office at the following address:

PWGA Pension and Health
2900 W. Alameda Ave.
Suite 1100
Burbank, CA 91505-4267

## WELLNESS CLAIMS FROM NON-TRADITIONAL HEALTH CARE PROVIDERS

Some examples of wellness claims from non-traditional health care providers are as follows:

- A flu shot you receive at a drug store (submit receipt with claim);
- A smoking cessation program (submit receipt with claim);
- A weight-loss program (submit receipt with claim); and
- Lifestyle classes offered by the Motion Picture & Television Fund (MPTF).

## FOREIGN CLAIMS

While traveling, if you receive medical treatment in a foreign country, you should first contact the Blue Cross Blue Shield Global Core® for access to medical assistance services and health care providers around the world. (The phone number is listed under the title "BlueCard Worldwide" or "Blue Cross Blue Shield Global Core" on the backside of your Medical ID Card). For inpatient care at a Blue Cross Blue Shield Global Core hospital arranged through the Blue Cross Blue Shield Global Core Service Center, you only pay the provider the usual out-of-pocket expenses (i.e., non-covered services, deductible, coinsurance and copayment expenses) when cashless access is arranged. The provider files the claim for you. Otherwise, if you receive medical treatment in a foreign country, you must pay the provider fees at the time of service, and then submit a claim in English with invoices, any applicable medical records, and a statement which includes the U.S. currency and currency exchange rate at the time of payment.

For outpatient facility and physician services or inpatient care not arranged through the Blue Cross Blue Shield Global Core Service Center, you must pay the health care provider directly, and then submit a Blue Cross Blue Shield Global Core International claim form with original bills, your Participant Health Fund ID No. (as it appears on the Health Fund ID Card), and receipts to the Blue Cross Blue Shield Global Core Service Center.

If you receive medical treatment in a foreign country, submit your claims directly to the BlueCard Worldwide Service Center for processing. They will handle the front-end processing of your claim by converting the foreign currency and providing any necessary billing translation. The claim will be electronically transmitted to the Fund for benefits determination.

Blue Cross Blue Shield Global Core International claim forms are available on our website, wgaplans.org, under "Forms" or visit bcbsglobalcore.com. It is recommended that you always retain copies of the claim(s) you are submitting.

You may contact the Blue Cross Blue Shield Global Core Service Center by calling: (800) 810-2583 or calling collect: (804) 673-1177.

## NON-ASSIGNMENT

"Assignment of benefits" means that you're transferring to a medical provider or facility a right that you have, such as your right to receive payment or a right under the law. The Fund categorically prohibits and will not accept under any circumstance any assignment of any of the following (any attempt to assign the following will be void and will not apply):

- Benefits claims;
- Right to coverage;
- Legal rights to information; or
- Any other type of claims, regardless of the nature of such claims.

Except as described below, benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person, including the Participant, a Participant's dependent, or a creditor of the Participant without the express written permission of the Fund. However, a Participant may request that benefits due him/her be paid to a health care provider in consideration for hospital, medical, dental, and/or vision care services rendered, or to be rendered.

Although benefits are paid automatically to in-network providers based on their agreement with the PPO network and benefits may also be paid at your request to an out-of-network provider (if allowed), such payment shall be done solely as a convenience and does not constitute an assignment of any right under the Fund or under ERISA. Such payment also:

- Does not constitute authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Fund;
- Is not an assignment of rights respecting anyone's fiduciary duty;
- Is not an assignment of any legal or equitable right to institute any court proceeding against the Fund; and
- In no way shall be construed or interpreted as a waiver on the Fund's prohibition on assignments.

The Fund is not responsible for paying health care provider invoices that are balance billed to a Participant.

## TIMELY FILING RULES

In-network claims (facility and professional claims) are subject to BlueCross Blue Shield Global Core's time limit for submitting claims. Out-of-network claims (facility and professional claims) not filed within two years of the date of service will be denied.

## FILING AN ACCIDENT-RELATED CLAIM

If your medical claim is the result of injuries suffered in an accident, you must submit details concerning the accident with the accident-related claim. (See The Fund's Right of Reimbursement and Subrogation section starting on page 215 of the Summary Plan Description.)

If the accident or injury is the result of a third party, you must submit a third party liability form. (See The Fund's Right of Reimbursement and Subrogation section starting on page 215 of the Summary Plan Description.)

## CLAIM DETERMINATIONS

The Claims Administrator may deny or grant a claim, in whole or in part, at his/her discretion. (See Claims and Appeals Rules on page 192 of this SPD for more information about your rights under the claims and appeal process. In-network providers are subject to Anthem Blue Cross and BlueCard's time limit for submitting claims.)

## UNDERSTANDING COORDINATION OF BENEFITS (COB)

### IF YOU'RE COVERED BY MORE THAN ONE PLAN – ACTIVE PARTICIPANTS

In many families, both spouses work. Each may be covered by a group health plan, and each may include the other and/or their children as dependents. You should notify the Fund Office when you or your dependents are covered by another plan, and you should understand how your benefits are paid under these circumstances. Most group medical plans contain a provision explaining how payments of benefits from two plans are coordinated.

Coordination of benefits is simply a way of dividing responsibility for payment among the separate health plans that cover an individual. Charges include all items of care covered under at least one of the plans. The COB rules ensure that a person is not reimbursed for more than the actual expense incurred for a medical service or supply. The goal is to cover your costs so that no more than the total of all services, subject to the Allowed Charge limits or network contracted rates for eligible expenses, will be paid. The Fund reviews and pays coordinated benefit claims based on the highest allowable charges, up to the greater allowable expense of either plan.

Types of plans with which the Health Plan coordinates benefits include:

- Group insurance coverage;
- Government-provided programs (Medicare/Medicaid, Tricare);
- Coverage provided by court order; and
- Employer-sponsored coverage (COBRA, disability).

**NOTE:** The Fund only applies COB to group health plans, not to individual policies (including policies purchased through the Health Insurance Marketplaces). However, a plan is primary if it doesn't have COB rules.

**INFORMATION REQUIRED**

The Fund Office will ask you annually to update information about other group health coverage you and/ or your covered dependents may have.

A request for COB information may occur in connection with a claim you've submitted. In that case, you will be advised that the other insurance information, including an Explanation of Benefit (EOB) statement from the other insurance carrier, is required before your claim can be processed.

Benefits paid when other insurance coverage exists are subject to the Plan's Overpayment Policy.

## GENERAL RULES

The first of the following rules that applies to the Participant's situation is used to determine which plan is primary:

1. The plan without a coordination of benefits provision is always primary. The Fund only applies COB to group health plans, not to individual policies (including coverage purchased from the Health Insurance Marketplaces).
2. The plan covering a person as a Participant is primary to the plan covering the person as a dependent, with one exception: In the case of a Participant with inactive coverage (such as retiree coverage) who is covered by Medicare and also covered as a dependent by a working spouse, the plan which covers him/her as the dependent of a working spouse is primary, Medicare is secondary, and his/her own inactive coverage is tertiary. For more information on Medicare, please see pages 84-87 in the Medical Benefits section.
3. The plan covering the person as an active employee pays benefits before the plan covering that person as an inactive, laid-off, self-pay, COBRA, or retired employee.
4. The plan under which the Participant has had the longest continuous eligibility as a Participant is the Participant's primary plan and pays benefits first. If the Participant has the same effective date in both plans, each plan is responsible for 50% of the allowable charges.

## RULES FOR DEPENDENT CHILDREN

The first of the following rules that apply to the dependent child's situation (a dependent child under 26 years old or a totally disabled dependent over 26 years old who meets the eligibility requirements for coverage under the Plan, as defined in Eligible Dependents) is used to determine which plan is primary:

1. If the claim is for a child, the plan of the parent whose birthday falls earlier (month and day) in the year is primary.
2. If both parents have the same birthday, the plan which covered the parent longer is primary.
3. If the claim is for a child of divorced or separated parents, the plan of the parent with custody is primary, the plan of the spouse of the parent with custody is secondary, and the plan of the parent not having custody is tertiary. Notwithstanding the foregoing, court orders and judgments will be followed. A copy of the court order or judgment must be submitted to the Health Plan.

4. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined using the longer/ shorter length of coverage. If the length of coverage is the same, then the birthday rule applies between the dependent child's parent's coverage and the dependent spouse's coverage.

If the Fund does not have COB information for the first claim we receive for a dependent child, where the spouse's birthday occurs earliest (see No. 1 on opposite page), claims may be delayed until the Fund receives the required COB information.

## PAYMENT OF COORDINATED CLAIMS

Once responsibility for first payment is established, the Health Plan proceeds in one of two ways:

1. If the Health Plan is the primary plan, we determine and pay benefits in the regular manner, with no consideration of what the secondary plan may or may not pay.

2. If the Health Plan is the secondary plan, we begin by determining how much we would have paid had there been no other group coverage. Next, we find out what the primary plan paid. Then we make a payment for the difference, if any, between the total COB allowable expenses and the amount paid by the primary plan, but not to exceed the liability under the Fund's plan coverage.

For example:

| If the Fund is Primary... | | If the Fund is Secondary... | |
|---|---|---|---|
| Allowable Charge | $500 | Allowable Charge | $500 |
| In-network coinsurance | 85% | Primary plan pays | $400 |
| The Fund pays | $425 | The Fund pays | $100 |
| Participant pays | $75 | Participant pays | $0 |

**NOTE:** The example above assumes the annual deductible has been met.

## MEDICARE PARTS A AND B

Medicare is divided into different parts. Part A covers hospitalization and certain follow up services, which is at no cost to most people when you are Medicare eligible. Part B, which helps pay doctor bills and other medical bills, requires payment of a monthly premium, and you must enroll prior to turning age 65 if you have Certified Retiree Health Coverage. In order for you and your eligible dependents to receive optimum coverage and reimbursement for your hospital and doctor bills, it is important that you enroll in both Part A and Part B of Medicare.

**THIS IS REALLY, REALLY IMPORTANT!**

If you are a Certified Retiree and fail to enroll in Medicare Part A and B, you will be fully liable for all the medical costs that Medicare otherwise would have paid. If you don't enroll in Medicare, the Health Fund will pay its portion of the costs as if you did enroll and Medicare had paid its share. This means that you will be responsible for paying the difference between what the Health Fund pays and what Medicare would have paid. Don't let this happen to you!

Medicare coverage will be the primary plan when you turn 65 and have Certified Retiree Health Coverage. This will also hold true for your eligible dependent(s) under 65 who are totally disabled and meet the eligibility requirements for coverage under the Plan, as defined in Eligible Dependents on page 28. If you have not enrolled in Medicare, the Fund will pay benefits as if you are enrolled in both Part A and Part B and will coordinate benefits as if you or your eligible dependent(s) had received reimbursement for medical expenses from Medicare.

After the first 30 months of end-stage renal disease ("ESRD"), or if you have been deemed totally and permanently disabled by the Social Security Administration ("SSA"), Medicare coverage will be the primary plan when you turn 65. This will also hold true for your eligible dependents under age 65 who are totally disabled. If you have not enrolled in Medicare, the Fund will pay benefits as if you are enrolled in both Part A and Part B and will coordinate benefits as if you or your eligible dependent(s) had received reimbursement for medical expenses from Medicare.

If you are approaching age 65, you are not automatically enrolled in Medicare unless you have filed an application and you are receiving your monthly Social Security benefit. If you have not applied for Social Security benefit, you must file a Medicare application form during the 3-month period prior to the month in which you reach age 65. Call or write to your nearest Social Security Office 90 days prior to your 65th birthday and ask for an application.

## SUMMARY CHART ON COORDINATION OF BENEFITS (COB) WITH MEDICARE

If you are covered by Medicare and also have other group health plan coverage, the coordination of benefits (COB) rules are set by the Centers for Medicare & Medicaid Services (CMS). These COB rules are outlined below:

**Summary of the Coordination of Benefits between Medicare and the Group Health Plan**

| If you: | Situation | Pays First | Pays Second |
|---|---|---|---|
| Are covered by both Medicare and Medicaid | Entitled to Medicare and Medicaid | Medicare | Medicaid, but only after other coverage such as a group health plan has paid |

| Summary of the Coordination of Benefits between Medicare and the Group Health Plan | | | |
|---|---|---|---|
| **If you:** | **Situation** | **Pays First** | **Pays Second** |
| Are age 65 and older and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age | Entitled to Medicare | Group health plan | Medicare |
| Have an employer group health plan after you retire and are age 65 or older | Entitled to Medicare | Medicare | Group health plan<br><br>(e.g. retiree coverage) |
| Are disabled and covered by a large group health plan from your work or from a family member who is working | Entitled to Medicare | Group health plan | Medicare |
| Have End-Stage Renal Disease (ESRD is permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including retiree coverage) | First 30 months of eligibility or entitlement to Medicare<br><br>After 30 months of eligibility or entitlement to Medicare | Group health plan<br><br>Medicare | Medicare<br><br>Group health plan |
| Are covered under workers' compensation because of a job-related injury or illness | Entitled to Medicare | Workers' compensation for worker's compensation-related claims | Usually does not apply however Medicare may make a conditional payment. |
| Have black lung disease and are covered under the Federal Black Lung Benefits Program | Entitled to Medicare and the Federal Black Lung Benefits Program | Federal Black Lung Benefits Program for Black Lung-related claims | Medicare |
| Have been in an accident where no-fault or liability insurance is involved | Entitled to Medicare | No-fault or liability insurance, for the accident-related claims | Medicare |
| Are a veteran and have veterans' benefits | Entitled to Medicare and Veterans' benefits | Medicare pays for Medicare-covered services. Veterans' Affairs pays for VA-authorized services. Generally, Medicare and VA cannot pay for the same service. | Usually does not apply |
| Are covered under Tri-Care | Entitled to Medicare and Tri-Care | Medicare pays for Medicare-covered services. Tri-Care pays for services from a military hospital or any other federal provider. | Tri-Care may pay second |
| Are age 65 or over or are disabled and covered by both Medicare and COBRA | Entitled to Medicare | Medicare | COBRA |
| Have End-Stage Renal Disease (ESRD) and COBRA | First 30 months of eligibility or entitlement to Medicare<br><br>After 30 months of eligibility or entitlement to Medicare | COBRA<br><br>Medicare | Medicare<br><br>COBRA |

## MEDICARE PART C

This is called Medicare Advantage, but it is almost universally referred to as Medicare Part C. If you join a Medicare Advantage Plan, you still have Medicare, but you'll get your Medicare Part A and Medicare Part B coverage through the Medicare Advantage Plan, not "traditional" Medicare.

Medicare Advantage might place you in an HMO like Kaiser, or in an open-access or gatekeeper plan such as are typically offered by large health carriers like Blue Cross. If the cost-certainty of such a situation appeals to you despite the other restrictions you are likely to encounter, then this might be an option to consider.

**IMPORTANT!**

Once you reach Medicare age, it's important to find out if your health care provider accepts Medicare. Medicare does not cover or reimburse the doctor or patient for any services provided by "opt-out providers" (meaning providers who have opted not to accept Medicare). This means that Medicare patients are responsible for the entire cost of any services they receive from opt-out providers. In such cases, the Health Fund will process your claims as if Medicare is involved and estimate Medicare's benefit. You will be responsible to pay the difference between what the Health Fund pays and what Medicare would have paid.

## MEDICARE PRIVATE CONTRACT

Under the law, the Participant is entitled to enter into a Medicare private contract with certain health care providers under which the Participant and health care provider agree that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care provider. Benefits will be subject to all of the Plan's terms and provisions, including those relating to exclusions, Medical Necessity, the Allowed Charge, and utilization management.

If the Participant goes to a doctor who does not participate in Medicare, and Medicare is the Participant's primary plan, the Health Plan will calculate the Participant's benefits as if the Participant has received reimbursement for eligible expenses from Medicare first. That is, for most procedures, the Health Plan will consider 20% of the allowable charge after the deductible is satisfied, and you are responsible for the remaining balance. This means you will have substantially higher out-of-pocket costs.

## ADMINISTRATION OF COB

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits through the Fund must provide the Administrative Office with all the information the Fund needs to apply the COB rules.

To administer the COB provision, the Fund reserves the right to exchange information with other plans involved in paying claims, require that you or your health care provider furnish any necessary information, reimburse any plan that made payments that this Fund should have made, and recover any overpayment from your hospital, physician, dentist, other health care provider, or other insurance company for you or your covered dependent.

If this Fund should have paid benefits that were paid by any other plan, this Fund may pay the plan that made the other payments in the amount the Fund determines to be proper under this provision. Any amounts paid will be considered to be benefits through this Fund and this Fund will be fully discharged from any liability it may have to the extent of such payment.

If your personal information has changed — for example, if you've gained other insurance coverage — you must contact the Fund Office to update your records. Visit our website at wgaplans.org to access the COB form — simply click on the "Forms" tab under the Health Fund menu, and then "Coordination of Benefits."

## IF YOU'RE COVERED BY MORE THAN ONE PLAN – CERTIFIED RETIREES

If you're a Participant who retired with Certified Retiree status on or before March 1, 1997 and you're receiving a benefit from the PWGA Pension Plan of less than $800 per month when you become eligible for Medicare, the Fund coordinates your benefits with Medicare with the method that was in effect on April 1, 1997. This approach allows for reimbursement up to 100% of the Medicare-allowed amount (an example of this COB calculation is presented in the table located at the top of page 87.) Surviving Spouses of such Certified Retirees, upon their becoming eligible for Medicare, will then have their medical benefits coordinated with Medicare in the same way.

***Claim Example:*** Let us assume that you're enrolled in the PPO Plan, you have met your individual calendar year deductible, and you have eligible expenses of $2,300. Let's also assume that under the Fund, the in-network coinsurance is 85% and out-of-network coinsurance is 60% of Allowed Charge.

| **PPO Plan Option** | | |
|---|---|---|
| | **In-network Provider** | **Out-of-network Provider** |
| Eligible expenses (Medicare-allowed amount) Assume Medicare pays first | $2,300 - $1,840 | $2,300 - $1,840 |
| Balance before the Fund pays | $460 | $460 |
| Maximum the Fund would pay if it were primary plan | $2,300 x 85% = $1,955 | $2,300 x 60% = $1,380 |
| Medicare payment | $1,840 | $1,840 |
| Amount the Fund Pays | $115 | $0 |
| Balance after the Fund pays | $345 | $460 |
| Amount you pay | $345 | $460 |

If you are a Participant who retired with Certified Retiree status after March 1, 1997, or you are a Participant who retired with Certified Retiree status on or before March 1, 1997 and you are receiving a benefit from the PWGA Pension Plan in the amount of $800 or more per month when you become eligible for Medicare, the Fund coordinates your benefits with Medicare so that the combined medical payments of Medicare and the Fund are equal to but not more than what the Fund would have paid if Medicare was not involved. Surviving Spouses of such Certified Retirees, upon becoming eligible for Medicare, will then have their medical benefits coordinated with Medicare in the same way.

# LOOKING AT ELIGIBLE AND INELIGIBLE MEDICAL EXPENSES

## ELIGIBLE EXPENSES

The PPO Plan (including out-of-area benefits) and Low Option Plan cover a wide range of services, including those described below. If you want to know whether a particular service is covered, contact the Fund Office.

Once you satisfy the deductible, the Fund will pay a percentage of charges for Medically Necessary services required to treat an illness or injury. The percentage will depend on whether you see a network or out-of-network provider, or whether you live outside the network area. (For details, see the Summary of Benefits starting on page 4.)

A health care professional must possess valid licensure or certification appropriate to his/her scope of practice, and provide services within the scope of that license, and any facility that provides health services must possess a license, state accreditation, or Medicare recognition appropriate to the services it is providing, and provided the services are within the scope of that license.

The following eligible services appear in alphabetical order. This list includes most, but not all, eligible services. Services are eligible only if Medically Necessary and not more than the network allowances or the Allowed Charge.

## ALTERNATIVE MEDICAL BENEFIT

Benefits for therapy provided by a covered provider (refer to definition on the following page) are covered for the following services and therapies:

- Acupuncture (solely for treatment of chronic pain)
- Biofeedback[24]
- Chiropractic treatment
- Hydrotherapy/Aquatic Therapy[24]
- Lymphedema therapy[24]
- Occupational therapy[24]
- Osteopathic manipulation
- Physical therapy[24]
- Orthoptic treatment (e.g. vision therapy).

The Fund allows up to $60 per visit, per type of service (e.g., acupuncture, chiropractic, etc.), per provider, payable at the in-network or out-of-network coinsurance level. Effective Jan. 1, 2019 and thereafter, the Fund allows up to $90 per visit, per provider

**IMPORTANT!**

All alternative therapy claims are subject to review to determine Medical Necessity. See the section to the left for the services that require a referral from a licensed health care provider acting within the scope of his/her license.

[24] Services require a referral from a licensed health care professional acting within the scope of his/her license.

**WHAT IS A COVERED PROVIDER?**

For the purposes of the alternative medical benefit, the Fund will consider services provided by the following licensed providers acting within the scope of licensure:

Licensed Acupuncturist

Doctor of Chiropractic

Doctor of Medicine

Doctor of Oriental Medicine (only acupuncture treatments are covered)

Doctor of Osteopathy

Registered Occupational Therapist

Registered Physical Therapist

## AMBULATORY SURGICAL CENTER

For Plan coverage to be provided, an ambulatory surgical center must be a permanent facility equipped to function primarily for the purpose of performing surgical procedures, and must be Medicare-certified or state-licensed as an ambulatory surgical facility, or have certification from a private accreditation agency accepted by the state in lieu of state licensure.

The type of procedures performed must permit discharge from the center on the same working day. In-network ambulatory surgical center charges will be based on the network contracted allowances. Out-of-network ambulatory surgical center charges will be reimbursed up to a maximum payment of $1,500 if all of the conditions for coverage described here are met. Any applicable deductibles and coinsurance will apply.

**IMPORTANT!**

Because the Fund requires operative and pathology reports for most surgeries, claims submissions must include these reports. We recommend that you ask your surgeon and/or facility where the services are being rendered to include this detail at the time of claim submission so you can avoid delay or denial of your claims.

## TREATMENT PLAN FOR ONGOING THERAPY

When utilizing ongoing physical therapy, speech therapy, occupational therapy, and mental health counseling, your health care provider will be required to submit what is referred to as a "treatment plan." A treatment plan is a tool used by a provider to shape the focus of ongoing treatment, helping health care professionals and clients make positive change happen through purpose, focus, and direction.

A treatment plan is specific to the individual's needs and should include the following:

- A diagnosis;
- The start date for services;
- The requested frequency and duration of care;
- Measurable goals and objectives;
- Subjective/objective functional improvement;

- Identification of impediments to progress; and
- A signature by the health professional rendering the service.

## BIRTHING CENTERS

A birthing center is a facility established to manage low risk, normal, uncomplicated pregnancies with delivery within 24 hours of admission to the center. For Plan coverage to be provided, it must be licensed by the state (if required by the state) as a birthing center.

As an alternative to traditional hospital delivery of a child, the Plan pays benefits for the following services provided by a birthing center:

- Pre-natal care;
- Use of the birthing room;
- Services rendered during delivery, including the first 48 hours of follow-up care;
- Care for the newborn and post-partum care of the mother;
- Routine nursery care; and
- Services of a midwife under the supervision of a medical doctor.

## BREAST PUMP

Under the Affordable Care Act (ACA), this durable medical item is required to be covered without cost sharing if obtained from an in-network durable medical equipment (DME) provider.

As of January 1, 2020, the Fund allows breast pumps for newborns without a parent capable of lactation (e.g., same-sex parents or parents incapable of breast feeding). This benefit requires a prescription from a licensed provider acting within the scope of his/her license and is available in-network only, with no cost sharing for Participants who have active eligibility with the Fund at the time services are rendered, post child delivery, and if the newborn is added as a dependent to the Participant's coverage under the Fund.

In addition, the Fund will cover the purchase of one (1) breast pump per child, per family, per year, not to exceed a $200 per breast pump cost limitation. In the event a breast pump is prescribed by a licensed provider that exceeds the $200 limitation per breast pump, the Fund will review each case on an individual basis for medical necessity. To request medical necessity review, the treating provider will need to provide a letter or other information/ evidence explaining why the prescribed breast pump is medically necessary in place of a standard/customary breast pump costing no more than $200.

**NOTE:** Under federal and/or state law, if a breast pump is provided when the lactating mother is not a Fund Participant (for example when the newborn is a dependent of a same-sex couple, one of whom is a Participant in the Fund), the payment or reimbursement of the breast pump may be taxable.

Please consult a personal tax advisor.

The following charges are not eligible. Examples of non-covered expenses include, but are not limited to:

- Batteries, battery-powered adaptors, and battery packs;
- Electrical power adapters for travel;
- Bottles which are not specific to breast pump operation – this includes the associated bottle nipples, caps, and lids;
- Travel bags, and other similar travel or carrying accessories;
- Breast pump cleaning supplies including soap, sprays, wipes, steam cleaning bags, and other similar products;
- Baby weight scales;
- Garments or other products that allow hands-free pump operation;
- Breast milk, storage bags, ice-packs, labels, labeling lids, and other similar products;
- Nursing bras, bra pads, breast shells, nipple shields, and other similar products; and
- Over-the-counter (OTC) creams, ointments, and other products that relieve breastfeeding related symptoms or conditions of the breasts or nipples.

## CIRCUMCISION

Circumcision is covered when the following conditions are met:

- Newborn male circumcision, in the absence of a medical condition, is a covered benefit if performed within the first 31 days after delivery, by a licensed health care provider acting within the scope of his/her license and performed in a clinical facility; and
- Male circumcision performed at any age to treat certain medical conditions, is also a covered benefit.

## CONTACT LENSES OR EYEGLASSES – POST CATARACT SURGERY

The first pair of contact lenses or eyeglasses that are required within six months after cataract surgery are covered as a medical benefit.

## CONTRACEPTION

Contraceptive care includes contraceptive products and services, including clinical services (e.g., education and counseling) rendered by a network health care provider that are needed for the provision of the contraceptive product or service. In addition, contraceptive care includes initiation of contraceptive use, follow-up care (e.g., management and evaluation as well as changes to, and removal or discontinuation of, the contraceptive method), and instruction in fertility awareness-based methods, including the lactation amenorrhea method, for women desiring an alternative method. Further, contraceptive care include items and services that are "integral" to providing covered contraceptive products and services such as, for example, covering anesthesia necessary to perform a tubal ligation or pregnancy tests needed before provision of an IUD.

Various forms of contraceptive products and services are covered by the Health Fund. Some forms are covered under medical benefits and some under prescription drug benefits (see the Prescription Drug Benefits section beginning on page 139 for more information).

Examples of covered contraceptive products and services include:

- Depo-Provera, IUDs, and subcutaneous implantable contraceptives are covered under the prescription drug benefits if they are purchased at a retail pharmacy or via mail order services. Otherwise they are covered under medical benefits.
- Vasectomies and tubal ligations are covered under medical benefits.
- Diaphragms and birth control pills are covered under prescription drug benefits.

**NOTE:** The Fund will cover approved women's contraceptive care under the Preventive Care Benefits at 100% with no deductible or copayment if rendered by a network health care provider in accordance with the applicable requirements under PPACA (PPO and Low Option Plan). See page 109 for additional information.

## CORONAVIRUS/COVID-19

In an effort to protect participants and dependents, the Plan waived participant cost-sharing (deductible and co-insurance) on medically necessary screening and diagnostic testing for Coronavirus/COVID-19, including hospital, emergency department, urgent care and provider office visits where the purpose of the visit is to be screened and/or tested for Coronavirus/ COVID-19.

In addition, with respect to the Coronavirus/COVID-19 vaccines that are recommended from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the following rules will apply for the remainder of the Coronavirus/COVID-19 public health emergency:

- The Plan will waive all cost-sharing (deductible and co-insurance) on the Coronavirus/ COVID-19 vaccines and related administration charges, regardless of whether the vaccine is administered by an in-network or out-of-network provider;
- For Coronavirus/COVID-19 vaccines administered by an out-of-network provider, the Plan will reimburse the provider a reasonable amount, determined in comparison to the prevailing market rates.

The Coronavirus/COVID-19 public health emergency was declared by the Secretary of the US Department of Health and Human Services, effective January 27, 2020. The public health emergency is scheduled to end on May 11, 2023.

After the public health emergency ends on May 11, 2023, the Health Plan's normal rules will apply. This means that:

- The Plan will cover Coronavirus/COVID-19 vaccines and related administration charges without cost-sharing as ACA-required preventive services only if provided by an in-network provider
- The Plan's normal cost-sharing rules for hospital, emergency department, urgent care, and provider office visits will apply for medically necessary screening and diagnostic testing for COVID-19

## EMERGENCY ROOM SERVICES

The Fund will charge you the same copayment or coinsurance for hospital emergency services whether you obtain those services from an in-network health care facility or from an out-of-network health care facility.

Accordingly, emergency services provided in an emergency room by an out-of-network health care facility (unless you consent in writing to out-of-network billing rates for certain post-stabilization services, if applicable) will be considered at the in-network coinsurance level or 85% for the PPO Plan and 70% for the Low Option Plan, subject to a copay (the copay is waived if you are admitted to the hospital, though the hospital admission copay applies) and the annual deductible.

If you obtain emergency services from an out-of-network health care facility, that facility may not bill you separately if the hospital's charges exceed the Fund's Allowed Charge. Coverage for the emergency services at the in-network coinsurance level must meet the definition of emergency services as noted on page 75. In-hospital emergency room services are covered without prior authorization.

## SECOND SURGICAL OPINION (NON-EMERGENCY)

If your doctor recommends elective, non-emergency surgery, the Fund will pay for the following services in connection with a second opinion at 100 percent of the Allowed Charge with no deductible or copay:

- Services of physician; and
- Diagnostic testing, such as:
  - Imaging; and
  - Laboratory services.

## ELECTRO-CONVULSIVE THERAPY (ECT)

ECT services prescribed by a licensed health care provider acting within the scope of his/her license, are eligible for coverage under the Plan.

## ENHANCED EXTERNAL COUNTERPULSATION (EECP) THERAPY

EECP services prescribed by a licensed health care provider acting within the scope of his/her license, are eligible for coverage under the Plan. Coverage for EECP services is limited to no more than 35 treatment sessions within a seven-week period for patients who meet the following criteria:

- Disabling chronic stable angina (New York Heart Association Class III or Class IV angina); and
- Refractory to maximum medical therapy and not readily amenable to surgical intervention, such as percutaneous transluminal coronary angioplasty (PTCA) or cardiac bypass.

**Note:** Repeat courses of EECP must meet the above criteria and occur three or more months from the prior EECP treatment. (See the Summary of Benefits section beginning on page 10 for additional details.)

## CASE MANAGEMENT

Among the Plan's most important services for individuals with a chronic or catastrophic illness or injury are voluntary case management services. Case management offers a personal

approach: A registered nurse works in concert with you, your physician, your family, and other members of your health care team to help you receive timely, appropriate care while also helping you work through any difficulties you may encounter during the course of your care.

Nurse case management support services by telephone are provided by Anthem Blue Cross at no extra cost to you. If you choose to enroll in case management, a case manager will be assigned to you to provide you with continuity of care and personalized service. You may choose to opt out of case management at any time.

If you are interested in enrolling in case management, or if you have further questions, please call Anthem Blue Cross at (888) 613-1130.

**Home Health Care/Home Infusion Therapy and Hospice require preauthorization (see call out below).** Please have your health care provider contact the Fund's Utilization Administrator to facilitate your care. The phone number for preauthorization, or pre-service review, is on the back of your Health Plan ID. These services must be preauthorized; if not, your claim may be subject to post-service Medical Necessity review at the sole and absolute discretion of the Trustees. Consideration of post-service review shall not be deemed a waiver of the preauthorization requirement.

## HOME HEALTH CARE

The Fund covers home health services for individuals who are homebound due to illness or injury. To be considered for coverage, these services must:

- Be provided on an hourly (intermittent) basis;
- Be ordered by a licensed health care provider acting within the scope of his/her license;
- Be provided by a licensed health care provider acting within the scope of his/her license; and
- Undergo review for Medical Necessity by the Fund's Utilization Administrator.

**IMPORTANT!**

The Fund's Utilization Administrator is a service provided by Anthem Blue Cross to conduct preauthorization and pre-service reviews.

Below is a list of providers that may administer home health services:

- Registered Nurse (RN);
- Licensed Vocational Nurses (LVN);
- Licensed Practical Nurse (LPN); and
- Licensed/Registered Physical, Occupational, Speech, and Respiratory Therapists.

**Note:** Custodial Care — such as bathing, dressing, cooking, or house cleaning — is not a covered benefit.

To be considered for coverage, home health care must be:

- Used in place of hospital or skilled nursing facility inpatient care, or otherwise meet the Fund's Utilization Administrator requirements; and
- Must be periodically reviewed for Medical Necessity through preauthorization.

## HOME INFUSION THERAPY

Home infusion therapy is the administration of fluids and/or medications, either through a peripheral vein or a central vein, in the home as an alternative to hospitalization. Infusion therapy services include the necessary maintenance of the venous catheter. For home infusion therapy to be considered for coverage, services must:

- Be ordered by a licensed health care provider acting within the scope of his/her license;
- Be administered by a licensed health care provider acting within the scope of his or her license; and
- Undergo review for Medical Necessity by the Fund's Utilization Administrator.

Examples of Home Infusion Therapy include:

- Protocol maintenance, including flushes and dressings, for peripheral and central venous catheters;
- Catheter changes for peripheral IVs;
- Chemotherapy;
- Intravenous, intramuscular or subcutaneous medication administration;
- Intravenous fluid administration;
- Total Parenteral Nutrition (TPN); and
- Intravenous immunoglobulin (IVIG).

## HOSPICE

A covered person is eligible for hospice if his/her physician has determined that the patient has a medical prognosis of six months or less to live. Hospice programs enable terminally ill patients to remain in the familiar surroundings of their home for as long as they are able. Most terminally ill patients can be adequately treated using outpatient home hospice, but inpatient hospice is also an option. The patient, the family, and the attending physician must all agree that medical treatment that aggressively prolongs life, including artificial life support systems, will no longer be used. Please refer to the call out at right.

Services covered by the hospice program include:

- Home visits by nurses and social workers;
- Instruction and supervision of caregivers;
- Pain management and symptom control;
- Counseling and emotional support;
- Rental of all equipment needed for care in the home, such as a hospital bed or bedside commode; and
- Any other services required for the patient's comfort.

**IMPORTANT!**

The Fund's Utilization Administrator is a service provided by Anthem Blue Cross to conduct preauthorization and pre-service reviews.

The Fund's Utilization Administrator will confirm that the physician, the patient, and the family agree to use the hospice benefit and will make the referral to a participating hospice provider. Respite care for short-term temporary relief of the primary caregiver and/or family may be available.

## CLINICAL TRIALS

The Plan provides benefits for "routine patient costs" while participating in an "approved clinical trial." Routine patient costs are those services and items that are typically covered benefits of the Plan. The following criteria must be met in order to qualify for benefit coverage while in a clinical trial:

- You must meet eligibility as a "qualified individual," which is determined by selective criteria for each clinical trial;
- The referring health care professional is a participating provider and has concluded that your participation in the trial would be appropriate or you have provided medical and scientific information establishing that your participation is appropriate; and
- Only Phase I, II, III, or IV clinical trials qualify for coverage.

## AIR AMBULANCE SERVICES

Please note that the Fund covers air ambulance services only under carefully prescribed circumstances and when approved by the Fund's Medical Consultant. To receive coverage, both of the following must be true:

- Ground ambulance transportation is not available; and
- Your condition is unstable, requiring medical supervision and rapid transport.

If you need to go from one hospital to another hospital during a medical emergency and the first hospital does not have the required services or facilities to treat your condition, air ambulance services may be covered if your situation meets both conditions above.

Out-of-network air ambulance services are protected by the No Surprises Act.

## SEA AMBULANCE SERVICES

To help you avoid a bill with a substantial amount of uncovered expenses, please note that the Fund covers sea ambulance services only under carefully prescribed circumstances and when approved by the Fund's Medical Consultant. To receive coverage, both of the following must be true:

- Ground ambulance transportation is not available; and
- Your condition is unstable, requiring medical supervision and rapid transport.

If you need to go from one hospital to another hospital during a medical emergency and the first hospital does not have the required services or facilities to treat your condition, sea ambulance services may be covered if your situation meets both conditions above.

Out-of-network sea ambulance services are **not** protected under the No Surprises Act.

## GROUND AMBULANCE SERVICES

To help you avoid a bill with excessive uncovered expenses, the Fund provides coverage for ground ambulance services under the following circumstances:

- Transportation to a hospital by ambulance is Medically Necessary, and treatment is provided during a medical emergency;
- Transportation from one hospital to another hospital is required during a medical emergency, when the first hospital does not have the required services or facilities to treat your condition;
- Transportation from the hospital to the patient's home or to another facility is necessary when other means of transportation would be considered unsafe due to your medical condition; and;
- During a covered inpatient stay at a hospital, skilled nursing facility, or acute rehabilitation hospital, transportation to an inpatient or outpatient facility is necessary when an ambulance is required to safely and adequately transport the patient.

## HOSPITAL, SURGICAL, AND MEDICAL

All Plan options cover the following at the applicable in-network or out-of-network level of benefits:

- Alternative therapies (such as physical and occupational therapy, etc.) see Alternative Medical Benefit for Plan limitations on page 9 and page 88;
- Artificial limbs and eyes;
- Bariatric surgery, if it meets Medical Necessity (if coverage is not preauthorized, your claim may be subject to post-service Medical Necessity review at the sole and absolute discretion of the Trustees. The consideration of post-service review shall not be deemed a waiver of the preauthorization requirement);
- Blood and blood products, including autologous (self-donated) blood collection, processing, and storage, when collected for a planned and covered surgical procedure;
- Cardiac rehabilitation following a procedure (angioplasty, stent implantation, etc.);
- Cardiac diagnostic testing (such as EKGs, echocardiograms, angiograms);
- Casts, splints, dressings, and crutches;
- Charges for room, board, and staff nursing services generally provided in an inpatient setting. These charges will be considered up to the semi-private room rate;
- Colonoscopies:
  - Screening; and
  - Diagnostic (and other endoscopic procedures);
- Diagnostic testing, such as laboratory (blood and other body fluids), and imaging studies, such as X-ray, MRI, and CT scans;
- Emergency air or sea ambulance, when approved by the Fund's Medical Consultant, (see the Summary of Benefits section, page 9, for details);

- Emergency ground ambulance transfer to the nearest hospital (see the Summary of Benefits section, page 9, for details);
- Emergency medical care;
- Hearing aids, including fitting and other associated charges, subject to limitations (see the Summary of Benefits section, page 10, for details);
- Hospital or surgery/ambulatory surgery center (ASC) and associated services subject to limitations (see the Summary of Benefits section, page 9, for details);
- Hydrotherapy/Aquatic Therapy (see Alternative Medical Benefit for Plan limitations on page 9 and page 88);
- Inpatient rehabilitation provided at an accredited acute rehabilitation facility and subject to the Fund's Utilization Administrator review for the following criteria:
  - The patient has a condition that results in a significant decrease in functional ability;
  - There is a reasonable expectation that the patient will improve in a reasonable and generally predictable period of time and that such recovery will be aided by the inpatient rehabilitation care;
  - The intensity of service required cannot be provided in a lower intensity setting;
  - The patient requires and will receive multidisciplinary team care, defined as at least two therapies (i.e., speech, occupational, physical, and/or respiratory therapies); and
  - The patient's medical condition and treatment require physician supervision at least three times per week.
- Laboratory, X-ray, and diagnostic tests;
- Maternity and newborn infant care is covered when the mother is a Participant or a Participant's dependent spouse. Services for maternity and newborn care are not covered when the mother is a dependent child (any age) of the Participant. Benefits for any hospital stay in connection with childbirth for the mother or newborn child will be provided for a minimum of 48 hours for the mother and infant after a vaginal delivery and for a minimum of 96 hours after a Caesarean section.
- Medication administered as part of the treatment while in a facility (excluding take home medication);
- Newborn circumcision (see page 91);
- Outpatient hospital/ambulatory center care and treatment;
- Oxygen and necessary accessories (cannula, mask, or tank);
- Professional medical or surgical services provided by a health care provider acting within the scope of his/her license, in or out of the hospital setting;
- Radiology, nuclear medicine and radiation therapy services;

- Rental of durable medical equipment (DME), including manually or power-operated wheelchairs, or semi-electric hospital-type beds used in the patient's home. If the rental lasts more than one month, the monthly rental rate will be paid until the sum of all payments equals the purchase price. At this point, no further rental payments will be covered. DME is subject to Medical Necessity review and authorization of services by the Fund;
- Services of surgeons, assistant surgeons, anesthesiologists, and other specialists;
- Specialized "units" in an acute care facility, such as intensive care units, critical care units, newborn intensive care units, or pediatric intensive care units;
- Supplies required for surgery and special procedures; and
- Testing and short-term storage of umbilical cord blood when a Participant is undergoing treatment for which the use of umbilical cord blood stem cells is a viable alternative treatment to conventional allogeneic bone marrow transplant.

## INVERSION DEVICE

The rental or purchase of an inversion device is covered if prescribed by a health care provider acting within the scope of his/her license, as treatment for chronic back pain. The Fund requires documentation of at least six months of prior medical treatment.

## PALLIATIVE CARE

Palliative Care is a medical specialty that supports individuals with serious, chronic and life-limiting conditions at any stage of their illness. Unlike hospice care, which supports a patient solely at the end of life, Palliative Care supports patients throughout their illness and focuses not only on physical symptoms but also a person's (and their family's and caregivers') mental, emotional and spiritual health. Palliative Care takes an interdisciplinary approach to assist patients in every aspect of their lives, thereby improving their quality of life and aiding in their recovery.

Palliative Care covers such things as:

- Assistance with advance care planning;
- Assessments for depression, anxiety and other issues related to a diagnosis;
- Supportive counseling to assist you and your family in processing the changes a serious diagnosis can bring;
- Placements;
- Home health;
- Durable medical equipment;
- Legal assistance;
- Food delivery programs; and
- Caregiver support.

## TELEMEDICINE — LIVEHEALTH ONLINE

There are three types of LiveHealth Online (LHO) care, namely Medical, Psychology, and Psychiatry. See the Summary of Benefits chart on page 4 for benefit details.

LiveHealth Online is a convenient online health care access model that allows patients to receive around-the-clock medical and mental health care from Anthem Blue Cross providers.

Through LHO, you will have quick access to a doctor, therapist, psychologist, or psychiatrist using a computer or mobile device with a webcam. It is not meant to replace your primary physician. However, LHO can be a suitable option for care if your provider is not available. LHO is available in all 50 states. To get started, visit livehealthonline.com.

LHO Medical covers care for Medically Necessary services including common problems like cold and flu symptoms, or such things as a cough, fever, headache, allergies, or sinus infection. A typical LiveHealth Online session takes approximately 10 minutes. Doctors are available at LiveHealth Online 24 hours per day, 365 days a year. Doctors can also prescribe medications. (Prescription availability is subject to physician judgment and state regulations.)

LHO Psychology has two separate practices — one for treating patients 10-17 years old and the other for ages 18 and above:

- Patients 18 and above must have their own LHO account to see a therapist under the LHO Psychology suite.
- Patients between the ages of 10–17 must be added to the parent's account to see a therapist under the LHO Psychology suite. The parent initiates the therapy session for the minor using LHO Psychology for teens. The therapist gets needed information and then requests the parent leave the room for the session with the minor.
- LHO Psychology is not available to children under 10 years of age.

**NOTE:** Psychologists and therapists can refer patients to LiveHealth Online Psychiatry in situations where a combination of medication management and talk therapy would be helpful.

LHO psychiatrists are available to provide an evaluation and medication management to help those coping with a common behavioral health condition. During the first 45-minute evaluation, the LHO psychiatrist will assess the patient's condition, discuss past treatment options, and make any necessary medication updates. The psychiatrist can provide ongoing medication management through15-minute follow-up visits.

- To see a psychiatrist under the LHO Psychiatry suite, the patient must be at least 18 years old and must have his/her own LHO account.
- An LHO psychiatrist can prescribe only non-controlled substances.

The following services are **not** available through LiveHealth Online:

- LHO Psychology does not prescribe medications, as psychologists and therapists are not licensed to write prescriptions.
- Although LHO Psychiatry and LHO Medical providers can prescribe medications, they may not prescribe any "controlled substance" (as defined by the Controlled Substances Act under federal law) through LiveHealth Online.
- Psychiatrists do not offer counseling or talk therapy through LHO Psychiatry.

**NOTE:** To accommodate the COVID-19 pandemic, between March 16, 2020 and May 11, 2023, any office visit (in-network or out-of-network) that is otherwise covered under the Plan

and that can be conducted online will not be excluded solely because it is held online. These office visits will be covered, subject to normal Plan rules

## OFF-LABEL DRUG USE

Off-label drug use will be considered Medically Necessary when all of the following conditions are met:

- The drug is approved by the United States Food and Drug Administration;
- The drug is Medically Necessary to treat the specific medical condition, including life-threatening conditions or chronic and seriously debilitating conditions;
- The drug has been recognized for treatment of that condition by ANY of the following:
  - The American Hospital Formulary Service's Drug Information;
  - One of the following Compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
    - The Elsevier Gold Standard's Clinical Pharmacology;
    - The National Comprehensive Cancer Network Drug and Biologics Compendium; or
    - The Thomson Micromedex Drugdex; or
  - two articles from major peer-reviewed journals that have validated and uncontested data supporting the proposed use for the specific medical condition as safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

If the off-label use is determined to be Medically Necessary, its use shall also be determined to be "non-investigational" for the purposes of benefit determination.

This policy shall not be construed to be required coverage for any drug when the United States Food and Drug Administration has determined its use to be contraindicated.

Please refer to the definitions of Medically Necessary and Necessary Treatment on page 234 and page 235.

## NEUROPSYCHOLOGICAL TESTING

Neuropsychological testing (NPT) is considered Medically Necessary when provided to aid in the assessment of cognitive impairment due to medical or psychiatric conditions, when all of the following criteria are met:

- The requested number of hours or units requested for testing does not exceed 8 to 10 hours, which meets the medical efficacy of reasonable time necessary to address the clinical questions with the identified measures;
- Testing techniques are validated for the proposed diagnostic question or treatment plan;
- Testing techniques do not represent redundant measurements of the same cognitive, behavioral, or emotional domain;

- Testing techniques submitted are both validated for the age and population of the member, and they are the most updated version of the instrument; and
- The instruments selected have the empirically substantiated reliability, validity, standardized administration, and clinically relevant normative data to assess the diagnostic question or treatment planning goals.

Services not covered:

- Services not considered Medically Necessary;
- Services for or related to educational testing or learning disabilities;
- Experimental or investigational therapies; and
- Non-abstinence-based or nutritionally based substance abuse treatment.

## ORGAN AND TISSUE TRANSPLANTS

Organ and tissue transplants must be preauthorized to be eligible for coverage. Please refer to the Preauthorization call out at right.

Each transplant request will be reviewed by the Fund's Utilization Administrator to determine candidacy based on Medical Necessity.

The following organ and tissue transplants are eligible for coverage:

- Bone;
- Bone marrow;
- Cornea;
- Heart;
- Heart valves;
- Intestines;
- Kidney;
- Islet cells;
- Liver;
- Lung;
- Pancreas;
- Skin;
- Stem cells; and
- Tendon.

**IMPORTANT!**

The Fund's Utilization Administrator is a service provided by Anthem Blue Cross to conduct preauthorization and pre-service reviews.

If preauthorization of an organ or tissue transplant is denied by the Fund or the Fund's Utilization Administrator, the organ or tissue transplant may be subject to post-service Medical Necessity review at the sole and absolute discretion of the Trustees. Consideration of post-service review shall not be deemed a waiver of the preauthorization requirement. The final

decision regarding coverage will be made at the sole discretion of the Benefits Committee (or its delegate), which will base its determination in part on current peer-reviewed medical literature and guidelines issued by appropriate medical societies. All transplants will be reviewed on a case-by-case basis.

If your transplant surgery is covered and donor expenses are involved, and the donor has no coverage under his/her medical insurance plan for donor expenses, the Health Plan will cover the donor's expenses (subject to the limitations noted below). Written documentation from the donor's insurance plan substantiating lack of coverage for donor expenses is required.

Coverage of expenses for the donor will be limited to the surgical removal of the organ or tissue, related inpatient hospitalization, and storage and transportation of the organ or tissue, not to exceed the dollar limitation established by the Fund for the procedure performed. Also, donor expenses will be covered only if the procedures are performed by an in-network health care provider at an in-network facility. If you are the transplant recipient, donor expenses will be processed under your claim file and will be subject to the same level of copayments, coinsurance, deductibles, and maximums that apply to you. The Participant (the recipient of the donated organ or tissue) is responsible for the amount of any donor expenses not covered by the Fund. For example, if you are covered by the PPO Plan and the donor has the organ removal performed by a network physician at a network facility, the Fund will pay 85% of the donor expenses, and you will be responsible for the remaining 15% (plus any applicable copays, deductibles, etc.).

Please have your provider contact the Fund's Utilization Administrator to facilitate your care. The phone number for Preauthorization Review is on the back of your medical ID card.

## TRANSPLANT TISSUE COMPATIBILITY TESTING AND ORGAN DONOR PROGRAMS

A transplant team will determine your candidacy for organ or tissue transplantation. Once you are determined to be a candidate, you will be listed on the national waiting list database of the Organ Procurement and Transplantation Network (OPTN). Matching criteria for each organ or tissue is different. Finding a compatible tissue/ organ donor is part of the process of organ/tissue transplantation. Sometimes a family member may be a tissue match and able to donate the needed tissue or organ. More often, a tissue/ organ recipient must rely on organ donation registries. These registries charge compatibility testing fees, which will be an out-of-pocket expense to the recipient, as these services are not a covered benefit under the Health Plan.

**IMPORTANT!**

Because the Fund requires operative and pathology reports for most surgeries, claims submissions must include these reports. We recommend that you ask your surgeon and/or facility where the services are being rendered to include this detail at the time of claim submission so you can avoid delay or denial of your claims.

## INPATIENT AND OUTPATIENT FACILITY EXPENSES

To receive the highest level of benefits for inpatient and outpatient facility expenses, you must see an in-network provider, who will work with Anthem Blue Cross to preauthorize your care. It is your responsibility, however, to first call Anthem Blue Cross to verify that the health care provider is in the network. You must also make sure the provider preauthorized your initial and ongoing care, which must be considered Medically Necessary in order to be authorized by Anthem Blue Cross.

Preauthorization is required for:

- All in-network and out-of-network inpatient admissions; and
- All in-network and out-of-network outpatient facilities.

**NOTE:** If you do not preauthorize your care, your claim may be subject to a post-service Medical Necessity review, which may delay the processing of your claim and/ or result in your claim being denied.

Preauthorization for inpatient or outpatient facilities should be obtained 7 to 10 days in advance by calling Anthem Blue Cross or the Blue Cross and Blue Shield plan in your area.

If you are admitted to the hospital through the Emergency Department, your hospitalization must be preauthorized within 48 hours (or two business days) of your admission by calling BlueCross Blue Shield Global Core.

**NOTE:** Please have your provider contact the Fund's Utilization Administrator to facilitate your care. The phone number for Preauthorization Review is on the back of your medical ID card.

## PHYSICIAN CARE

The Health Plan provides coverage for the following physician care (in or out of a hospital setting):

- Home, office, and hospital visits; and
- Services of physicians, surgeons, and assistant surgeons, including specialists.

The allowance for a physician assistant surgeon will not exceed 20% of the allowance for the procedure.

The allowance for assistant surgery services by a physician assistant or other assistive surgical personnel permitted to assist at surgery under state regulation will be no more than 10% of the allowance for the procedure, except if determined otherwise by in-network pricing.

**IMPORTANT!**

The Fund's Utilization Administrator is a service provided by Anthem Blue Cross to conduct preauthorization and pre-service reviews.

The use of an assistant surgeon must be Medically Necessary. An assistant surgeon is considered Medically Necessary when a procedure is at a level of technical surgical complexity that the assistance of another surgeon is required.

Services of operating room technicians are included in the surgeon or operating room facility charges and are not eligible for separate benefits.

If multiple surgical procedures are performed through the same incision, benefits will be based on the primary procedure. If two or more surgical procedures are performed through separate incision, the primary procedure will be considered up to 100% of the allowable charges and 50% of the allowable charges for the remaining procedures. No additional allowance will be given for those procedures considered incidental or non-covered.

## PREVENTIVE CARE SERVICES

Preventive care is an evaluation of your current health status when you are symptom-free. Preventive care services are covered at 100% (that means no out-of-pocket cost to you) if:

- They are considered preventive services under the ACA guidelines, which are:
  - You obtain services from an in-network provider;
  - The purpose of your visit is to obtain preventive care; and
  - The services are billed as preventive care services.

Preventive care services are based on the following guidelines. Pages 107-111 list preventive care services that are currently covered at this level under the Plan, but this will change automatically as the guidelines and recommendations listed below change. You may find additional details regarding these preventive care services guidelines online as listed below:

- The U.S. Preventive Services Task Force (USPSTF), A and B recommendations uspreventiveservicestaskforce.org;
- The Center for Disease Control (CDC) cdc.gov/vaccines/schedules/ and the affiliated Advisory Committee on Immunization Practices (ACIP); or
- Health Resources & Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines and HRSA guidelines relating to services for women hrsa.gov.

Many of the tests and screenings listed on these charts are already covered under the Plan's wellness benefits. Some wellness services are not considered "preventive services," and will continue to be covered under the Plan's wellness benefits. Accordingly, the Fund will apply the preventive care benefits first, and any remaining wellness benefits (that do not constitute preventive care service) will be applied toward the Plan's annual wellness benefits (see Summary of Benefits section, page 4, for details).

Generally speaking, whether or not you must share the costs for office visits during which recommended preventive health care services are rendered, either in whole or in part, depends upon how the preventive health service is billed and the primary nature of the office visit. Cost sharing for office visits will be applied if either of the following apply:

1. A preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit where the primary purpose of the visit was for preventive services; or
2. The primary purpose of the office visit was not to provide a preventive service or item, regardless of whether preventive services are billed separately (or are tracked as individual encounter data) from an office visit.

Cost sharing for office visits will not be applied if recommended preventive services are not billed separately (or are tracked as individual encounter data) from an office visit and the primary purpose of the visit was the delivery of a preventive service or item.

There may be times when you are seen by your doctor for your annual physical examination, but your doctor may order several tests. Some of those tests may be considered preventive care. These tests will be paid at 100% of the network contract allowance only if they are provided by in-network providers. Some of the tests ordered by your doctor might not be for preventive services and may be subject to any applicable deductibles, copays, or coinsurance. For example, if you go to an in-network provider for a sore throat, and while there

your doctor recommends that you have your cholesterol checked, the office visit is subject to any applicable deductible, copay, and/or coinsurance, and the cholesterol test is paid at 100%.

Additionally, if you are diagnosed with a condition such as hyperlipidemia (high cholesterol) and your doctor performs a cholesterol test, then that test is subject to cost sharing, as it is in connection with a medical condition, and not preventive services. Please also note that the Fund will only pay for preventive services which are considered Medically Necessary. For example, a routine colonoscopy for an individual under the age of 50 would not be a covered expense, as this test is performed routinely only for individuals age 50 and over.

**Note:** the following applies to the charts on pages 107-111.

- Preventive care benefits are available under the PPO Plan and Low Option Plan (in-network providers only);
- Any additional recommendations provided in the future will be covered as of the first Plan year beginning on or after the first anniversary of when the recommendations are updated; and
- Wellness benefits are not available under the Low Option Plan.

## LIST OF COVERED PREVENTIVE CARE SERVICES (IN-NETWORK ONLY)

The wellness and preventive services payable by this Plan are designed to comply with ACA regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures, and the Centers for Disease Control & Prevention (CDC). The following websites (periodically updated) list the types of covered preventive services, including immunizations:

- healthcare.gov/what-are-my-preventive-care-benefits/ with more details at cdc.gov/vaccines/schedules/hcp/index.html;
- hrsa.gov/womens-guidelines/; and
- uspreventiveservicestaskforce.org/BrowseRec/Index (A and B rated recommendations).

Where the information in this document conflicts with newly released health reform regulations, this Plan will comply with the new requirements on the date required.

## ADULT PREVENTIVE CARE SERVICES

Preventive physical exam, annually

| Screenings and Services |
| --- |
| Alcohol misuse: screening and behavioral counseling |
| Abdominal Aortic Aneurysm (men age 65 to 75 who have smoked) |
| Blood Pressure |
| Chlamydia Infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit |
| Cholesterol screening for adults aged 40 to 75 years |
| Colorectal cancer using stool-based methods (such as fecal occult blood testing), sigmoidoscopy, or colonoscopy: beginning at age 50 up to 75 |
| Depression with referral for follow-up (adolescents and adults) |
| Diabetes Type II ("adult-onset") ages 40-70 if overweight |
| Nutrition and diet counseling for those at higher risk for chronic disease |
| Domestic violence: referral to intervention services if needed |
| Exercise or physical therapy to prevent falls for people over age 65 |
| Hepatitis B: testing for persons at high risk |
| Hepatitis C: screening for those at high risk for infection and a one-time testing for anyone born between 1945–1965 |
| HIV (adolescents and adults aged 15 to 65 and those at increased risk of infection) |
| Lung cancer: annual low-dose CT in past smokers age 55-80 who currently smoke or those who have quit within the last 15 years |
| Obesity: weight and BMI: if BMI is 30 or greater, intensive behavioral counseling |
| Osteoporosis testing: (bone density): women, age 60 and older, based on risk factors |
| Sexually transmitted disease/infection (STD/STI) prevention counseling for high risk adults |
| Tobacco use screening and, for users, behavioral and cessation interventions |
| Skin cancer: adults and adolescents: counseling on how to minimize UV radiation exposure |
| Syphilis: for at-risk populations |
| Tuberculosis (TB): for at-risk populations |

## ADULT PREVENTIVE CARE SERVICES

Preventive physical exam, annually

### Immunizations

Diphtheria, Tetanus and Pertussis (DPT)

Hepatitis A and B (depending on risk factors determined by your provider)

Human Papillomavirus (HPV) ages 19 to 26

Influenza (flu)

Meningococcal (Meningitis) (depending on risk factors determined by your provider)

Measles, Mumps, and Rubella (MMR)

Pneumococcal (Pneumonia) Age 60–65 and older (before age 60–65 depending on risk factors determined by your provider)

Varicella (Chicken Pox)

Zoster (Shingles), Shingrix for age 50 and older or Zostavax for age 60 and older

### Medication

(generic medication unless medically inappropriate with a prescription from your physician)

Aspirin: To reduce risk of heart attack or colorectal cancer (one bottle of generic 100 tablets every three months)

Low to moderate dose statin medications for adults at increased risk of cardiovascular disease, but without prior cardiovascular events

Vitamin D supplementation in adults age 65 or older who are at risk for falls

Smoking Cessation drugs (both OTC and prescription) for two 90-day treatment regimens annually. Preparation products for colon cancer screening tests for adults over age 50

Preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.

## WOMEN'S PREVENTIVE CARE SERVICES

Well woman visit, annually

Breast Cancer Testing

- Mammogram every other year, for women age 40 and older
- BRCA 1 and 2 counseling and testing (depending on risk factors determined by your provider)

Breast cancer preventive medication ("chemoprevention") counseling for women at increased risk for breast cancer

Breast feeding (lactation) interventions for the duration of breast feeding (includes counseling, instruction and supplies)

Cervical Cancer Testing

- Pap smear every 3 to 5 years for women age 21 to 65
- Human Papillomavirus (HPV) testing every 3 to 5 years for women age 30 to 65

Contraception (FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity)

Counseling for genetic testing for women with a family history of ovarian or breast cancer

Domestic violence counseling

Folic Acid supplements (0.4mg - 0.8mg) for women who may become pregnant

Pelvic exam, including Pap smear

Sexually transmitted disease/infection (STD, STI) testing in sexually active women

- Chlamydia
- Gonorrhea
- HIV
- HPV (see cervical cancer screening above)
- Syphilis

Pregnancy-related screening

- Bacteriuria testing at 12 to 16 weeks gestation or first prenatal visit (if earlier
- Gestational diabetes
- Hepatitis B
- HIV
- Rh incompatibility
- Sexually transmitted infection testing (for diseases such as gonorrhea, chlamydia, HIV and syphilis)

### Medication

- Medication to reduce the risk of breast cancer (for example Tamoxifen or Evista) for women age 35 or older at increased risk for breast cancer and at low risk for adverse medication effects
- Folic Acid supplements (0.4mg - 0.8mg) for women planning to become or capable of becoming pregnant
- Aspirin: low dose (81mg/d) after 12 weeks of gestation to persons who are high risk for preeclampsia

## CHILD AND ADOLESCENT PREVENTIVE CARE SERVICES

Preventive physical exam, through age 21

| Screenings, services and medications |
|---|
| Newborns |
| • Critical congenital heart defect |
| • Gonorrhea preventive medication |
| • Hearing assessment |
| • Hypothyroidism |
| • Phenylketonuria (PKU) |
| • Sickle-cell (Hemoglobinopathies) |
| • Critical congenital heart defect |
| Infants, adolescents and teenagers: |
| • Alcohol and drug use (adolescents) |
| • Tobacco use prevention counseling |
| • Autism (age 18 to 24 months) |
| • Behavioral assessment (age 0 to 17 years of age) |
| • Blood pressure (age 0 to 17 years of age) |
| • Cervical dysplasia screening (sexually active females 21+) |
| • Depression screening, age 12 to 18 |
| • Developmental (age 3 and under) |
| • Fluoride (for children without fluoride in their water source) |
| • Hearing |
| • Height, weight, body max index (age 0 to 17 years of age) |
| • Hematocrit and hemoglobin |
| • Hepatitis B (high risk adolescents) |
| • HIV (adolescents at high risk or those 15+) |
| • Iron supplements (age 6 to 12 months at risk for anemia) |
| • Lead (for children at risk for exposure) |
| • Lipid/cholesterol screening (for high risk, age 1 to 17 years) |
| • Medical history |
| • Nutrition and diet counseling (obesity screening/counseling) |
| • Obesity screening and counseling for those 6 and older |

- Skin cancer: adults and adolescents: counseling on how to minimize UV radiation exposure
- Oral health (age 0 to 10 years)
- Oral fluoride supplementation (for infants and children through 5 years, preventive coverage required for application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices and oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient)

Infants, adolescents and teenagers:

- Oral health (age 0 to 10 years)
- Screening and counseling for interpersonal and domestic violence
- Sexually transmitted infection screening/counseling for all sexually active adolescents
- Syphilis screening for those at high risk
- Tobacco use prevention counseling
- Tuberculin testing for those at higher risk for tuberculosis
- Vision

| Immunizations |
|---|
| Diphtheria, pertussis, tetanus (DPT) |
| H. influenza type B (Hib) |
| Hepatitis A and B |
| Human Papillomavirus (HPV) |
| Influenza |
| Measles, mumps, rubella (MMR) |
| Meningococcal |
| Pneumococcal conjugate vaccine (PCV) |
| Polio: inactivated poliovirus (IPV) |
| Rotavirus |
| Varicella (chickenpox) |

## RECONSTRUCTIVE MASTECTOMY BENEFIT

In accordance with the requirements of the Women's Health and Cancer Rights Act of 1998, if the Fund provides medical and surgical benefits in connection with a mastectomy, the Fund will also provide benefits for certain reconstructive surgery. In particular, the Fund will provide, to a Participant or beneficiary receiving or claiming benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for the following:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and/or

- Prostheses and physical complications associated with all stages of mastectomy, including lymphedemas, in a manner determined in consultation between the attending physician and the patient.

To the extent permitted by applicable law, this coverage is subject to applicable copays, referral requirements, annual deductibles, and coinsurance provisions that may apply under the Health Plan. If you have any questions, please contact the Fund Office.

## SKILLED NURSING FACILITIES

Please refer to the preauthorization call-out box at right for preauthorization requirements for admission to a skilled nursing facility. If your admission to a skilled nursing facility is not preauthorized, your claim may be subject to post-service medical necessity review at the sole and absolute discretion of the Trustees. Consideration of post-service review shall not be deemed a waiver of the preauthorization requirement.

**IMPORTANT!**

The Fund's Utilization Administrator is a service provided by Anthem Blue Cross to conduct preauthorization and pre-service reviews.

Inpatient care at a skilled nursing facility is covered if you meet the following medical necessity criteria:

- The illness requires constant or frequent skilled nursing care on a 24-hour basis and/or while the patient is receiving rehabilitative services (at least five days per week), and this care cannot be safely or efficiently provided on an outpatient basis; and
- There is an expectation that the patient will improve within a reasonable period of time that would permit him/her to be discharged home with minimal patient services.

**Please have your health care provider contact the Fund's Utilization Administrator to facilitate your care. The phone number for preauthorization, or pre-service review, is on the back of your Health Plan ID.**

## SPEECH THERAPY

The Fund covers speech or voice therapy when it is both prescribed and performed by a licensed health care provider acting within the scope of his/her license. Speech therapy is not covered when it is part of an educational program for a child with learning delays, unless the child has been diagnosed with autism, pervasive developmental disorder, severe attention deficit hyperactivity disorder, or another condition for which speech therapy is deemed to be medically necessary by the Fund.

The Fund will cover up to 100 visits annually for speech therapy, which is subject to review for medical necessity to treat one or more of the following conditions:

- An organic, objectively documented illness, an injury or surgery that affects the oral-motor mechanism;
- Articulation disorder, when diagnosed by a licensed speech pathologist;
- Attention deficit hyperactivity disorder (ADHD), pervasive development disorder (PDD), or autism;

- Cognitive disorders impairing speech as a result of an organic, objectively documented illness, injury, or surgery;
- Congenital anomalies that have been surgically corrected;
- Documented hearing loss for children who have failed to develop normal speech, based upon developmental norms for age;
- Speech impairment by surgery, accidental injury, stroke, radiation injury, or other structural or neurological diseases; and/or
- Speech impairment in a child who has failed to acquire comprehensible speech articulation as the result of hearing loss, Down's syndrome, cerebral palsy, or another neurological disease.

Speech therapy benefits for your child must be coordinated with speech therapy benefits provided through your child's school. If your physician prescribes more than one speech therapy visit per week, you must provide satisfactory evidence to the Fund Office that you have applied for the federally mandated individual education program (IEP) benefit through your child's school. For each IEP-covered visit, the visits covered by the Fund will be reduced by one. When the IEP benefits are coordinated, the Fund pays for fewer than 100 visits each calendar year. If the IEP denies a request for speech therapy, you must provide documentation of the denial before the Fund will consider benefits. As with all Fund benefits, eligibility for benefits is subject to review for medical necessity.

## TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

Treatment for Temporomandibular Joint Dysfunction (TMJ) is a covered benefit, including imaging studies for diagnostic purposes, physiotherapy, and charges for a TMJ appliance or splint, including follow-up visits for adjustments, will be paid at the applicable in-network or out-of-network benefit levels, all subject to review for medical necessity.

## TRANSGENDER SERVICES

Fund coverage includes Medically Necessary services related to gender transition as described below.

Services and supplies provided in connection with gender transition are covered if you have been diagnosed with gender identity disorder or gender dysphoria by a licensed health care professional acting within the scope of his/her license. This coverage is provided according to the terms and conditions of the Plan that apply to all other covered medical conditions, including medical necessity requirements, utilization management, and exclusions, for the following:

- Transgender surgery (also known as gender reassignment surgery);
- Continuous hormone replacement therapy (hormones of the desired gender);
- Laboratory testing to monitor the safety of continuous hormone therapy;
- Female to male transgender chest reconstruction;
- Diagnosis of, and psychotherapy for, gender identity disorders/dysphoria and associated comorbid psychiatric diagnoses; and
- Puberty-Suppression Hormone Therapy for transgender adolescents.

Coverage is provided and payable according to the Plan benefit that applies to that specific service. For example, transgender surgery, if it is Medically Necessary and meets the guidelines of the Plan, would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under the Plan's prescription drug benefits, and psychotherapy would be covered under the medical benefit. If coverage for a specific service is not included, the service will not be covered. This coverage includes the following covered services, when Medically Necessary:

- Blepharoplasty;
- Breast augmentation;
- Chest reconstruction for female to male gender transitions;
- Brow lift;
- Calf implants;
- Chin augmentation/implant or genioplasty;
- Face lift;
- Facial bone reconstruction;
- Forehead contouring;
- Gluteal augmentation/buttocks implant;
- Hair removal/hairplasty;
- Jaw implant;
- Jaw reduction (jaw contouring) and/or chin re-shaping;
- Lip reduction/enhancement;
- Laryngoplasty;
- Lipofilling/collagen injections;
- Liposuction;
- Malar (cheek) implants;
- Mons lift/mons reduction;
- Pectoral implants;
- Rhinoplasty;
- Rib excision;
- Scalp (hairline) advancement;
- Thyroid cartilage reduction/chondroplasty;
- Tracheal shave;
- Voice modification; and
- Voice therapy.

However, not all charges related to transgender services are eligible for coverage under the Plan. Examples of non-covered services or expenses include, but are not limited to:

- Breast reduction (with the exception of female to male transgender chest reconstruction when medically necessary);
- Drugs for hair loss or hair growth;
- Drugs for sexual performance or cosmetic purposes;
- Sperm or gamete procurement for future infertility or storage of sperm, gametes, or embryos;
- Treatment received outside the United States; and
- Transportation, meals, lodging, or similar expenses

Surgery related to transgender services including transgender surgery (also called gender reassignment surgery) are subject to prior authorization in order for coverage to be provided. If you fail to receive or request preauthorization, then the Trustees at their sole and absolute discretion may authorize a postservice medical necessity review. Consideration of post-service medical necessity review shall not be deemed a waiver of the preauthorization requirement.

Preauthorization Coverage Criteria:

- Any transgender surgery must be performed at a facility designated and approved by the Fund and performed by a qualified provider;
- The treatment plan must conform to Harry Benjamin International Gender Dysphoria standards;
- The treatment plan must conform to the most recent edition of World Professional Association for Transgender Health (WPATH), Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People;
- For surgical intervention (with the exception of female to male transgender chest reconstruction when medically necessary), the patient must be 18 years or older; and
- Before surgery, the patient must, among other things, complete 12 months of successful continuous full-time real-life experience in their desired gender.

The above is not an all-inclusive list. Contact the Fund Office for specific and detailed guidelines regarding benefits for treatment of gender identity disorder and gender dysphoria.

For individuals with gender dysphoria who are not planning reassignment surgery, contact the Fund Office for Plan benefits.

## WELLNESS BENEFIT

The PPO Plan provides each family with a calendar year wellness benefit, up to a maximum calendar year limitation. The Low Option Plan does not have a wellness benefit.

(See the Summary of Benefits, page 4 for the maximum amount):

- Flu shots and other vaccinations (also called immunizations). Charges in connection with a wellness visit for children under age seven are considered an eligible expense under the Plan's medical benefits rather than under the wellness benefit;
- Genetic testing;

- Lifestyle classes and Fitness Enhancement (offered at the UCLA Health/Motion Picture & Television Fund Health Centers located in Southern California);
- Nutritional counseling if to treat a specific disease diagnosed by a physician;
- Routine mammograms;
- Routine Pap smears;
- Routine physical examinations;
- Smoking cessation programs;
- Weight-Control or Weight-Loss programs that meet the criteria listed below: (Reimbursement will only be provided after services are rendered, and coverage excludes food or beverages provided or recommended by a weight loss program.)
  - The program requires the individual to physically report in to their clinic to monitor weight and review progress (e.g., Weight Watchers or Jenny Craig);
  - The program must include treatment for a specific disease diagnosed by a physician; and
  - The program must provide proof of attendance when you submit your claim.
- Well-child care for children age seven and older;

Some of the services that would be considered wellness benefits are already covered under the preventive care benefits. By law, preventive care benefits are required to be covered without any participant cost-sharing when provided by an in-network provider. The Plan will apply the preventive care benefits first. (Please see pages 105 for more information on what constitutes a preventive care benefit.) Where a wellness service does not constitute a required preventive-care benefit, then the service is considered under the wellness benefit.

As with all Fund benefits, only services performed by a licensed practitioner acting within the scope of his/her license will be covered by the wellness benefit. If you want to know if a service or treatment is covered under the wellness benefit before you visit a health care provider, contact the Fund Office.

**NOTE:** If the wellness benefit is exhausted, the expenses will be considered under medical benefits, subject to the Plan's annual deductible, Coinsurance Out-of-Pocket Limit, and ACA Network Out-of-Pocket Limit. This rule doesn't apply to the Low Option Plan. See the Summary of Benefits section beginning on pages 2 for more information.

## WIGS

Wigs are covered, when there is severe hair loss due to injury or disease, or as a side effect of a treatment of a disease (e.g., chemotherapy, alopecia). Wigs are not covered for cosmetic purposes.

## EXCLUSIONS AND LIMITATIONS

Notwithstanding the above, none of the Plan options cover any of the following expenses:

- Acupressure, massage therapy, Feldenkrais, Alexander method, Pilates, and Yoga, even when prescribed by a physician;

- Acupuncture (except for treatment of chronic pain);
- Air conditioners, over-the-counter humidifiers, pillows, mattresses, mattress covers, and similar environmental control equipment;
- Autologous (self-donated) blood storage charges, unless in association with a scheduled surgery that is normally covered by the Fund;
- Charges associated with the translation of foreign claims;
- Charges billed for procedure codes determined by the Plan to be incidental or mutually exclusive to/unbundled from a more global procedure code, except as determined by network pricing;
- Charges for completing claim forms, reports, etc.;
- Charges for copying medical file records, except when requested by the Fund for Medically Necessary review;
- Charges in connection with wig or hairpiece supplies, or the maintenance of a wig or hairpiece;
- Charges for mailing and shipping of medical supplies;
- Charges for umbilical cord blood collection, to randomly freeze and/or store umbilical cord blood for possible future use;
- Charges in connection with private duty or full-time nursing care while hospitalized;
- Charges in connection with the pregnancy of dependent children, except for certain screenings as described under the Preventive Care Services on pages 107-111 (however complications of pregnancy are covered);
- Charges the patient is not required to pay;
- Charges for cancelled or missed appointments;
- Christian Science treatment;
- Cold or heat therapy supplies or equipment for home use;
- Collagen or fat injections;
- Charges to have preferred access to a physician's services such as boutique or concierge physician practices; or other personalized medicine billed as an all-inclusive package;
- Cosmetic surgery or medications used for cosmetic purposes;
- Cultured chondrocyte transplantation to joints other than the knee;
- Custodial care at home, in a skilled nursing facility or hospital, including convalescent, nursing or rest homes whether provided by licensed or unlicensed personnel as defined on pages 94;
- Cutting, trimming, or partial removal of toenails, corns and calluses, except when Medically Necessary due to vascular impairment or loss of protective sensation caused by diabetes or other disease;

- Dental expenses, including bone or metal bases for dental implants, except:
  - Treatment rendered within 90 days of accidental injuries to sound natural teeth (due to external blow), including the replacement of such teeth, applied without respect to when the individual is enrolled in the Plan. (There is no guarantee that treatment will be covered. The expense must be reviewed and be deemed medically necessary);
  - Setting of jaw fractured or dislocated in an accident; or
  - Dental expenses that may be covered under the dental benefits. (See Dental Benefits beginning on pages 152 for details).
- Diet pills or other medications for the purpose of appetite suppression or weight loss;
- Donor compatibility testing for transplants;
- Educational training, and associated supplies or equipment, except those mandated by law;
- Educational services, supplies, or equipment, including the following: therapeutic schools and associated services, therapy, academic evaluations, dance therapy, art therapy, play therapy, treatment of learning disabilities; computers, computer devices/ software, printers, books, tutoring or interpreters; visual aids, auditory or speech aids/ synthesizers, auxiliary aids, communication boards, listening systems; special education and associated costs in conjunction with tactile systems like Braille or sign language education for a patient or family members; and implantable medical identification/ tracking devices;
- Exercise equipment, whirlpools, sunlamps, heating pads, and other similar general use items, even when prescribed by your physician, except as provided under "Inversion Device" as described on pages 99;
- Expenses for services received by a minor participant or dependent available from or payable by a third party, including but not limited to services available from or payable by a federal, state, or local government agency, program, or initiative, services available from or payable by a pre-kindergarten, primary or secondary educational institution, and any other services available from or payable by a third party, including services conditioned on the participant or dependent not having individual group health coverage; in each case, only to the extent the services are not coordinated with Plan benefits on a "one-for-one" visit reduction basis, and, to the extent not otherwise specifically limited or prohibited by applicable law. Notwithstanding this provision, any service or expense covered by a government-insurance program (such as Medicare, Medicaid, the Children's Health Insurance Program, or Tricare) that is subject to the Plan's Coordination of Benefits provision, shall not be excluded under this provision and instead shall be subject to the Plan's Coordination of Benefits provisions;
- Expenses for a non-hospital wilderness therapy program, outdoor behavioral health program, or boot camp-type program, unless the program or treatment is determined to be Medically Necessary under the terms of the Plan, as well as expenses for boarding school, military school, foster home/care, group home, half-way/quarter-way house, or sober living/transitional living environment;

Wilderness Therapy programs are generally considered not Medically Necessary, because they typically lack the program structure, sufficiently detailed treatment plan, and pharmacological intervention to meet the appropriate standard of care for clinical treatment. They do not typically meet the definition of clinical residential treatment centers. Moreover, they have not sufficiently shown effectiveness, safety, relevance, and/or reliability in studies in peer-reviewed medical literature.

- Expenses incurred that are not due to illness or injury (except for otherwise covered preventive care services);
- Expenses related to an online (internet) consultation with a physician or other health care provider outside of Anthem LiveHealth Online network, (also called a virtual office visit/consultation, web visit, physician-patient web service, or physician-patient e-mail service, telemedicine (real time or store and forward types), telehealth, e-health, e-visit, online health service, remote diagnosis and treatment, real-time video-conferencing including receipt of advice, treatment plan, prescription drugs, or medical supplies obtained from an online internet provider). See pages 100 for a description of the network online health services payable by the Plan;
    - **Note: Due to the COVID-19 pandemic,** between March 16, 2020 and May 11, 2023, any office visit (in-network or out-of-network) that is otherwise covered under the Plan and that can be conducted online will not be excluded solely because it is held online. These visits will be covered, subject to normal Plan rules.
- Expenses that are in excess of the Allowed Charge as defined in the Glossary;
- Expenses that are not ordered by a licensed health care provider acting within the scope of his or her license;
- Expenses that are not considered medically necessary treatment as defined in the Glossary;
- Expenses written off by the provider or not charged to the patient;
- Experimental or investigational treatments (see the Glossary on page 234 for the definition of "Investigational/Experimental Treatment");
- Extra or increased charges, in addition to basic services, for services provided after hours, or during late hours at a 24-hour facility, or on weekends and holidays, or on an emergency basis;
- Fees for a surgical suite, unless the facility is state licensed and/or Medicare approved as an ambulatory surgical facility, or has certification from a private accreditation agency accepted by the state in lieu of state licensure;
- Fees for membership at a health club, gymnasium, YMCA, or similar facility;
- Food supplements and medical foods;
- Glasses, contact lenses, and eye refractions, except when provided following a covered eye surgery, such as cataract surgery, or any surgical procedure, such as LASIK, to correct a refractive error. Please refer to the Vision Benefits section on pages 135-138;
- Grocery items, including food and drink (includes food or beverages provided or recommended by a weight loss program);

- Hair implants or hair plugs;
- Hair growth removal products;
- Heel lifts and shoe inserts, except to treat plantar fasciitis or to prevent complications from diabetes (orthopedic shoes and other orthoses are subject to medical necessity review);
- Home IV infusion therapy, unless authorized through the Utilization Administrator;
- Homeopathic services, medicines, and remedies;
- Home uterine activity monitoring (HUAM), except when approved as Medically Necessary;
- Hospitalization or service which is not ordered by a licensed health care provider acting within the scope of his or her license;
- Hospitalization primarily for diagnostic studies;
- Hydrotherapy, if used for exercise purposes;
- Hypnosis;
- Illness or injury caused by declared or undeclared war or act of war;
- Loss caused by illness or injury:
  - That arises out of, or occurs in the course of, any occupation or employment (including self-employment) for wages or profit (even if the covered person was not covered by Workers' Compensation insurance or occupational disease law, or if the covered person waived or qualified his/her rights to such); or
  - For which the covered person is entitled to any benefits under a Workers' Compensation or occupational disease law (including benefits under a Workers' Compensation or occupational disease law that the covered person does not ultimately receive because of some action or inaction of the covered individual, such as waiving his/her benefits or rights, or his/her failure to follow relevant Workers' Compensation or occupational disease law guidelines (such as the failure to use approved Workers' Compensation providers));

**IMPORTANT!**

NOTE: The Fund does not cover charges in cases where a health care provider bills in the same service line for multiple diagnoses, or where one diagnosis is for covered services and one is for excluded services. To avoid delay or denial of claims, we recommend that you ask your health care provider and/or facility to bill on a separate line item the portion of any charge for illnesses or injuries for which Workers' Compensation or occupational disease law benefits are available.

- Medical care received in a United States, or Canadian government-operated hospital or from physicians employed by those governments, except charitable research hospitals, unless mandated by law;
- Medical expenses incurred by an organ donor for an eligible Participant or dependent, that are covered by the donor's own group health insurance;

- Neuromuscular stimulator or similar equipment, except when appropriate to prevent or treat muscular atrophy due to neuromuscular disease or injury (not covered to prevent or treat disuse atrophy due to pain, including post-operative pain);
- Naturopathic services and medications;
- Outpatient prescription drugs and medications not billed as part of a facility charge, except those provided by home health care (outpatient prescription drug benefits are described under Prescription Drug Benefits starting on page 139);
- Over-the-counter supplies for home care, such as bandages, cotton swabs, cotton balls, alcohol pads, gauze pads, or similar products;
- Parallel bars, biofeedback equipment or similar institutional equipment that is appropriate for use in a medical facility and is not appropriate for use in the home;
- Personal comfort or convenience items, including diapers and modifications to a home to facilitate care, such as a raised toilet seat or a shower bench;
- Prepared child birth classes (including Lamaze), parenting classes, and doulas;
- Reversal of vasectomies or tubal ligation (unless required to be treated as ACA preventive services);
- Replacement batteries for durable medical equipment;
- Routine foot care such as cutting or removal of corns and calluses, trimming, cutting, clipping, or debriding of nails and any other hygienic and preventive maintenance care, such as cleaning and soaking the feet or the use of skin creams to maintain skin tone of either ambulatory or bedridden patients, except when Medically Necessary due to vascular impairment or loss of protective sensation caused by diabetes or other diseases or injury;
- Routine physical examinations, preventive treatment or well child care, including tests, for children age seven or older, except as described in the Wellness Benefits section on page 115 and the Preventive Care Services section on pages 107-111;
- Sales or other taxes on services, products, and equipment;
- Services incidental to outpatient tests, procedures, or examination, including venipuncture, specimen handling, and conveyance, unless allowed by network pricing, or clinical editing system;
- Services received from a health care provider who is a member of your immediate family, or living with the person requiring treatment;
- Supports or devices used primarily for safety or performance in sports-related activities;
- Supplies for incontinence, except when approved as Medically Necessary;
- Thermography;
- Transgender services unless such services are included in the Plan's Transgender benefit on page 113;
- Transportation, except local ambulance services for emergencies;
- Travel costs for the patient or provider, except eligible travel costs for the patient related to accessing pregnancy termination services performed by a licensed medical provider acting within the scope of his or her license, as described on page 123;

- Infertility treatment not covered by the Plan's infertility benefit provided exclusively by Carrot (see page 125), r: Contact Carrot regarding benefit coverage; and
- Vitamins (outpatient) and minerals, even when in combination with a prescription product, except for B12 injections for pernicious anemia or a B12 deficiency or as otherwise required under the Affordable Care Act.

From time to time, other non-covered expenses may be added to this partial list. If you're not sure whether a particular treatment or service is covered, contact the Fund Office. (For contact information, see the Summary of Benefits, pages 21.)

# Maternity Expenses

## ABORTION

Therapeutic abortion is the termination of pregnancy before fetal viability in order to preserve maternal health. This is covered for participants, dependent spouses, and dependent children.

## TRAVEL REIMBURSEMENT BENEFIT

The Plan allows reimbursement of reasonable travel expenses to receive pregnancy termination services for Participants and dependents who reside or temporarily work in covered employment in a state where pregnancy termination is illegal (the "Travel Reimbursement Benefit").

When "you" is used in this section relating to the Travel Reimbursement Benefit, it means Participants and dependents.

The following rules apply to the Travel Reimbursement Benefit:

- You must obtain preauthorization in order to receive reimbursement of travel expenses for non-Emergency pregnancy termination services. If preauthorization isn't obtained when it is required, no Travel Reimbursement Benefit will be payable. Preauthorization is not required when the pregnancy termination constitutes Emergency services (for example, termination of an ectopic pregnancy).
- You must be unable to obtain pregnancy termination services without undergoing travel because you reside or are temporarily working in covered employment in a state where pregnancy termination is illegal.
- You may travel to a provider in the state or major metropolitan area closest to where the services are legal. If you are away from home in a temporary work location, you can also choose to travel home if pregnancy termination is legal there.
- Travel under this provision is limited to travel within the United States.

## ELIGIBLE TRAVEL EXPENSES

The following types of travel expenses are eligible for reimbursement under the Travel Reimbursement Benefit. In all instances, travel expenses must be primarily for, and essential to, accessing pregnancy termination services performed by a licensed medical provider acting within the scope of his or her license. Travel expenses that are not primarily for and essential to accessing pregnancy termination services are not Eligible Expenses and will not be reimbursed.

Transportation

- Bus, taxi, train, or plane fares (only coach fare is an Eligible Expense).
- Transportation expenses of a parent or legal guardian who must accompany a Participant under the age of 18 or a covered Dependent Child. Otherwise, travel expenses for a friend, family member, or other support person are not eligible.

Lodging

- Lodging will not be reimbursed if you travel home to receive pregnancy termination services.

- The lodging expense amount must be reasonable as determined by the Health Plan, but in no event greater than $300 per night.
- Please note that under IRS rules if your lodging is more than $50 per person per night, you will be taxed on the amount in excess of the IRS limit.

Car Expenses

- If you use your own car, mileage is reimbursable at the current medical mileage rate. The standard medical mileage rate is currently $0.22. Parking fees and tolls are also eligible, but gas is not.
- You can instead receive reimbursement for reasonable rental car expenses. In that case, gas, parking fees and tolls would be eligible but mileage would not.
- Daily local travel is not reimbursed.

## REQUIRED RECEIPTS AND DOCUMENTATION

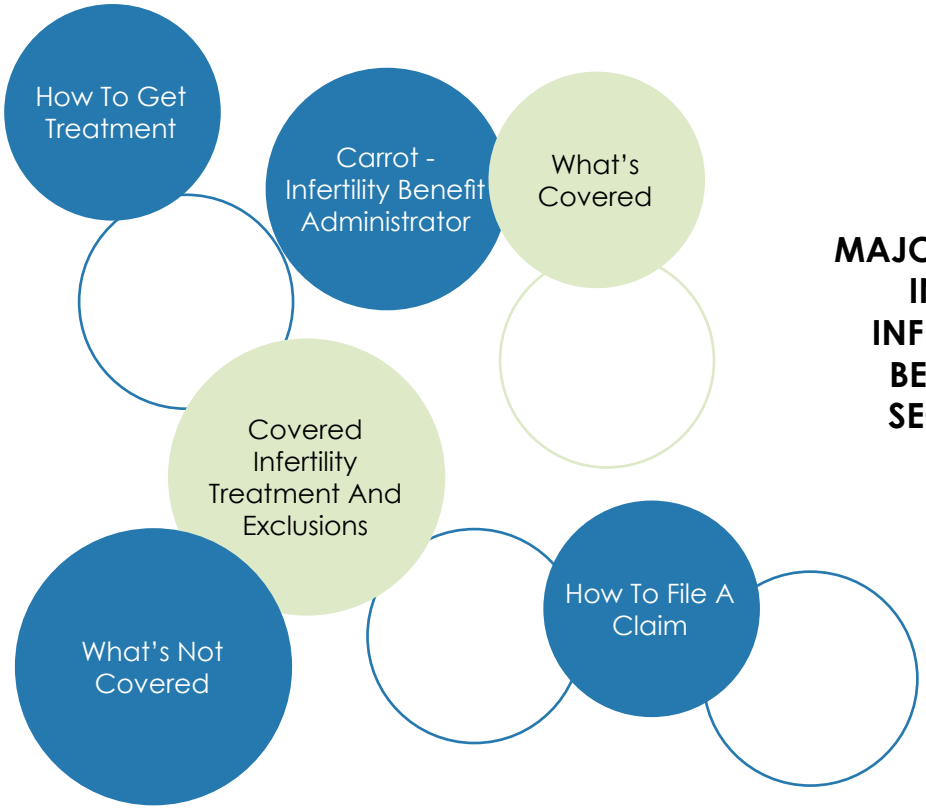
1. Reimbursement for the cost of lodging (hotel, motel) requires a copy of the paid invoice.
2. Reimbursement of transportation requires a copy of itinerary and paid ticket receipt.
3. Reimbursement for mileage requires a printout documenting the shortest route showing the mileage associated with that route.
4. Reimbursement for rental cars and gas for rental cars requires paid receipts.
5. Reimbursement of parking requires paid parking receipts.
6. Reimbursement of tolls requires a toll receipt or printout of a toll pass paid invoice.

## NOT ELIGIBLE EXPENSES

Excluded expenses include:

1. Meals (other than meals provided through inpatient care).
2. Childcare expenses/babysitting.
3. Extending an otherwise-medical trip for vacation or personal enjoyment.
4. Expenses for a caregiver or travel companion other than a parent or legal guardian accompanying a Participant or covered Dependent Child under the age of 18.

Participants (and their covered spouses) enrolled with active coverage (this includes Extended Coverage) who have a medical diagnosis of infertility, will be eligible for medically necessary infertility treatment coverage exclusively through Carrot, a comprehensive network of infertility treatment benefit providers.




**MAJOR TOPICS IN THE INFERTILITY BENEFITS SECTION**

# HOW TO GET TREATMENT

Infertility treatment must be obtained from an in-network Carrot provider to be eligible for coverage from the Fund. Infertility treatment coverage is limited to a lifetime maximum of $30,000 per eligible Participant and spousal dependent. If the Participant and their covered spouse are both receiving infertility treatment, each will have their own $30,000 lifetime limit. Neither limit may be applied toward the other's expenses.

Infertility treatment coverage is available only to Participants with active coverage and their covered spousal dependents. Other Participants and dependents (for examples, retirees or child dependents) are not eligible for the Fund's infertility treatment benefit. Cost-sharing is not imposed on infertility treatment.

You can find more information on the Health Fund's website.

# CARROT - INFERTILITY BENEFIT ADMINISTRATOR

The Fund's infertility benefit is administered by Carrot, a dedicated infertility benefit administrator and network of infertility treatment providers. The Fund's infertility benefit coverage is limited to covered infertility treatment delivered by in-network Carrot providers.

**Important:** This means that you must use an in-network Carrot provider for infertility treatment to be eligible for coverage from the Fund.

If you receive infertility treatment from a provider who is not part of the Carrot network, the infertility treatment will not be covered by the Fund and you will be responsible for payment in full.

**Example:** Your in-network OB-GYN refers you to a reproductive specialist for an infertility treatment consultation. The reproductive specialist is in the same network as your OB-GYN, but is not part of the Carrot network. The reproductive specialist charges $1,500 for the treatment consultation. Costs for the reproductive specialist visit are not covered by the Fund, because you did not use an in-network Carrot provider. You would be responsible for paying for all costs ($1,500) charged by the reproductive specialist for the consultation.

Carrot's provider network is listed within the Carrot portal. If you need help finding in-network Carrot providers, you can always visit www.app.get-carrot.com and schedule a call with your Care Navigator through this link. Once you enroll in Carrot, you can also communicate directly with your Carrot Care Navigator through your Carrot account.

## ENROLLING IN CARROT

Eligible Participants will receive a registration email from Carrot that includes a link to enroll in Carrot. If you need help enrolling with Carrot, you can always visit www.app.get-carrot.com and schedule a call with your Care Navigator through this link. Once you enroll in Carrot, you can also communicate directly with your Carrot Care Navigator through your Carrot account.

### CARROT CARD

When you enroll in Carrot, you will have the option to request a "Carrot Card," which works like a debit card and will be sent to your home address. Eligible Participants and spousal dependents with a medical diagnosis of infertility may use the Carrot Card to pay for covered infertility treatment eligible Carrot provider locations at the time of service. All services remain subject to medical necessity review, even if the charge has been approved on your Carrot Card. If you try to use the Carrot Card at an out-of-network provider, the payment will be declined and you will receive a real-time text message from Carrot. Please note that if you use your Carrot Card to pay for an ineligible expense, your Carrot Card may be suspended and you will need to repay the resulting overpayment. You have the option to pay out of pocket for covered infertility treatment at in-network Carrot providers and Carrot will reimburse you directly, subject to Carrot's reimbursement procedures.

**Remember:** You will only receive reimbursements for covered services if you use an in-network Carrot provider. Carrot's network is listed within the Carrot portal. Your Carrot Care Navigator is available if you have questions about different providers.

Carrot's Care Navigation team is available M-F, 5:30 AM to 6 PM PST and will respond to most issues within 24 hours (during normal business hours, Monday through Friday). You can reach Carrot at www.app.get-carrot.com and schedule a call with your Care Navigator through this link.

# COVERED INFERTILITY TREATMENT AND EXCLUSIONS

### WHAT'S COVERED

The Fund's infertility treatment benefit is limited to coverage for "Covered Infertility Care Expenses," which are defined as procedures and services to overcome an inability to have children as indicated by a medical diagnosis of infertility.

Covered Infertility Care Expenses must be recommended and supervised by an eligible provider who is in-network with Carrot, subject to the following mandatory provisions:

- Registered with the Society for Assisted Reproductive Technology (SART), or local equivalent
- Reports data into SART, or local equivalent, on an annual basis
- At least one board-certified reproductive endocrinologist on staff, or local equivalent
- Offers vitrification freezing and single embryo transfers for PGS embryos
    - Examples of Covered Infertility Care Expenses include but are not limited to:
- Fertility consultations
- Semen analysis

- Short-term fertility preservation for males and females (for example, short-term egg freezing or semen freezing if member is scheduled to undergo procedure that may result in loss of fertility, such as radiation or chemotherapy)
- Genetic testing related to fertility (e.g., PGT-A, PGT-M)
- Intrauterine insemination
- In vitro fertilization
- Transportation of reproductive material with an approved vendor
- Short-term storage costs for eggs, sperm, and/or embryos
- Fertility medications obtained through Express Scripts

## WHAT'S NOT COVERED

The Fund does not cover any items, treatment, or services that are not Covered Infertility Care Expenses.

The following treatments are examples of care that are not covered:

- Any infertility treatment or services received outside the United States
- Any infertility treatment or services delivered by any provider or facility that is not in-network with Carrot
- Any infertility treatment or services without a medical diagnosis of infertility
- Long-term fertility preservation, including elective egg or sperm freezing
- Any expenses relating to surrogacy or adoption
- Infertility-related treatments under the care of primary care providers or OB/GYNs
- Herbal treatments
- Nutrition counseling
- General genetic tests
- Physical therapy or fitness-related expenses
- Fertility medications not obtained through Express Scripts

## CLAIMS AND APPEALS

Carrot administers the claims and appeals process for the Fund's infertility treatment benefit. The claims and appeals rules that apply to the Fund's infertility treatment benefit are generally the same rules that apply for Fund determinations regarding post-service health care claims, which are described in Section Nine below, but there are some modifications described in this Section. Below is a summary of those rules as they apply to claims and appeals for infertility treatment benefits.

Filing a Claim: **You are responsible for submitting claims for covered services provided by in-network Carrot providers.** This is the case regardless of whether you use your Carrot Card or you pay for covered services out of pocket. You or your authorized representative will need to submit your claim directly to Carrot by uploading the paid statement or superbill from your in-network Carrot provider online at www.app.get-carrot.com.

Your claim must include:

- The name of the individual who received the covered service,
- The nature and date of the covered service,
- The amount of the requested reimbursement, and
- A statement that the covered service has not been reimbursed and is not eligible for reimbursement from another source (with the exception of reimbursement through your Carrot Card).

Deadline to File Claims: Claims for covered services must be submitted to Carrot, which is the Claims Administrator, within 30 days after the first to occur: (1) the end of the calendar year of the date of service (regardless of when you are billed or pay for the service), or (2) the date your Fund coverage terminates (which is the later of the date you lose earned coverage or COBRA coverage, if you elect COBRA). If you submit your claim after that deadline, your claim will be denied as untimely.

**Example 1:** You receive covered infertility treatment from an in-network Carrot provider on June 1, 2023. You must submit your claim to Carrot by January 30, 2024; if you do not submit your claim by that date, it will be denied as untimely.

**Example 2:** You receive covered infertility treatment from an in-network Carrot provider on June 1, 2024. Because you did not meet your earnings minimum, you lose your earned coverage on July 1, 2024. You do not elect COBRA. You must submit your claim to Carrot by July 31, 2024 (30 days after your loss of Fund coverage). If you do not submit your claim by that date, it will be denied as untimely.

Appealing a Denied Claim: If your claim is denied in whole or in part by the Claims Administrator, you or your authorized representative may file an appeal to the Appeals Administrator, which is Carrot. Your appeal should explain why you disagree with the Claims Administrator's determination regarding your claim, and must include your name and address and the date you received notice of your denied claim. You will be provided the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits. All the comments, documents, records, and other information that you submit relating to the claim will be considered by the Appeals Administrator, without regard to whether such information was submitted or considered in the claim determination. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

You should email your written appeal to: support@get-carrot.com with the subject "Appeal Requested for Denied Claim." You have 180 days from your receipt of the claim denial to file a written appeal. If you do not file your appeal within 180 days after receiving the Claims Administrator's decision denying your claim, the Claims Administrator's decision is final and you will not be allowed to pursue a claim in court. The Appeals Administrator will not be the same person who decided the claim that is the subject of your appeal, nor the subordinate of such person.

You will be notified of the decision on your appeal within 60 days after receipt of your appeal. If your appeal is denied by the Appeals Administrator in whole or in part, you have the right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA). Please be advised that you may bring an action under Section 502(a) of ERISA only after you have exhausted the claims and appeals process as described above. If you do file any lawsuit, it must be brought within two years after your appeal is denied and

in the United States District Court for the Central District of California. However, as explained above, if you do not file an appeal within 180 days of receiving the denial of your claim, you will not have a right to bring an action in court under ERISA.

## VOLUNTARY APPEAL TO BENEFITS COMMITTEE

Before filing a lawsuit, you may also submit a voluntary appeal to the Fund's Benefits Committee. While your voluntary appeal to the Benefits Committee is being processed, the limitations period for filing a lawsuit described above is tolled. While you may not bring a lawsuit regarding a claim without first exhausting the claims and appeal procedures, you are not required to first submit a voluntary appeal. To file a voluntary appeal with the Benefits Committee, please mail your written appeal to: Benefits Committee, PWGA Pension and Health, 2900 W. Alameda Avenue, Suite 1100, Burbank, CA 91505-4267. For more information on submitting a voluntary appeal, please contact the Fund Office during normal business hours at: (818) 846-1015 or toll-free (800) 227-7863 or email your questions to: participantservices@wgaplans.org.

## EXTERNAL REVIEW

If, after exhausting the appeals procedure, you are not satisfied with the final determination, you may choose to participate in the Fund's external review program as described in Section Nine.

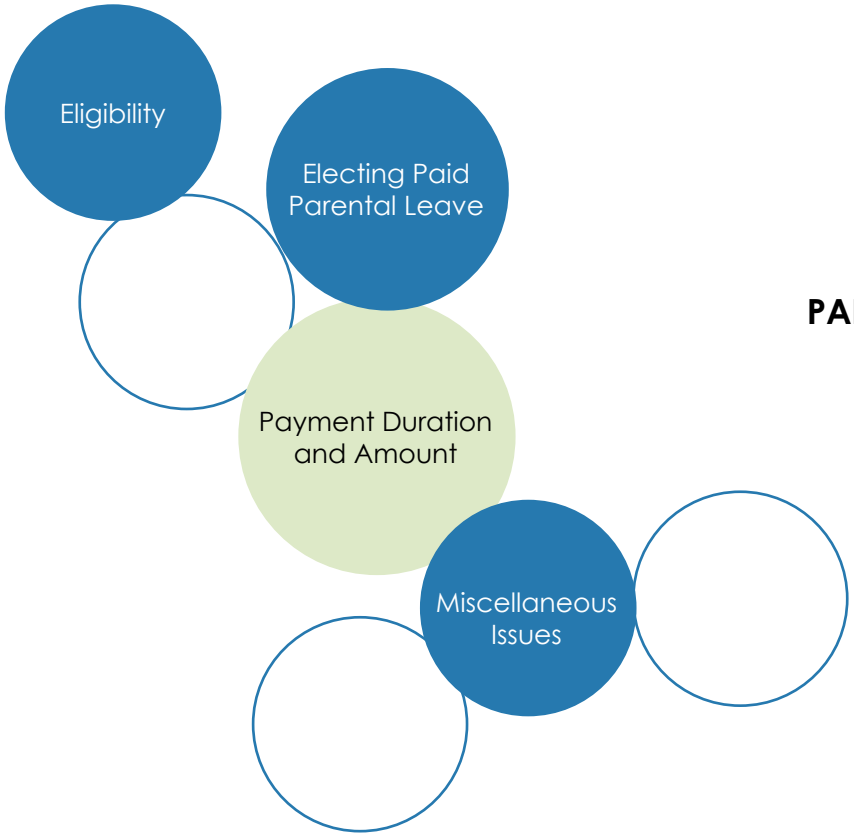
Your claim is eligible for external review only if the adverse benefit determination is based on

- Clinical reasons (e.g., medical necessity);
- A rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time;
- The exclusions for experimental or investigational services or unproven services;
- Non-quantitative treatment limitations that apply to the provision of medical benefits;
- Compliance with the surprise billing and cost-sharing protections under the No Surprises Act; or
- As otherwise required by applicable law.

For more information on the availability of external review, please contact the Fund Office during normal business hours at: (818) 846-1015 or toll-free (800) 227-7863 or email your questions to: participantservices@wgaplans.org.

If a Participant's child is born or the Participant newly adopts or fosters (or has a child placed for adoption after May 2, 2021, they shall have a period of 12 months from that date to utilize the Paid Parental Leave benefit.

The purpose of this benefit is to provide income replacement for Participants who take leave from employment to bond with their newborn, newly adopted, or newly fostered child.




**MAJOR TOPICS IN THE PAID PARENTAL LEAVE BENEFITS SECTION**

# ELIGIBILITY

In order to qualify for the Paid Parental Leave benefit, the Participant must have Writers' Guild-Industry Health Fund health coverage at the time of the birth, date of adoption of the child, or the date of formally fostering of a child. The health coverage only needs to be in place at that time – it need not be maintained throughout the leave period.

For this purpose, adoption includes placement for adoption. Fostering of a child means that the child is placed with the Participant by an authorized placement agency or a court order. In all cases, the child must be new to the Participant. (Thus, for example, if the Participant adopts the child of a spouse who has already lived with the Participant for an extended period of time, the Paid Parental Leave benefit would not be available.)

The qualifying Writers' Guild-Industry Health Fund health coverage may be Active Coverage, Extended Points Coverage, or COBRA Coverage (but not Total Disability Extension Coverage or Retiree Coverage). The qualifying health coverage must have been earned from contributions of employers that contribute for the Paid Parental Leave benefit.

A Participant can only have one Paid Parental Leave benefit in any 12-month period. However, if both parents are Participants with qualifying Writers' Guild-Industry Health Fund health coverage, then each is separately eligible for their own, individual Paid Parental Leave benefit, which can be taken concurrently or separately.

The Paid Parental Leave benefit is not available to employees of Named Employers. In addition, dependents of Participants are not eligible to receive the Paid Parental Leave benefit should they have a child, adopt a child, or foster a child.

If there are multiple births, adoptions, or foster placements at a time, there is only one Paid Parental Leave benefit.

# ELECTING PAID PARENTAL LEAVE

Paid Parental Leave is intended as a replacement for income lost during a parental leave. Therefore, if a Participant is eligible for Paid Parental Leave and wishes to receive the benefit, the Participant must not work for an employer during, or be paid by an employer for, the period for which the Paid Parental Leave is taken. The Participant must elect Paid Parental Leave by completing an application provided by the Administrative Office. As part of this application, the Participant must sign an attestation that they will not perform work for an employer during, or be paid by an employer for, the period for which the Participant is receiving the Paid Parental Leave benefit.

The Participant must advise the Fund Office immediately if, after applying for Paid Parental Leave benefit, the Participant decides to return to work during (or is going to be paid by an employer for) any portion of the period for which the Participant applied for Paid Parental Leave.

# PAYMENT DURATION AND AMOUNT

Once the Paid Parental Leave benefit is elected, and the attestation is signed, the Participant writer will receive $2,000 a week for a period of up to 8 weeks, for a total of up to $16,000.

The Paid Parental Leave benefit may be taken sequentially or it can be broken into weekly increments, not to exceed the total number of sequential Paid Parental Leave benefit weeks

(and, as described above, not to be paid beyond 12 months after the birth/adoption/ fostership). The minimum increment is one week. Payment will be made on a weekly basis. The child must be in the home for all weeks for which payment is made.

The Paid Parental Leave benefit is net of any state-mandated paid family leave benefit (including post-birth disability leave benefit) the Participant may receive. The Participant must inform the Plan of any state-mandated family leave benefit the Participant is receiving or will receive as result of the newly acquired child.

Once twelve months have passed since the birth, adoption, or fostering of a child, the Participant is no longer eligible to receive the Paid Parental Leave benefit, regardless of whether the full available amount has been used.

# CLAIMS AND APPEALS RULES

The claims and appeals rules that apply to Paid Parental Leave (PPL) benefits are generally the same rules that apply to claims and appeals for Fund determinations regarding protection benefits offered under the Health Fund, which are described in Section Nine of the SPD for the Health Fund, under "Other Claims – Life Insurance, Accidental Death and Dismemberment and Eligibility Claims." Below is a summary of those rules as they apply to PPL benefits. For more information, please refer to your Health Fund SPD or call the numbers at this end of this SMM.

A claim is a request for the PPL benefit, made in accordance with the Health Fund's rules for filing such claims. Filing an application for the PPL benefit is a claim for the PPL benefit. In addition, if you disagree with the Fund's determination regarding your eligibility for the PPL benefit in connection with a contribution audit, you may file a claim for the PPL benefit within 20 days of receiving notice of the contribution audit. To file a claim, you will need to send a letter to the Administrative Office explaining why you disagree with the contribution audit. You should mail your claim to: Administrative Office, PWGA Pension and Health, 2900 W. Alameda Avenue, Suite 1100, Burbank, CA 91505-4267.

If your claim is denied in whole or in part by the Administrative Office, you may file an appeal to the Benefits Committee. You are entitled to, upon request and free of charge, reasonable access to and copies of documents and other information relevant to your claim. You have 60 days from the receipt of the letter denying your claim to file a written appeal. You should mail your written appeal to: Benefits Committee, PWGA Pension and Health, 2900 W. Alameda Avenue, Suite 1100, Burbank, CA 91505-4267. If you do not file your appeal within 60 days after receiving the Administrative Office's decision denying your claim, the decision is final and you will not be allowed to pursue a claim in court.

If your appeal is denied by the Benefits Committee in whole or in part, you have the right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA). Please be advised that you may bring an action under Section 502(a) of ERISA only after you have exhausted the Fund's claims and appeals process as described above and in Section 9 – Claims and Appeals Rules – of the Health Fund SPD. If you do file any lawsuit, it must be brought within two years after your appeal is denied. However, as explained above, if you do not file an appeal within 60 days of receiving the Administrative Office's denial of your claim, you will not have a right to bring an action in court under ERISA.

For more information about the claims and appeals rules that apply to the PPL Benefit, or to request a copy of your Health Fund SPD, please contact the Fund at (818) 846-1015 or toll-free (800) 227-7863. You may also view the Health Fund SPD at wgaplans.org

# MISCELLANEOUS ISSUES

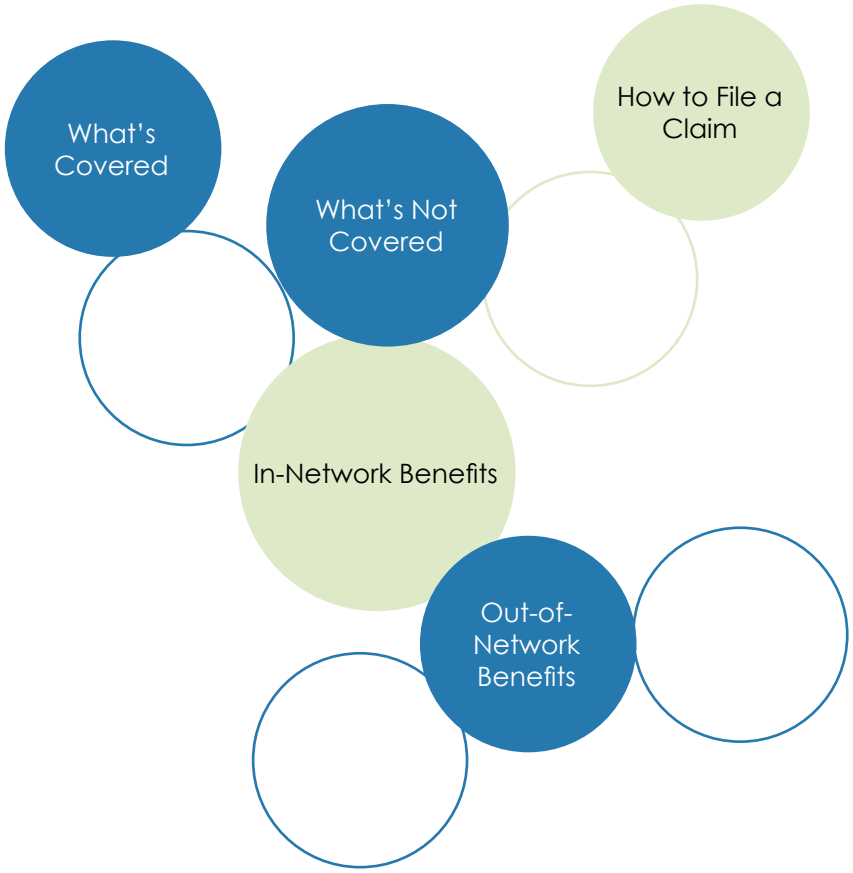
The monies distributed via the Paid Parental Leave benefit will not be counted toward pension benefits or vesting or toward health coverage eligibility. A Participant's eligibility for health coverage is determined independent of the Paid Parental Leave benefit.

All Paid Parental Leave benefits are subject to the applicable tax deductions and withholdings.

The Paid Parental Leave Program is funded solely by the 0.5% contribution described above (as adjusted by any investment gains or losses), and no other Health Fund assets can be used to fund the benefit. If at any time the amount available is depleted, Paid Parental Leave benefits will not be available.

More information (as well as an application for the benefit) can be found on the website.You can also request assistance via email at Pmailbox@wgaplans.org.

Outpatient vision benefits **are not available** if you enroll in the Low Option Plan.




**MAJOR TOPICS IN THE VISION BENEFITS SECTION**

# VISION BENEFITS

All eligible Participants (excluding Participants covered under the Low Option Plan) will automatically be enrolled in the Vision Service Plan (VSP) Choice Plan. For detailed information about the vision benefits, see the chart below.

## WHAT'S COVERED

Please see Summary of Benefits on pages 19-20 for list of benefits.

## WHAT'S NOT COVERED

The vision plan does not cover:

- Laser eye surgery (Lasik);
- Shipping and handling charges; and
- Any cost for services above the calendar year maximum benefit.

## HOW TO FILE A CLAIM

For in-network claims, your provider will bill VSP directly on your behalf. For information about filing out-of-network claims, please refer to VSP's website at: vsp.com or mail your itemized bills/receipts to:

VSP
P.O. BOX 385018
Birmingham, AL 35238-5018

## IN-NETWORK BENEFITS

| VSP IN-NETWORK BENEFITS | | | |
|---|---|---|---|
| **Benefit** | **Description** | **Copay** | **Frequency** |
| **Well Vision Exam** | Regular vision wellness exam | $30 | Once every calendar year |
| **Prescription Glasses** | | **$30** (materials copay) | **See frame and lenses** |
| **Frames** | • $150 allowance for a wide selection of frames<br>• $200 allowance for featured frame brands<br>• 20% savings on the amount over your allowance<br>• $80 Costco frame allowance | No additional copay required (included in prescription glasses) | Once every other calendar year |
| **Lenses** | • Single vision, lined bifocal, and lined trifocal lenses<br>• Polycarbonate lenses for adults<br>• Polycarbonate lenses for dependent children | Included with prescription glasses<br>$31 for single vision; $35 for multifocal<br>Included with prescription glasses | Once every calendar year |
| **Lens Enhancements** | • Standard progressive lenses<br>• Premium progressive lenses<br>• Custom progressive lenses<br>• Average savings of 20-25% on other lens enhancements | $0<br>$95 – $105<br>$150 – $175 | Once every calendar year |
| **Contacts** (elective; instead of glasses)<br>**Contact lenses** (Medically Necessary)[25] | • $150 allowance for elective contacts; copay does not apply<br>• Materials covered in full with prior approval (less a $30 materials copay) | Up to $60 for exam, fitting, and evaluation<br>$30 (for materials) | Once every calendar year |
| **Suncare** | $150 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contacts | $30 | Once every other calendar year |
| **Diabetic Eye Care Plus Program** | Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible Participants with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. | $20 | As needed |

25 When VSP benefit criteria is met and verified by an in-network doctor for eye conditions that would prohibit the use of glasses, contact lenses are considered Medically Necessary. Covered conditions include aphakia, aniridia, anisometropia, corneal transplant, high ametropia, nystagmus, keratoconus, heredity corneal dystrophies, and other eye conditions that make contact lenses necessary.

## OUT-OF-NETWORK BENEFITS

A Participant may receive vision care services from an out-of-network health care provider. If a Participant chooses an out-of-network provider, he/she must pay the provider directly for all charges and then submit a claim for reimbursement to:

VSP
PO Box 385018
Birmingham, AL. 35238-5018

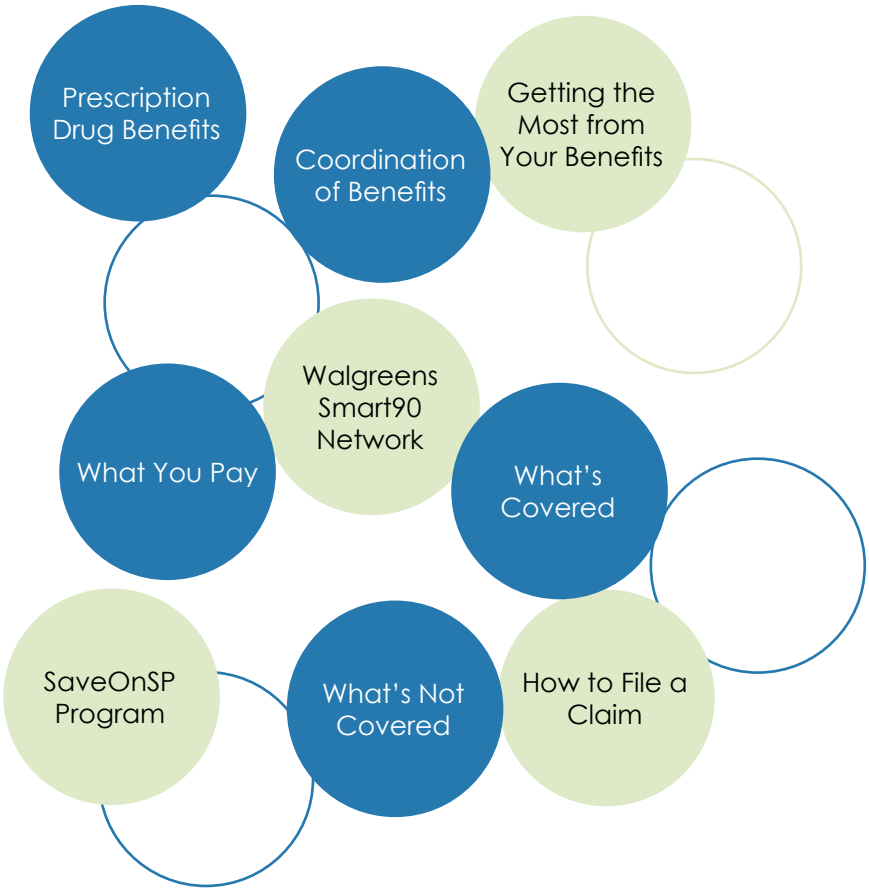
You can obtain a copy of the VSP Vision Claim Form at: wgaplans.org or online at: vsp.com.

Claims for out-of-network vision care must be filed with VSP no later than 12 months after the date of service.

The chart below outlines the VSP out-of-network benefit.

| OUT-OF-NETWORK BENEFITS<br>Visit vsp.com for details if you plan to see a provider that is not in the VSP network | |
|---|---|
| **Description** | **Benefit** |
| Exam | Up to $76 |
| Frames | Up to $70 |
| Single Vision Lenses | Up to $33 |
| Lined Bifocal Lenses | Up to $50 |
| Lined Trifocal Lenses | Up to $65 |
| Progressive Lenses | Up to $50 |
| Contacts (instead of glasses) | Up to $115 for elective contacts |
| Contacts (Medically Necessary) | Up to $327 for Medically Necessary contacts |
| VSP will reimburse the patient according to each benefit's out-of-network schedule of allowances, not to exceed the actual exam fee and the cost of corrective eyewear. | |

Outpatient prescription drug benefits **are not available** if you enroll in the Low Option Plan.




**MAJOR TOPICS IN THE PRESCRIPTION DRUG BENEFITS SECTION**

# PRESCRIPTION DRUG BENEFITS

The Health Fund's prescription drug benefits are administered by Express Scripts, Inc. (ESI), an independent claims administrator. Under the PPO Plan, the Participant and his/her covered dependent(s) are covered for prescription benefits for all outpatient needs (with a copayment) through ESI. The Low Option Plan does not provide prescription benefits except for preventive drugs required by the ACA.

Maintenance medications (medications taken for more than 90 days, such as insulin or blood pressure medication) must be purchased through ESI's mail order pharmacy or through the Walgreens Smart90 program after the first two fills. For more information see Express Scripts by mail and Walgreens Smart90 prescriptions section on pages 144-146.

## WHO'S COVERED

You and your covered dependents are covered for outpatient prescription drugs if you're enrolled in the PPO Plan. Your coverage begins when you become eligible for medical benefits. Coverage for your dependents begins after you enroll them and pay the required dependent coverage premium. Certified Retirees enrolled in a Medicare Part D plan will lose their pharmacy benefit under the Health Fund for the duration they are covered under the Part D plan. See Medicare Part D section below for more information.

# COORDINATION OF BENEFITS (COB)

## (FOR GENERAL DESCRIPTION OF COB RULES, PLEASE SEE Page 82)

The COB provision will be applied to prescription drug benefits. COB will apply when you fill your prescription at a retail pharmacy or when you use Express Scripts by Mail. If your primary plan requires you to pay a portion of the drug cost, you may submit that portion to the Fund for reimbursement consideration. This will not apply to Certified Retirees, whose primary medical coverage is Medicare (and are not enrolled in a Medicare Part D plan); in this case, the Fund will continue to provide primary coverage only for prescription drugs. If your coverage through the Fund is secondary, you must complete an Express Scripts COB Claim Form, which is available from Express Scripts or our website at wgaplans.org ("Forms" | "Health Fund").

You must submit the completed form along with the following information:

- The primary plan's explanation of benefits (EOB) statement; and
- A copy of the pharmacy receipt or invoice for the prescription submitted to the primary plan for coverage.

Express Scripts will coordinate with your primary plan and reimburse you the lesser of:

- The amount your primary plan did not cover; or
- What the Fund would have paid if it was the primary plan

***Claim Example:*** You show your primary plan's prescription card at the pharmacy and are only responsible for your primary plan's $20 copay. This is how your claim would be coordinated with the primary plan and how benefits would be paid:

| Amount Submitted for Secondary Payment | |
|---|---|
| Allowed amount | $50.00 |
| Less: Primary Plan's copay amount | -$20.00 |
| Primary Plan's benefit payment | $30.00 |
| Primary Plan Participant copay | $20.00 |
| Less: Fund's reimbursement to the Participant after coordination | -$20.00 |
| Participant's out-of-pocket (net patient's responsibility) | $0.00 |

## HOW THE PRESCRIPTION DRUG PROGRAM WORKS

There are three categories of prescription drugs under your prescription drug benefit:

- **Generic drugs** - Generic equivalent drugs contain identical active ingredients to the original brand-name drug at the same dosage. When you choose generic drugs, you'll pay the least out-of-pocket:
  - Copay Retail $10 (30-day supply)
  - Mail $20 (90-day supply)
- **Preferred brand name drugs**[26] - Brand-name drugs that appear on the Preferred Drug List (PDL) are the Plan's preferred choices in selected drug categories. When you choose preferred brand name drugs, you will pay more out-of-pocket than you would for generic drugs, but less than for other brand name drugs:
  - Copay Retail $25 (30-day supply)
  - Mail $50 (90-day supply); and
- **Non-preferred brand name drugs**[26] - Brand-name drugs that do not appear on the PDL require the highest out-of-pocket costs:
  - Copay Retail $50 (30-day supply)
  - Mail $100 (90-day supply)

The Plan's prescription benefit, managed by ESI, provides coverage for a wide variety of brand-name and generic medications. A national panel of physicians and pharmacists continually reviews and compares prescription drugs to ensure your drug list includes proven medications to treat a wide range of medical and mental health conditions.

[26] There are additional costs to you if you select a brand name drug, whether preferred or non-preferred, when a generic equivalent is available to you. See page 145 for further information.

## PREFERRED DRUG LIST

The Plan's prescription benefit includes a list of preferred drugs that ESI has concluded are either more effective at treating a particular condition than other drugs in the same class, or are as effective and are less costly than similar medications. Some non-preferred drugs may also be covered under the prescription drug benefit, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's Formulary, which is based on Express Scripts' National Preferred Formulary. The Plan's Formulary is updated periodically and is subject to change. In addition, Express Scripts has a Drug Exclusion list. Medications on the exclusion list are not covered under your prescription drug benefit.

Visit Express Scripts' website to see if your medication is on the preferred or non-preferred drug at Express-Scripts.com ("Health & Benefit Information" | "Learn About Formularies").

**IMPORTANT!**

Your out-of-pocket expenses will be significantly lower when you use Express Scripts by Mail or the Walgreens Smart90 program. Both provide 90-day supplies of medication. Also, choosing generic medications will significantly reduce your out-of-pocket costs. Keep in mind that you will pay the same copay for a 90-day supply through Express Scripts by Mail as you would pay for a 60-day supply from a retail pharmacy.The Plan has special rules for maintenance medications (e.g., insulin or blood pressure drugs). After the second fill at retail, a Participant is required to obtain a new prescription for a 90-day supply (plus refills) and submit through ESI's mail order pharmacy or present at any Walgreens or Duane Reade retail pharmacy. (For more information, see Express Scripts by mail and Walgreens Smart90 prescriptions section below).

## DRUG EXCLUSION LIST

If you fill a prescription for a drug on the Drug Exclusion List, you will pay the full non-discounted retail price.

Exceptions to this rule may be authorized in limited circumstances through the Formulary Exception Process managed by Express Scripts. If approved through that process, the applicable Formulary copay would apply for the approved drug based on the Plan's tiered formulary. Your physician may initiate the Formulary Exception Process by calling Express Scripts at (800) 753-2851. Exceptions must be requested in advance.

If the request for a formulary exception is denied by Express Scripts, the Participant may appeal the denial to the Benefits Committee.

Please note that the Plan's formulary includes covered medications across all therapeutic classes. While a covered alternative medication won't be identical to a drug on the Non-Covered Drug List (meaning it has been excluded from the formulary), Express Scripts' Pharmacy and Therapeutics Committee has evaluated these covered alternatives and determined that they are at least as effective at treating the same medical conditions as the excluded drug.

Here's what this means for you:

- Medications not on the Plan's Formulary List **will not be covered by the Plan.**
- If you try to fill a prescription for a medication that is not covered, and you have not applied for and received approval for an exception, **you will be required to pay the full, non-discounted retail price of the drug.**

To see if a medication is covered on the Express Scripts Preferred Drug List, or to view the ESI Preferred Drug List Exclusions, please visit Express-Scripts.com or the Fund's website at wgaplans.org ("Health Fund" | "External Links").

# GETTING THE MOST FROM YOUR BENEFITS

## RETAIL PURCHASES

If you have a short-term illness or injury and you need to fill a prescription for up to a 30-day supply and one refill, you may purchase your medication at a retail pharmacy. You may go to any retail pharmacy you wish, but if you use an in-network pharmacy, you will only pay a copay at the time of purchase. In-network pharmacies have negotiated a lower rate for prescription drugs, so you pay less. If you go to an out-of-network pharmacy, you will pay more. You will also have to pay the full cost of the medication up-front, and then send in your receipt for proof of purchase for reimbursement.

## WHEN YOU GO TO AN IN-NETWORK PHARMACY

- Present your medical ID card to the pharmacist whenever you need to fill up to a 30-day supply (and one refill) of a prescription.
- An in-network pharmacy will automatically fill the prescription with a generic equivalent, unless your licensed health care provider indicates "Dispense as Written" (DAW). If he/she makes that specification, your pharmacist must provide the exact brand and dosage indicated. Under these circumstances, dispensing a generic equivalent is not an option available to you. This means you would be responsible for paying the generic copay, plus the difference in cost between the generic drugs and the brand-name drug.
- The pharmacy will provide a pharmacy claim voucher for your signature and tell you the copay amount you owe. Sign the voucher and pay the appropriate copay — one for each prescription —depending on the type of drug dispensed. (See "What You Pay" on page 146.)

For a copy of the participating retail pharmacies within your home state or where you may be traveling, call Express Scripts or visit express-scripts.com. (See the Summary of Benefits, page 21, for contact information.)

**IMPORTANT!**

Both the Fund and you will pay the least when you purchase generic drugs through Express Scripts by Mail or Walgreens Smart90 program. Conversely, you will incur the highest copay when you purchase non-preferred brand-name drugs at retail pharmacies.

If you purchase a brand name drug when a generic drug is available — even if the licensed health care provider prescribes "Dispense as Written" (DAW) — you'll pay the generic copay plus the difference in price between the generic and the brand-name drug. Keep in mind that the price difference can be considerable, so you may want to ask your pharmacist to give you the price information before you make your decision. Whenever your licensed health care provider writes a prescription, ask him/her to prescribe generic equivalent medications when they are available, and to consider generic alternatives when they are appropriate for your care.

## ACA PREVENTIVE SERVICES - CONTRACEPTION

Generally, the concepts described above regarding brand-name drugs and generic equivalents apply to drugs that are covered as ACA preventive care. However, if your attending provider determines that a particular FDA-approved, cleared, or granted brand-name contraceptive drug is medically appropriate for you, you may be eligible to receive

such brand-name contraceptive drug without cost-sharing. Your provider should contact Express Scripts to verify.

## WHEN YOU GO TO AN OUT-OF-NETWORK PHARMACY

- Present the pharmacist with your prescription for up to a 30-day supply (and one refill) of a medication.
- Pay the pharmacy the full cost of your prescription.
- Get a copy of the pharmacy claim form from our website at wgaplans.org ("Forms"). Submit your receipt along with the completed claim form to Express Scripts. You'll receive reimbursement according to the Plan formula. (Filing Claims in General on page 194.)

**IMPORTANT!**

You are eligible to receive a discounted purchase price for any prescription drug not covered by the Health Plan. This pricing discount is available at any retail pharmacy that participates in ESI's pharmacy network and through Express Scripts by Mail.

At a participating retail pharmacy, just present your Health Plan ID card. The pharmacy will run your card through ESI's system to obtain your discounted cost. You will pay 100% of the discounted cost for the non-covered drug.

To use Express Scripts by Mail, simply mail the prescription in with your completed Express Scripts Mail Order Form to ESI for processing. You can determine your cost for the medication in advance by visiting express-scripts.com.

## WALGREENS SMART90 NETWORK

For maintenance medication, after the second fill at retail, a Participant and/or covered dependent(s) is required to obtain a new prescription for a 90-day supply (plus refills) in one of two ways:

**Option #1:** Use Express Scripts by Mail for any or all maintenance medications.

**Option #2:** Fill any or all of your prescriptions for maintenance medications through a retail pharmacy in the Smart90 Walgreens Network including Duane Reade or Happy Harry's, (receiving equivalent cost savings as the current mail order benefit).

## EXPRESS SCRIPTS BY MAIL AND WALGREENS SMART90 PRESCRIPTIONS

**Option 1: ESI mail order**
Express Scripts by Mail allows you to have your 90-day prescription (with up to three automatic refills) conveniently delivered to your home – postage paid. Simply follow the steps below:

1. Have your provider write a prescription for 90 days.
2. Complete the ESI mail order form (available at wgaplans.org), or may be requested by calling the Fund Office).
3. Mail the prescription and completed form to ESI (the address is on the form).

**Option 2: The Smart90 program**
Smart90 allows you to fill a 90-day prescription (with up to three refills) at in-network Walgreens, Duane Reade, or Happy Harry's retail pharmacies. Have your provider write a prescription for 90 days and take it to an in-network retail pharmacy. To find a Smart90 pharmacy:

1. Visit express-scripts.com.

2. Log in (you will have to register if you haven't already).
3. Go to the "Prescriptions" link at the top and scroll down to the "Find a Pharmacy" link.
4. Take your prescription to the Smart90 pharmacy of your choice.

**Note:** If you currently receive your maintenance medications through Express Scripts by Mail and you wish to change to the Smart90 program, go to express-scripts.com and cancel your mail order automatic refill. Have your licensed health care provider write a new 90-day prescription and take it to the in-network Smart90 pharmacy of your choice.

**Option 3: Not using the mail order or Smart90 benefit**
If you choose to continue to fill your prescription(s) at a retail pharmacy after the first two retail purchases, you will be responsible for the entire cost of the prescription.

Express Scripts, your mail order service and online pharmacy, conveniently delivers your long-term maintenance medications for up to a 90-day supply — postage paid — to your home.

After you've completed the first month of your prescription plus one refill, the prescription drug program requires you to use the mail order or Smart90 service for all maintenance medications. If you go to a retail pharmacy to refill a prescription for a third consecutive month, you will be responsible for the entire cost of the prescription.

To avoid this situation:

1. Ask your licensed health care provider to prescribe a 90-day supply for your maintenance medications with the appropriate number of refills. You may want to share the PDL with your provider. This list is available upon request from the Fund Office or from Express Scripts. The pharmacist will automatically fill the prescription with a generic equivalent, unless your provider specifies "DAW" (dispense as written).
    - DAW – If the Participant insists on receiving the brand-name drug when a generic equivalent is available, the Participant will be charged the generic copay plus the cost difference between the generic and brand-name drug.
    - In certain cases, the Participant may contact the Fund office to request a medical review when the generic drug is not an effective alternative. The Participant's provider must provide a letter explaining why the prescribed drug is Medically Necessary.
2. If you are prescribed a new medication for maintenance, or currently on maintenance medication, and would like to receive your medication by mail order, your licensed health care provider should write two prescriptions:
    - A prescription for up to a 30-day supply to be filled immediately at a retail pharmacy; and
    - Another prescription for up to a 90-day supply (plus up to three refills, if applicable) to be filled through the mail order service.
3. If your licensed health care provider prescribes a 30-day or 60-day supply of medication and you send the prescription to the mail order service, you will be charged the full mail order copay for a 90-day supply, so it may be more cost-effective to fill the prescription at a retail pharmacy.
4. If you are currently on a maintenance medication that you want to start obtaining through the mail order service, ask your licensed health care provider to write a new prescription for a 90-day supply with three refills.

## SAVINGS SYNOPSIS

When you purchase prescription drugs through Express Scripts by Mail, you pay one low copay for up to a 90-day supply, and you pay the lowest copay possible when your licensed health care provider prescribes generic medications. Keep in mind that you will pay the same copay for a 90-day supply through the mail order as you would pay for a 60-day supply from a retail pharmacy.

You will be asked to complete a patient profile card the first time you use the mail order service. Every time you fill a new prescription, you will need to complete an Express Scripts Mail Order Form. The form is available by visiting wgaplans.org ("Forms") or express-scripts.com, and remember to include your prescription drug ID card number on the form. You may also request the form by contacting the Fund Office.

Mail the following to ESI using the pre-addressed envelope provided:

- Your Patient Profile Card;
- The completed order form;
- The original prescription(s) written by your physician; and
- Your copay(s). Refer to the Summary of Benefits, page 13 for the correct copay amounts.

You should receive your medication within 10 to 14 days from the date you mail your order. Due to this short delay, it's important to plan ahead for your long-term medication needs.

## REFILLS

Your prescription label lists the date when you can request a refill and the number of refills remaining. Refills will be filled only 30 days or less before your current supply runs out.

The fastest way to receive your refills through Express Scripts by Mail is to log on to Express Scripts website at express-scripts.com. To order a refill, have the following ready:

- Prescription number;
- ZIP code; and
- Credit card information.

You may also:

- Call Express Scripts; or
- Mail in an authorization (sent with your mail order prescriptions) for refills of medication currently on file.

# WHAT YOU PAY

You're responsible for paying a copay for each prescription. What you pay depends on:

- Whether the drug is a generic, a preferred brand, or a non-preferred brand;
- The quantity (e.g., 30-day or 90-day supply); and

- Whether you purchase it at an in-network pharmacy (including Smart90) or an out-of-network pharmacy, or through the mail order service.

Whether you use a retail pharmacy or the mail order service, you do not have to meet a calendar-year deductible before benefits begin. The prescription drug program generally pays 100% of eligible prescription drug costs after you pay a copayment for each prescription, and there is no Coinsurance Out-of-Pocket Limit, although the ACA In-Network Out-of-Pocket Limit applies.

# SAVEONSP SPECIALTY PHARMACY COPAYMENT ASSISTANCE PROGRAM

The Health Plan is participating in a specialty pharmacy copay assistance program. Under the program, participants can enroll in copay assistance programs with drug manufacturers for certain high cost specialty drugs. The copayment assistance that you receive from the drug manufacturer and other payments under the program are expected to cover completely the Participant's cost share for the specialty drug, so that there is no required payment from you as long as you remain enrolled in the assistance program and the medication qualifies for the assistance.

The specialty drugs included in the program are non-essential health benefits under the Plan and the cost of those specialty drugs will not be applied toward satisfying your Coinsurance Out-of-Pocket Limit or the ACA Network Out-of-Pocket Limit in all cases, whether or not you choose to participate in the copayment assistance program.

Although the cost of the program's drugs will not be applied toward satisfying your out-of-pocket maximums, the manufacturer and/or other payments under the program cover the copayment required for these drugs, and there is no cost share charge to you. Even in circumstances where you apply to enroll in the manufacturer copay assistance program but are denied, or if a manufacturer assistance payment doesn't cover the full copayment, there is still no payment due from you.

Copays for the program's drugs are reset under the Plan based on the amount of any available manufacturer copay assistance. Therefore, if a Participant doesn't participate in the program, the Participant's copayment is likely to be higher than it was before the program took effect.

The list of program drugs and their copayment amounts change from time to time. An updated list of program drugs and their copayments amounts can be found at www.saveonsp.com/wga or obtained by request from the Fund Office (818) 846-1015.

# WHAT'S COVERED

The Health Plan's prescription drug benefits cover medications when prescribed by a licensed practitioner acting within the scope of his/her license. The Plan covers the following medications, whether purchased at a retail pharmacy or through the mail order service:

- Prescription medications and insulin;
- Diabetic supplies when purchased with insulin, including:
  - Alcohol swabs;
  - Glucose meter;
  - Lancets;
  - Needles/syringes/cartridges; and
  - Test strips.

    **NOTE:** When ordered by a licensed health care provider acting within the scope of his/her license and purchased separately, these diabetic supplies may also be covered under the Health Plan.
- Compounded medications: For compounded drugs to be covered under the Plan, they must satisfy certain requirements. In addition to being Medically Necessary and not experimental or investigative, compound drugs must not contain any ingredient on ESI's list of excluded ingredients. Any denial of coverage of a compounded drug may be appealed in the same manner as any other drug claim denial under the Plan;
- Prescription contraceptives, when prescribed by a licensed health care provider acting within the scope of his/her license (such as pills, patches, injectables, etc.);
- Prescription retinoids for the treatment of acne in individuals under the age of 26;
- Vitamins that require a prescription; and
- Any other drug which, under state law, may be dispensed only upon written prescription by a licensed health care practitioner within their scope of license unless excluded as indicated under What's Not Covered below.

# WHAT'S NOT COVERED

The following is a list of non-covered prescription drugs and services:

- Any charge for the administration of a prescription drug or insulin;
- Any medication, prescription or otherwise, that is administered at the place where it is dispensed, such as:
  - Botulinum Toxin A and B ("Botox") (unless approved for certain conditions, contact the Fund office to obtain a medical review);
  - Charges you or your dependents aren't required to pay;

  - Contraceptives not prescribed by a licensed health care provider acting within the scope of his/her license, except as otherwise provided under the ACA preventive benefit as described above;
  - Cosmetic hair growth removal products;
  - Depigmenting agents;
  - Hair-growth stimulators; and
  - Hypodermic needles and/or syringes for non-medical purposes;
- Immunization agents (vaccines) (except for Synagis which requires pre-authorization);
- Investigational or experimental drugs, even if the drug is prescribed by a licensed health care provider acting within the scope of his/her license;
- Items that may be purchased without a written prescription (over-the-counter "OTC"). Exceptions are the over-the-counter drugs covered under preventive care services, see page 109;
- Medications for the sole treatment of erectile dysfunction;
- Medications that are to be taken by or administered to an individual, in whole or in part, while he/she is a patient in a licensed hospital, nursing home, mental health facility, extended care facility, convalescent hospital, rest home, or similar institution that dispenses pharmaceuticals on its premises;
- Medications to treat obesity;
- Naturopathic medicines;
- Non-sedating antihistamines, such as Allegra, except in certain cases when your licensed health care provider acting within the scope of his or her license provides a letter explaining why the prescribed drug is Medically Necessary and why the over-the-counter version is not an effective alternative for his/her patient. (Contact the Fund office to obtain a medical review);
- Over-the-counter medications, such as Tylenol, Colace, etc. except as otherwise covered under preventive care services;
- Prescription medications to treat photoaging or other cosmetic purposes, including retinoids;
- Prescription medications that don't meet Medical Necessity criteria;
- Prescription drugs that may be obtained without charge under local, state, or federal programs, including Workers' Compensation;
- Prescriptions for more than a 60-day supply for retail purchase, or more than a 90-day supply using the Mail Order or Smart90 programs, unless you will be out of the state or country for more than 90 days, and then you would need to contact the Eligibility Department to make special arrangements to obtain your medication;
- Proton pump inhibitors (PPIs), such as Nexium or Prevacid will be excluded except for liquid forms for infants and toddlers, patients diagnosed with esophagitis, cancer, and other similar Medically Necessary conditions that require higher doses (i.e., 40 mg);

- Refilling of a prescription over the amount specified by the licensed practitioner working within the scope of his/her license, or any refill purchased more than one year from the date of the original/initial prescription; and
- Therapeutic devices or appliances, including support garments, and other non-medical items.

# HOW TO FILE A CLAIM

You need to file a claim whenever you purchase a prescription at an out-of-network pharmacy. Claim forms can be obtained at wgaplans.org ("Forms" | "Health Fund"). You may submit the claim directly to Express Scripts, and you will be reimbursed directly by Express Scripts for your out-of-pocket expense, less the applicable copay.

**NOTE:** Over-the-counter medications for preventive care services are covered under the Plan's pharmacy benefit at no cost if they are prescribed by a licensed health care provider and obtained at an in-network pharmacy.

## MEDICARE PART D

Medicare prescription drug coverage became available in 2006 to everyone eligible for Medicare. You may get this coverage if you join a Medicare Prescription Drug Plan or a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage (some do not). All Medicare prescription drug plans provide at least a standard level of coverage established by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The Fund has determined that its prescription drug coverage is, on average for all Plan Participants (except those enrolled in the Low Option Plan), expected to pay out as much as the standard Medicare prescription drug coverage would pay; therefore, Medicare considers the Plan's PPO prescription drug coverage Creditable Coverage. Because the Plan's PPO coverage is Creditable Coverage, you may keep the Plan's PPO coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug.

## WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you are covered as an active Participant and enroll in a Medicare Part D plan, your prescription drug coverage under the Fund will pay primary and the Medicare Part D plan will pay secondary. If you are covered as a Certified Retiree and enroll in a Medicare Part D plan, your prescription drug coverage under the Fund will be terminated. You will, however, remain eligible for all other Plan benefits that you were eligible for prior to enrolling in the Medicare Part D plan, provided that you continue to qualify for those benefits. Your eligible covered dependents who have not enrolled in Medicare Part D coverage will continue to receive prescription drug coverage from the Health Fund. Be aware that you will not be able to reinstate your Health Fund prescription drug coverage until you provide documentation that you have terminated Medicare Part D coverage.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. Every year, in the mail, you will get a copy of the handbook from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov;
- Call your State Health Insurance Assistance Program for personalized help; or
- Call (800) 633-4227 — or just remember 1 (800) MEDICARE.
  TTY users should call (877) 486-2048.

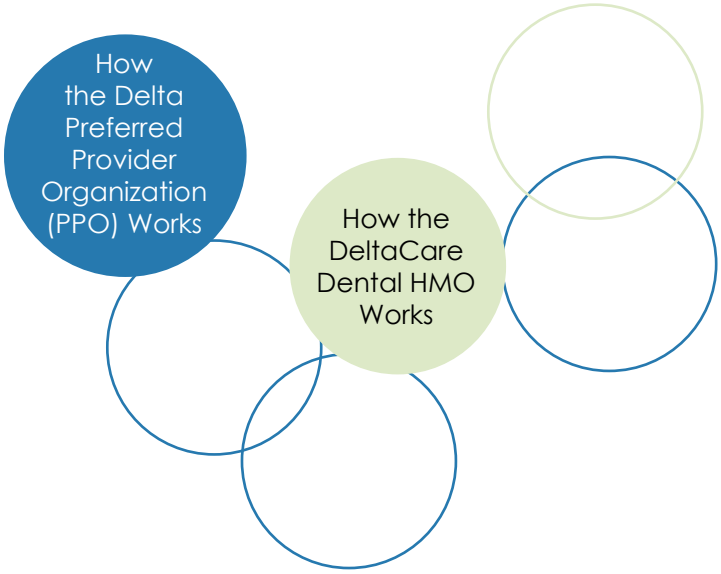
If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at ssa.gov, or call them at (800) 772-1213 or TTY (800) 325-0778.

The Health Fund offers you two Dental Plan options to choose from, depending on where you live.

| PLAN | AVAILABILITY |
|---|---|
| Delta Preferred Provider Organization (PPO) | Nationwide |
| DeltaCare USA (DHMO) | California locations with DeltaCare USA participating providers |

Participants and their covered dependents will automatically be enrolled in the Delta Preferred Provider Organization (PPO) Plan. If the Participant lives in California, he/she also has the option of enrolling in the DHMO. However, the entire family must be covered under the same Dental Plan option as the Participant.

NOTE: There is **no dental coverage** benefit in the Low Option Plan.




**MAJOR TOPICS IN THE DENTAL BENEFITS SECTION**

# HOW THE DELTA PREFERRED PROVIDER ORGANIZATION (PPO) WORKS

With the Dental PPO, which is administered by Delta Dental, you and your family members can choose to see any dentist you wish whenever you need dental care. The Dental Plan also gives you access to a nationwide network of dentists who have contracted with Delta Dental to charge lower, negotiated rates for dental services.

The dental benefit covers several categories of services, including:

- Basic benefits (usually includes restorations (fillings), oral surgery (extractions), endodontics (root canals), periodontal treatment (root planing), and sealants);
- Diagnostic and preventive care;
- Emergency care;
- Major benefits (usually includes crowns, dentures, implants and oral surgery, jackets, and cast restorations);
- Orthodontic care for children up to age 19; and
- Prosthodontic care.

The amount the dental benefit pays for each dental service depends on the dental care provider you choose. You can choose:

- A dentist who participates in the Delta Dental network (a "Delta dentist"), including:
  - A dentist who participates in the PPO network – a special network within the larger Delta Dental network; and
  - A dentist who participates in the Delta Dental network but doesn't participate in the specialized PPO network; or
- A dentist who doesn't participate in the Delta Dental network (a "non-Delta dentist").

**IMPORTANT!**

The Summary of Benefits lists contact information for both the PPO and DHMO Dental Plan options.

If you want to lower your out-of-pocket dental costs, you may want to choose a Delta dentist. Ultimately, the choice is yours.

## SUB-TOPICS:

## PAYING FOR YOUR CARE

Under the PPO Plan, whether you see a Delta dentist or a non-Delta dentist, the Dental Plan covers the same broad range of dental services, including emergency dental care. However, the amount you pay for each service depends on the type of provider you see.

## DEDUCTIBLE

Before the dental benefit begins to pay benefits, you must meet either an individual or a family calendar-year dental deductible for most services. In addition, there's a separate lifetime deductible for orthodontia treatment.

There is no deductible for diagnostic and preventive care. That means you can receive diagnostic and preventive care services without first meeting your deductible.

There is a maximum family deductible for each Plan year. Once two covered family members meet their individual deductibles, the family maximum has been met. That means that no other covered family member is required to meet his/her individual deductible for that Plan year before benefits are paid.

## COINSURANCE

Once you meet the deductible, the dental benefit pays a percentage of the dental service, and you pay the rest. This is called coinsurance. You are responsible for a higher coinsurance when you see a non-Delta dentist.

## COORDINATION OF BENEFITS

For the general COB rules, see page 82. The Dental Plan will allow up to the negotiated rate of the primary carrier, not the total billed amount. The COB processing will review the charges on the Primary plan's EOB. If the EOB demonstrates that a service is not covered under the primary carrier, but is a covered benefit under the Fund's dental benefits, the charge will be allowed showing a zero dollar payment from the primary plan, and will use the total billed charge as the eligible amount. There is no coordination between two dental HMO plans. There can be coordination between a Dental HMO and a PPO plan in the following scenario:

If your primary dental coverage is provided by an HMO and your secondary coverage is provided by a PPO, the dentist can bill out your copayments from your dental HMO to the PPO coverage. However, if your primary coverage is a PPO plan and your secondary coverage is an HMO plan, there will be no coordination of benefits.

## ALLOWED CHARGE LIMITS

The Allowed Charge applies **only** when you see a non-Delta dentist. The Plan doesn't cover charges above the Allowed Charge — they are your responsibility. To find out whether your out-of-network dentist's charges fall within the Allowed Charge for a specific service before you receive care, ask your dentist to submit a predetermination of benefits to Delta Dental which describes the anticipated service and charges. Delta Dental will provide a written response stating what it will pay for the service. (See Predetermination of Benefits on page 158 for more information.)

## ANNUAL BENEFIT MAXIMUM

The annual benefit maximum represents the total amount the dental benefit will pay for each family member in a calendar year before you must begin paying 100% of the cost of your dental care.

Orthodontic treatment for children up to age 19 is subject to a separate calendar-year maximum and a lifetime maximum benefit for each covered person. In addition, the maximum paid by Delta Dental will be reduced by the amounts paid for orthodontic treatment by your previous dental care program, if any.

## EMERGENCY CARE

The Dental Plan provides coverage if you or a covered dependent needs emergency dental care. The Dental Plan will reimburse you up to 100% per visit for emergency treatment when you use a Delta dentist and 80% per visit when you use a non-Delta dentist, up to the Plan-year benefit maximum. Emergency treatment should be used for temporary relief of pain only. If additional dental care is required, you should receive routine dental services instead of relying on emergency care.

When you access emergency care, your dentist must provide a description of the nature of the emergency and the treatment you received.

**IMPORTANT!**

Delta Dental will use the dentist's Statement of Treatment to process the claim, so it's very important that the statement include a description of each service the dentist performs.

## GETTING THE MOST FROM YOUR PLAN

**IMPORTANT!**

Within the Delta Dental network is a select group of dentists called PPO dentists. Both PPO dentists and non-PPO dentists are part of the larger Delta Dental network, but PPO dentists agree to offer lower negotiated rates. See the "When You Choose…" chart below for more information.

## CHOOSING A PPO DENTIST

You receive the maximum benefits available when you use a PPO dentist. PPO dentists are Delta dentists who have agreed to charge PPO patients reduced fees. The dentist you choose will impact the level of benefits you receive. Here's how it works:

| WHEN YOU CHOOSE... | |
|---|---|
| **A Delta dentist, including:** | |
| **A PPO dentist** | • Your out-of-pocket costs will probably be less because PPO dentists agree to charge PPO patients reduced fees.<br>• You will pay a deductible[27], copay and/or any amount over the annual benefit maximum when you receive care.<br>• You do not need to file a claim form. |
| **A non-PPO dentist** | • You will be charged no more than the fees approved by Delta Dental, but these fees could be higher than those charged by a PPO dentist.<br>• You will pay a deductible[27], copay and/or any amount over the annual benefit maximum when you receive care.<br>• You do not need to file a claim form. |
| **A non-PPO dentist:** | |
| • The dentist's fee may be higher than the rates negotiated for PPO providers or other Delta providers.<br>• You will pay a deductible[28], copay and/or any amount over the annual benefit maximum when you receive care.<br>• You will also be responsible for any charges over the Allowed Charge limit.<br>• You may have to pay the entire cost in advance.<br>• You may have to complete and submit your own claim form and wait for reimbursement from the Dental Plan. | |

You will automatically receive an in-network provider list at no charge. To learn more about the dentists who participate in the nationwide PPO network, as well as other Delta Dental providers, you can also:

- Call Delta Dental for a list of participating dentists in your area (800) 765-6003, Group No. 0825; or
- Log on to Delta Dental's website at deltadentalins.com to search for an in-network dentist online.

Keep in mind that in-network dentists occasionally change, so you will want to make sure the dentist you choose is still in the PPO or Delta Dental network before you make an appointment. For the most up-to-date information, including whether a dentist is accepting new patients, call the dentist directly.

[27] The deductible is waived for diagnostic and preventive care.
[28] The deductible is waived for diagnostic and preventive care.

***Claim Example (Dental Benefits):*** Janet has a toothache and it is beginning to interrupt her work. She contacts her dentist to make an appointment and was informed that her dentist is retiring. Janet decides to try a PPO dentist, to take advantage of the lower, negotiated rates.

Janet chooses a dentist online using Delta Dental's website and finds Dr. Cooper, who is part of the PPO network, and is accepting new patients. After examining the tooth that has been bothering Janet, Dr. Cooper recommends a crown. The following examples illustrate the cost difference between a Delta PPO dentist and a non-Delta dentist:

**IMPORTANT!**

The DHMO is available only to Participants that reside in California. Before choosing this plan option, be sure to carefully review the plan's provider directory to ensure there's a provider in your area.

| WITH A DELTA PPO IN-NETWORK DENTIST | |
|---|---|
| Charge for crown | $175.00 |
| Janet's deductible | - $75.00 = $100.00 |
| Plan pays 80% of the remaining $100 | - $80.00 |
| Janet pays 20% | $20.00 |
| Janet's cost with a PPO dentist (deductible + her coinsurance ) | $95.00 |
| **WITH AN OUT-OF-NETWORK DENTIST** | |
| Charge for crown | $280.00 |
| Delta-approved fee for a crown (Allowed Charge) | $175.00 |
| Janet's deductible | - $75.00 = $100.00 |
| Plan pays 70% of the remaining $100 | - $70.00 |
| Janet pays 30% | $30.00 |
| Plus the difference between an out-of-network dentist submitted fee and Delta-approved fee | $105.00 |
| Janet's cost with a non-Delta dentist (deductible + amount over Allowed Charge + her coinsurance) | $210.00 |
| **JANET'S SAVINGS WITH AN IN-NETWORK DELTA PPO DENTIST** | |
| Janet's cost with an out-of-network dentist | $210.00 |
| Janet's cost with an in-network PPO dentist | - $95.00 |
| Janet's savings with an in-network PPO dentist | $115.00 |

**NOTE:** Costs cited in this example are for illustrative purposes only. Your own costs may be different.

## PREDETERMINATION OF BENEFITS

The Plan offers a service called predetermination of benefits for dental work. This lets you know in advance how much the dental benefit will pay before your dentist actually begins the work he/ she recommends. Predetermination of benefits allows you to have your questions answered before you incur an expense, and it may help to prevent any misunderstanding about your financial responsibilities.

You and your dentist should consider obtaining a predetermination of benefits if the total charges for the planned course of treatment are expected to be more than $300 — or if extensive services, such as crowns or bridges, are being recommended. While predetermination of benefits is recommended, it is not required.

Here's how predetermination of benefits works: when deciding on a treatment plan, your dentist should submit an Attending Dentist's Statement to Delta Dental specifying the proposed course of treatment. Delta Dental will send your dentist a Notice of Predetermination, which estimates how much of the proposed charges you will have to pay.

Predetermination of benefits doesn't guarantee that benefits will be paid. Actual benefits may differ from the estimated benefits, depending on:

- The actual services provided;
- The amount of the deductible;
- Whether you have met the Plan-year benefit maximum; and
- Whether you're covered by more than one dental plan.

If you have any concerns about the predetermination of benefits, you may contact Delta Dental before your treatment begins.

## ALTERNATIVE BENEFIT PROVISION

If you or your dentist selects a treatment plan that is more expensive than the treatment normally provided, you may be responsible for additional out-of-pocket costs. The Plan will pay the applicable percentage of the least expensive professionally acceptable treatment plan. If you choose a more expensive treatment plan, you will be responsible for the remainder of the dentist's fee after the Plan pays benefits.

For example, let's say you choose a gold crown when one made of semi-precious metals would restore the tooth just as well. Because you've chosen a more expensive treatment, you would be responsible for the cost above what the Plan would pay for a crown made of semi-precious metals.

## LOOKING AT ELIGIBLE AND INELIGIBLE EXPENSES

### ELIGIBLE EXPENSES

The Health Plan's dental benefit covers a wide range of services, including those described below. If you want to know whether a particular service is covered, contact the Delta Dental office. (See the Summary of Benefits section, page 17-18, for contact information.)

Once you satisfy the deductible, the Plan will pay the appropriate coinsurance (based on the negotiated rate for in-network services or based on Allowed Charge for out-of-network services) for necessary treatment under the generally accepted standards of dental practice.

### BASIC BENEFITS

Basic benefits include:

- Adjunctive general services (e.g., general anesthesia; office visit for observation; office visit after regularly scheduled hours; therapeutic drug injection; treatment of post-surgical complications/unusual circumstances; and limited occlusal adjustment);
- Endodontics (treatment of the tooth pulp);
- Oral surgery (extractions and certain other surgical procedures, including pre- and post-operative care); and
- Restorative services (amalgam, silicate or composite/resin restorations/fillings for treatment of carious lesions/visible destruction of hard tooth structure resulting from the process of dental decay).

### CROWNS, JACKETS, INLAYS, ONLAYS, AND CAST RESTORATION BENEFITS

Benefits for the above services are provided only if the dental care is provided to treat cavities that cannot be restored with amalgam, silicate, or direct composite/resin restorations.

### DIAGNOSTIC AND PREVENTIVE BENEFITS

Diagnostic and preventive benefits include:

- Diagnostic work (e.g., oral examinations, including initial examinations, periodic examinations, and emergency examinations; X-rays; diagnostic casts; examination of biopsied tissue; palliative/emergency treatment of dental pain; and specialist consultation);
- Preventive care (e.g., prophylaxis/cleaning; fluoride treatment; and space maintainers); and
- Sealants for covered children up to age 14 (topically applied acrylic, plastic, or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay).

## IMPLANT BENEFITS

These include prosthetic appliances placed into or on bone of the maxillar or mandible (upper or lower jaw) to retain or support dental prostheses, including endosseous, transosseous, subperiosteal, and endodontic implants; implant connecting bars; implant repairs; and implant removal.

## ORTHODONTIC BENEFITS

These include procedures using appliances or surgery to straighten or realign teeth that otherwise would not function properly. Subject to any regulatory guidance to the contrary, these benefits are deemed to be non-essential health benefits and are available only for covered children up to age 19.

## PROSTHODONTIC BENEFITS

These include construction or repair of fixed bridges, partial dentures, and complete dentures (which is covered if provided to repair missing natural teeth) occlusal orthotic devices, removable metal overlay stabilizing appliances, and occlusal guards.

## PLAN LIMITATIONS

The following limitations apply to your Dental Plan coverage:

- Bitewing X-rays are provided on request by the dentist, but no more than once in a six-month period;
- Crowns, jackets, inlays, onlays, and cast restorations are covered on the same tooth once every five years, unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as the result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration;
- The Dental Plan will pay the applicable percentage of the dentist's fee for a standard partial or complete denture. A standard partial or complete denture is one made from accepted materials and by conventional methods;
- The Dental Plan's payments for orthodontic treatment will stop when the first payment is due to the dentist following either a loss of eligibility or the termination of treatment for any reason before it is completed;
- Full mouth X-rays and panoramic X-rays are covered only once in a three-year period;
- If orthodontic treatment is begun before you become eligible for coverage, the Plan's payments will begin with the first payment due to the dentist following your eligibility date;
- If you select a more expensive treatment plan than is customarily provided, or specialized techniques, an allowance will be made for the least expensive professionally acceptable alternative treatment plan. The Dental Plan will pay the applicable percentage of the lesser fee for the customary or standard treatment, and you will be responsible for the remainder of the dentist's fee;
- Implants are covered once every five years (from the date of the last implant);

- Only the first two oral examinations in a calendar year (January-December) are covered;
- Orthodontic payment is limited to treatment of covered children up to age 19;
- Prosthodontic appliances are covered once every five years, unless Delta Dental determines that there has been such an extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental plan will be made if it is unsatisfactory and cannot be made satisfactorily;
- Replacement implants are covered only following a five-year period after installation of an original implant provided under any Delta Dental plan;
- Sealant benefits are limited to covered children up to age 14. Sealant benefits include the application of sealants only to permanent posterior molars without caries (decay), without restorations and with the occlusal surface intact. Sealant benefits do not include the repair or replacement of a sealant on a tooth within three years of its application;
- Three cleanings or procedures that include a cleaning or combination thereof are covered every calendar year (January through December);
- X-rays and extractions that might be necessary for orthodontic treatment are not covered by orthodontic benefits, but may be covered under diagnostic and preventive or basic benefits;
- Full-mouth debridement (gross scale) is limited to one treatment in a lifetime; and
- Periodontal treatments (root planing/subgingival curettage) are limited to four quadrants during any 24 consecutive months.

## INELIGIBLE EXPENSES

The Dental Plan covers a wide range of dental services, but there are some services that are not covered. It is important for you to know what these services are before you visit your dentist.

The Dental Plan doesn't cover the following services:

- Anesthesia and intravenous (IV) sedation, except for general anesthesia given by a dentist for covered oral surgery procedures and/or for select endodontic and periodontal procedures;
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility;
- Charges for replacement or repair of an orthodontic appliance paid in part or in full by the Plan;
- Charges the patient is not required to pay;
- Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves, or tissues;
- Experimental procedures;
- Grafting of tissues from outside the mouth to tissues inside the mouth ("extraoral grafts");

- Complete occlusal adjustment;
- Prescribed drugs or applied therapeutic drugs, premedication, or analgesia;
- Replacement of existing restoration for any purpose other than restoring active tooth decay or fracture of the restoration;
- Services for cosmetic purposes or for conditions that are the result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel;
- Services for injuries covered by Workers' Compensation or employer's liability laws;
- Services for restoring tooth structure lost from wear (e.g., abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. (Examples of such treatment are equilibration and periodontal splinting); and
- Services that are provided by any federal or state government agency or that are provided without cost by any municipality, county or other political subdivision, except Medi-Cal benefits.

## PERIODONTIC PROCEDURES

| Code | Procedure |
|---|---|
| D4240 | Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant |
| D4241 | Gingival flap procedure, including root planning – one to three contiguous teeth or tooth bounded spaces per quadrant |
| D4260 | Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant |
| D4261 | Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant |
| D4263 | Bone replacement graft – first site in quadrant |
| D4264 | Bone replacement graft – each additional site in quadrant |
| D4266 | Guided tissue regeneration – resorbable barrier, per site |
| D4267 | Guided tissue regeneration – non-resorbable barrier, per site (includes membrane removal) |
| D4273 | Subepithelial connective tissue graft procedures, per tooth |
| D4276 | Combined connective tissue and double pedicle graft, per tooth |

## ENDODONTIC PROCEDURES

Anesthesia is covered for the following endodontic and periodontal procedures:

| Code | Procedure |
|---|---|
| D3410 | Apicoectomy/periadicular surgery – anterior |
| D3421 | Apicoectomy/periadicular surgery – bicuspid (first root) |
| D3425 | Apicoectomy/periadicular surgery – molar (first root) |
| D3426 | Apicoectomy/periadicular surgery (each additional root) |
| D3450 | Root amputation – per root |
| D3920 | Hemisection (including any root removal, not including canal therapy |

## FILING A CLAIM

One of the advantages of using a Delta Dental in-network dentist is that you do not have to file a claim form. These dentists will take care of all claims paperwork for you. However, when you use a dentist who is not part of Delta Dental's network, you may have to file a claim form on your own. Claims for dental care from an out-of-network provider should be submitted to Delta Dental within 90 days of your visit, and no later than two years after the expense was incurred.

When you need to file a claim form, here's what to do:

- Contact the Fund Office or log on to Delta Dental's website at deltadentalins.com to download a Delta claim form online;
- Complete sections 1 through 15 of the claim form; and
- Attach a copy of the dentist's Statement of Treatment, including the dentist's name and phone number.

Once the form is completed, make a copy for your records and mail the original to:

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

For questions regarding a claim or benefits issue please contact Delta Dental Customer Service at: (800) 765-6003, Group #0825.

Claims are usually processed by Delta Dental within two weeks of receipt, unless additional information is required from you or your dentist. (For more information about filing claims, see Claims and Appeals Rules on pages 192-206.)

# HOW THE DELTACARE USA DENTAL HMO WORKS

DeltaCare USA (DHMO) differs from the PPO in the way it provides dental care. The DHMO works just like a medical HMO. It provides coverage for preventive, basic, and major care services through its network of dental care providers. Except in certain emergency situations, you and your covered dependents must receive all your dental care from DHMO in-network dentists in order to receive benefits. There are no annual deductibles, no claim forms to complete and no annual or lifetime dollar maximums.

When you enroll in the DHMO, you must select a Primary Care Dentist (PCD), who will take care of your dental care needs. If you need to see a specialist, your PCD will handle the referral for you. Unlike the PPO, the DHMO requires that your treatment be coordinated by your PCD for you to receive benefits.

## SUB-TOPICS:

## PAYING FOR YOUR CARE

With the DHMO it is easy to estimate your out-of-pocket costs because your benefits are listed in the "Description of Benefits and Copayments" section of the EOC booklet (issued by Delta Dental), which can be found in the Forms section at wgaplans.org.

## COPAYS

"Copay" is a fixed-dollar amount that you pay your contract dentist for certain eligible expenses at the time the service is provided.

## COORDINATION OF BENEFITS

For the general COB rules, see page 82. See the Evidence of Coverage (EOC) provided by Delta Dental for specific COB rules that apply to the DHMO Plan.

## FILED FEES

Any procedure not listed in the EOC is considered a non-covered expense and you will be charged a "Filed Fee" for that service. This means the fee your in-network PPO dentist will charge you has been filed with Delta Dental and your dentist cannot charge you more than the "Filed Fee."

## OPTIONAL FEES

You will incur an additional charge if you request your in-network dentist to perform an alternative procedure that satisfies the same dental need as a covered procedure (i.e., a composite filling instead of an amalgam filling). Your contract dentist will charge you the difference between his/her "Filed Fee" for the "optional" procedure and the "Filed Fee" for the "covered" procedure, plus any applicable "copayment" for the covered procedure.

## GETTING THE MOST FROM YOUR PLAN

When you enroll in the DHMO, you must select a Primary Care Dentist (PCD), who will take care of your dental care needs. If you need to see a specialist, your PCD will handle the referral for you. Unlike the PPO, the DHMO requires that your treatment be coordinated by your PCD for you to receive benefits.

| When You See the Following Dental Care Provider | What to Expect |
|---|---|
| Primary Care Dentist (PCD) or a specialist referred by your PCD | • Most of your care will be covered at no cost to you or your covered dependents. Some services will require you to pay a copayment; the fee schedule is listed in the "Description of Benefits and Copayments" section of DeltaCare's "Evidence of Coverage" (EOC) booklet.<br>• You do not need to file a claim form. |
| Non-Primary Care Dentist | • Your care will not be covered, except under certain emergency circumstances (please see the section below entitled "Emergency Care" for more information). |

Here's how it works:

It is important to keep in mind that the DHMO is available only to Participants who reside in California, and there are a limited number of dentists in some areas. Before you choose this Dental Plan, you should be certain there's a DHMO dentist who is both convenient to you and accepting new patients. If you have a covered dependent that does not live with you, call Delta Dental's Customer Service Department to determine whether a DHMO in-network dentist is available where your dependent lives.

To learn more about the dentists who participate in the DHMO network, you may:

- Call Delta Dental's Customer Service Department at (800) 765-6003 for a list of participating dentists in your area; or
- Log on to the DHMO website at deltadentalins.com to search for a provider online.

In-network dentists occasionally change, so you will want to make sure the dentist you choose is still in the DHMO network before you make an appointment. For the most up-to-date information, including whether a dentist is accepting new patients, call the dentist directly.

## CHANGING PRIMARY CARE DENTIST

If you want to change your primary care dentist (PCD), you may notify Delta Dental's Customer Service Department by phone or in writing. You may also change your PCD online by visiting the DHMO website. If you make the change by the 21st day of any month, the change will take effect on the first day of the following month. You can change your PCD as often as you wish.

If your PCD leaves the network, you will be notified and asked to select another PCD. If you do not select a new PCD, one will automatically be assigned to you, based on your ZIP code. Having your PCD leave the network is not considered a qualified status change. That means that you won't be able to change your dental plan option until the next Open Enrollment period.

## OUT-OF-NETWORK DENTISTS

Except in an emergency situation, the DHMO does not pay any benefits if you go to an out-of-network dentist or if you receive care from a network dentist without the proper referral from your PCD. This

is the case even if you have a covered dependent that doesn't live with you and there's no DHMO network where your dependent lives.

## EMERGENCY CARE

The DHMO provides limited coverage if you or a covered dependent needs emergency dental care from an out-of-network dentist when at least one of these qualifying circumstances exists:

- You are outside the DHMO's service area;
- Your PCD is unavailable;
- Your PCD cannot see you within 24 hours of making contact with their office; or

- Your emergency makes it dentally/medically inappropriate for you to travel to your PCD to receive emergency for services.

The DHMO will reimburse up to $100 per emergency, per enrollee, for services performed by an out-of-network dentist. After you receive emergency care, you must contact your PCD to discuss any follow-up treatment.

For instructions on how to be reimbursed for expenses related to emergency care, call Delta Dental Customer Service Department at: (800) 422-4234, Group #72496.

## LOOKING AT ELIGIBLE AND INELIGIBLE EXPENSES

The DeltaCare USA DHMO covers a wide range of services, including but not limited to those described below. To find out whether a particular service not listed below is covered, please refer to your DeltaCare EOC Booklet or contact Delta Dental's Customer Service Department at (800) 422- 4234, Group #72496. The DeltaCare EOC Booklet can also be found on our website at wgaplans.org.

## ELIGIBLE EXPENSES

The sub-sections that follow list most, but not all, covered services that you can receive at no cost or for a minimal copayment:

## DIAGNOSTIC AND PREVENTIVE BENEFITS

These benefits include:

- Comprehensive oral evaluation;
- Comprehensive periodontal evaluation;
- Intraoral radiographs – complete series (including bitewings);
- Limited oral evaluation – problem-focused;
- Periodic oral evaluation;
- Prophylaxis (cleaning) – adult or child: one per 6-month period;
- Sealant, per tooth – limited to permanent molars through age 15;
- Space maintainer – fixed –unilateral;
- Space maintainer – fixed – bilateral;
- Space maintainer – removable – unilateral;
- Space maintainer – removable – bilateral; and
- Topical application of fluoride, including prophylaxis (up to age 19) – one per 6-month period.

## RESTORATIVE BENEFITS

Restorative benefits include:

- Amalgam – four or more surfaces, permanent;
- Amalgam – four or more surfaces, primary;
- Inlay – metallic/porcelain/ceramic/resin-based composite – three or more surfaces;
- Onlay – metallic/porcelain/ceramic/resin-based composite – four or more surfaces.
- Resin-based Composite crown, anterior – primary;
- Resin-based composite – four or more surfaces or involving incisal angle (anterior); and
- Resin based composite – four or more surfaces - posterior.

## ORAL AND MAXILLOFACIAL SURGERY BENEFITS

Oral surgery benefits include pre- and post-operative evaluations and treatment under local anesthetic, as well as:

- Biopsy of oral tissue – soft (does not include pathology laboratory procedures);
- Frenulectomy (also known as frenectomy or frenotomy);
- Removal of lateral exostosis (maxilla or mandible);
- Removal of impacted tooth – soft tissue/partially bony/completely bony;
- Root removal – exposed roots;
- Single tooth extraction/each additional;
- Surgical removal of erupted tooth; and
- Surgical removal of residual tooth roots.

## PERIODONTIC BENEFITS

Periodontic benefits include preoperative and postoperative evaluations and treatment under a local anesthetic, as well as:

- Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant;
- Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant; and
- Periodontal scaling and root planing – four or more teeth per quadrant (limited to four quadrants during any 12 consecutive months).

## PROSTHETIC BENEFITS (CROWNS, BRIDGES AND DENTURES)

Prosthetic benefits include:

- Crown – porcelain/ceramic[29];
- Crown – resin (laboratory);
- Denture – complete maxillary or mandibular (upper or lower);
- Inlay – three or more surfaces – base noble metal; and
- Onlay – four or more surfaces – base noble metal.

## ENDODONTIC BENEFITS

These benefits include:

- Apicoectomy/periadicular surgery – anterior;
- Apicoectomy/periadicular surgery – bicupsid (first root);
- Apicoectomy/periadicular surgery – molar (first root);
- Pulp capping (direct/indirect);
- Root canal therapy – anterior (excluding final restoration);
- Root canal therapy – bicuspid (excluding final restoration);
- Root canal therapy – molar (excluding final restoration); and
- Therapeutic pulpotomy (excluding final restoration).

## GENERAL SERVICES

These benefits include:

- Local anesthesia; and
- Palliative (emergency) treatment of dental pain.

## ORTHODONTIC BENEFITS

Orthodontic benefits are provided for:

- Adults (you, your covered spouse); and
- Dependent children up to age 26.

Subject to the limitations noted below, start-up fees (excluding records) which include initial examination, diagnosis, consultation, and initial banding, are also covered.

[29] Porcelain on molars is considered optional treatment. Base noble metal is the benefit. High noble metal (precious), if used, will be charged to the patient at the additional laboratory cost of the high noble metal. This applies to crowns, bridges, cast, and post cores, inlays, and onlays.

## DENTAL PLAN LIMITATIONS

For specific benefit limitations please refer to your DeltaCare EOC booklet (which can be found on our website) or contact Delta Dental's Customer Service Department. Generally speaking, the following dental benefits are subject to the following limitations:

- Bitewing X-rays are limited to not more than one series of four films in any 6-month period;
- Denture relines are limited to one per denture during any 12 consecutive months;
- Full-mouth debridement (gross scale) is limited to one treatment during any 12 consecutive months;
- Full-mouth X-rays are limited to one set every 24 consecutive months;
- Periodontal treatments (root planing/subgingival curettage) are limited to four quadrants during any 12 consecutive months;
- Prophylaxis treatment is covered once every six months (includes periodontal maintenance following active therapy);
- Replacement of an existing inlay, onlay, crown, fixed partial denture (bridge), or a removable full or partial denture is covered when the existing restoration/ bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and either of the following:
    - The existing non-functional restoration/bridge/denture was placed five or more years prior to its replacement; or
    - If an existing partial denture is less than five years old, but must be replaced by a new partial denture due to the loss of natural tooth, which cannot be replaced by adding another tooth to the existing partial denture; and
- Sealant benefits include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars up to age 9 and second molars up to age 14. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.

The DHMO provides coverage for orthodontic treatment plans when you see a DeltaCare network orthodontist. Your orthodontic benefits are subject to the following limitations:

- Orthodontic treatment must be provided by a DeltaCare orthodontist;
- The DHMO covers 24 months of orthodontic treatment;
- Should your coverage be canceled or terminated for any reason, and at the time of cancellation or termination you are receiving orthodontic treatment, you (and not DeltaCare) will be responsible for paying the balance due for treatment provided after cancellation or termination. In such a case, your payment will be based on a maximum of $2,300 for dependent children up to age 19 and $2,500 for the Participant and all covered dependents over the age of 19. The amount will be prorated over the number of months to completion of the treatment and will be payable on such terms and conditions as are arranged between you and the orthodontist. Start-up fees are included in these amounts; and

- Start-up fees cover the initial examination, diagnosis, consultation, and retention phase of treatment of up to two years. This includes initial construction, placement of retainers and adjustments to them, as well as office visits for a maximum period of two years.

## INELIGIBLE EXPENSES

Although the DHMO covers a wide range of dental services, some services are not covered. It is important for you to know what these services are before you visit your dentist. To find out if a specific benefit is ineligible under the DHMO, please refer to your DeltaCare EOC booklet, issued by DeltaCare USA (the EOC can also be found at wgaplans.org).

The DHMO does not cover the following services:

- Accidental injury, which is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (i.e., chewing) function will be covered at the normal schedule of benefits;
- Any procedure that is not specifically listed under Schedule A, Description of Benefits, and Copayments;
- Any procedure that in the professional opinion of the Contract Dentist:
  - Has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures; or
  - Is inconsistent with Generally Accepted Standards of Dentistry; and
- All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility;
- Congenital malformations (e.g., congenitally missing or supernumerary teeth, enamel, and dentinal dysplasias, etc. except for the treatment of newborn children with congenital defects or birth abnormalities);
- Consultations for non-covered benefits;
- Crown lengthening procedures;
- Cysts and malignancies;
- Dental conditions arising out of and due to your employment, or for which Workers' Compensation is payable;
- Dental expenses incurred in connection with any dental procedures started after eligibility for coverage has terminated;
- Dental services received from any dental office other than the assigned DeltaCare office, unless expressly authorized in writing by DeltaCare or as cited under "Emergency Services" of the EOC Booklet;
- Dispensing of drugs not normally supplied in a dental facility;
- General anesthesia and the services of a special anesthesiologist;
- Implant placement or removal, and appliances placed on or services associated with implants, including, but not limited to, prophylaxis, and periodontal treatment;

- Loss or theft of fixed and removable prosthetics (e.g., crowns, bridges, full or partial dentures);
- Prophylactic removal of impactions (asymptomatic/nonpathological); extraction of teeth when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including, but not limited to, the removal of third molars and orthodontic extractions;
- Restoration placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth;
- Services that are provided by a State government agency or are provided without cost by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code;
- Treatment of fractures and dislocations; and
- Treatment required by reason of war.

The following orthodontic services also are not covered:

- Changes in treatment necessitated by accident of any kind;
- Composite bands, lingual adaption of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances;
- Extractions solely for the purpose of orthodontics;
- Initial or continuing orthodontic treatment when such treatment would be inconsistent with generally Accepted Professional Standards;
- Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers, and expansion appliances;
- Myofunctional therapy;
- Phase I orthodontics, as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment, including interceptive orthodontia, prior to the development of late mixed dentition;
- Pre-treatment, mid-treatment and post-treatment records, including cephalometric X-rays, tracings, photographs, and study models;
- Restorative work caused by orthodontic treatment;
- Retreatment of orthodontic cases;
- Surgical procedures incidental to orthodontic treatment;
- Surgical procedures related to cleft palate micrognathia or macrognathia;
- Supplemental appliances not routinely used in typical comprehensive orthodontics;
- Treatment related to temporomandibular joint disturbances;
- Treatment in progress when eligibility for coverage begins;
- Transfer after banding has been initiated; and
- Treatment in progress at inception of eligibility, unless qualified for the orthodontic treatment in progress provision.

In addition, treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge at the orthodontist's reasonable and customary fee.

This section gives you information on several legal provisions that have been enacted to protect your rights. If you have any additional questions about your rights, please contact the Fund Office.

**MAJOR TOPICS IN THE WHAT ELSE YOU SHOULD KNOW ABOUT YOUR HEALTH PLAN SECTION**

- Newborns' and Mothers' Health Protection Act
- Family and Medical Leaves of Absence
- Qualified Medical Child Support Order
- Expanded FMLA Rules for Military Personnel
- Mental Health Parity and Addiction Equity Act
- Military Leave
- Not a Contract of Employment
- No Liability for Practice of Medicine
- Genetic Information Non-Discrimination Act ("GINA")
- No Vested Interest
- Applicable Law
- Construction of Terms
- Facility of Payment

## NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurers generally may not restrict benefits to Participants for any hospital length of stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a vaginal delivery; or
- Less than 96 hours following a Caesarean section.

However, the law doesn't generally prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn less than 48 hours after delivery (or 96 hours, as applicable). In any case, the Fund may not require the physician to obtain authorization from the Fund for prescribing a hospital stay of not more than 48 hours (or 96 hours, as applicable).

## QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A Qualified Medical Child Support Order is a decree issued by a court requiring health coverage for a child. The Fund will honor Qualified Medical Child Support Orders (QMCSOs).

If a QMCSO issued in a divorce or legal separation proceeding requires you to provide health coverage to a child who is not in your custody, you may do so. To be considered qualified, a Medical Child Support Order must include all of the following information:

- Name and last known address of the parent who is covered under the Fund;
- Name and last known address of each child to be covered under the Fund;
- Type of coverage to be provided to each child; and
- Period of time for which the coverage is to be provided.

Medical child support orders should be sent to the Fund Office so that the Fund can determine whether the order qualifies as a QMCSO. Upon receipt of the order, the Fund will provide you with a description of its procedures for determining whether the order is qualified. If the order is qualified, you may cover your children under the applicable health Plans. If you would like to obtain a copy of the Fund's procedures governing QMCSOs, you may request a copy in writing, at no charge, from the Fund Office.

## FAMILY AND MEDICAL LEAVES OF ABSENCE

Through the Family and Medical Leave Act (FMLA), you are allowed take up to 12 weeks of unpaid leave (in some cases, up to 26 weeks) 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.

If you take at least one week of unpaid FMLA leave, your employer is required to continue contributions on your behalf to the Fund for the entire period of unpaid leave. However, if, when your leave begins, the employer has already paid the maximum amount required under the collective bargaining agreement or the COBRA rate, no further employer contributions are required. Whether or not your employer is required to continue contributing, your coverage through the Fund will continue (and, in the case of a dependent, coverage will continue

provided you continue to pay the quarterly dependent coverage premiums in full and on time). Of course, any changes in the Fund'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.

If you do not return to work after your FMLA leave ends, you may be required to repay the amount that your employer paid before or during your leave which applies to your coverage during your leave. However, if you do not return to work due to your or a family member's serious health condition or other circumstances beyond your control, this repayment rule may not apply. Employees of Named Employers should refer to the "Employee Handbook" issued by their employer to understand how FMLA applies to them.

If you do not return to work after your FMLA leave ends, and your coverage ceases, you may qualify for COBRA Continuation Coverage, described here.

## EXPANDED FMLA RULES FOR MILITARY PERSONNEL

The 2010 National Defense Authorization Act (2010 NDAA) amends the Family and Medical Leave Act of 1993 by expanding its leave provisions relating to "Qualifying Exigency Leave" and "Military Caregiver Leave." FMLA leave is available to covered employees whose spouse, child, or parent is in the U.S. Armed Forces, including the National Guard or Reserves, who is ordered to active duty and who is deployed overseas. "Qualifying Exigencies" include time preparing for short notice deployment, arranging for child care, updating financial or legal arrangements, attending counseling, time for rest and recuperation, and post-deployment activities. You may be entitled to up to 12 weeks leave within a 12-month period for a "Qualified Exigency."

The 2010 NDAA also amends the FMLA to create leave protections for family members of injured veterans who provide "Military Caregiver Leave." They may be entitled to a total of 26 weeks of unpaid leave during a 12-month period to care for the service member. This form of leave applies only if the service member in need of care is undergoing medical treatment, recuperation, or therapy (including outpatient care) for a serious illness or injury that was incurred in the line of active duty and that may render the service member medically unfit to perform the duties of his/her office, grade, rank, or rating.

**NOTE:** If you take this type of leave along with a FMLA leave for any other purpose (for example, the birth of a child), the combined total leave may not exceed 26 weeks in the 12-month period.

If you believe you qualify for FMLA leave, please contact your employer and advise the Fund Office.

## MILITARY LEAVE

If you enter military service, you will be provided continuation and reinstatement rights under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). USERRA protects employees who leave for and return from active duty in the uniformed services (including the Army, Navy, Air Force, Marines, Coast Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service). If you elect continuation coverage under USERRA, you and any eligible dependents covered under this Fund when your leave began may continue coverage for up to 24 months.

If you are on active duty for less than 31 days, you (and your eligible dependents covered under the Fund when your leave began) will continue to receive the health coverage that

you would otherwise have received under the Fund. If you are on active duty for 31 days or more, you can continue coverage for yourself (and your eligible dependents covered under the Fund when your leave began) for up to 24 months, but you will need to pay the applicable COBRA premium for such coverage. Payment under USERRA and termination of coverage for nonpayment of USERRA work just like COBRA coverage (described above). In addition, you and your dependents may be eligible for health care coverage under TriCare (the Department of Defense's health care program for uniform service members and their families). This Fund coordinates benefits with TriCare with the Fund paying first and TriCare paying second. Please refer to Coordination of Benefits section on pages 81-87 and visit tricare.mil for additional information.

If you are called to active duty, you must notify the Fund Office in writing as soon as possible, but no later than 60 days after the date on which you will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice. Once the Fund Office receives notice that you have been called to active duty, you will be offered the right to elect USERRA coverage for yourself and any eligible dependents covered under the Fund on the day your leave started. Unlike COBRA coverage, if you do not elect USERRA for your dependent(s), he/she/they cannot elect it separately.

When you are discharged (not less than honorably) from the uniformed services, your full eligibility may be entitled to be reinstated on the day you return to work with a contributing employer, provided that you return to employment within:

- 90 days from the date of discharge, if the period was more than 180 days;
- 14 days from the date of discharge, if the period of service was at least 31 days but less than 180 days; or
- The next regularly scheduled working day following discharge (plus travel time and an additional eight hours), if the period of service was less than 31 days.

No waiting period or exclusion will be imposed in connection with such reinstatement (unless the waiting period or exclusion would have been imposed if you had remained covered during your military service) except in the case of illness or injury determined by the Secretary of Veterans' Affairs to be connected with your military service. Separation from uniformed service that is dishonorable or based on bad conduct, on grounds less than honorable, absence without leave (AWOL), or ending in a conviction under court martial would disqualify you from any rights under USERRA.

## GENETIC INFORMATION NON-DISCRIMINATION ACT ("GINA")

Effective June 1, 2009, the Genetic Information Non-Discrimination Act of 2008, as amended (GINA) prohibits discrimination by group health plans, such as the Fund, against an individual based on the individual's genetic information. Group health plans and health insurance issuers generally may not request, require, or purchase genetic information for underwriting purposes; plans and insurers also may not collect genetic information about an individual before the individual is enrolled or covered and generally may not request or require individuals to undergo genetic testing. Pursuant to the applicable requirements of GINA, the Fund is also prohibited from setting premium and contribution rates for the group on the basis of genetic information of an individual enrolled in the Fund.

## NOT A CONTRACT OF EMPLOYMENT

This SPD is not a contract of employment. It neither guarantees employment or continued employment with your contributing employer or any contributing employer, nor diminishes in any way the right of contributing employers to terminate the employment of any employee.

## SEVERABILITY

If any provision of this SPD is held invalid, unenforceable, or inconsistent with any law, regulation or requirement, its invalidity, unenforceability, or inconsistency will not affect any other provision of the SPD, and the SPD shall be construed and enforced as if such provision were not a part of the SPD.

## CONSTRUCTION OF TERMS

Words of gender shall include persons and entities of any gender; the plural shall include the singular and the singular shall include the plural. Section headings exist for reference purposes only and shall not be construed as part of the SPD.

## APPLICABLE LAW

The Fund shall be construed and enforced according to the laws of the State of California to the extent not preempted by ERISA and any other applicable federal law.

## NO VESTED INTEREST

Except for the right to receive any benefit payable under the Fund in regard to a previously incurred claim, no person shall have any right, title, or interest in or to the assets of any contributing employer due to its relationship with the Fund.

## NO LIABILITY FOR PRACTICE OF MEDICINE

The Fund and the Trustees, or any of their designees are not engaged in the practice of medicine, nor do they 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 Fund, the Trustees, nor any of their designees will have any liability whatsoever for any loss or injury caused to you by any provider by reason of negligence, by failure to provide care or treatment, or otherwise.

## FACILITY OF PAYMENT

Every person receiving or claiming benefits through the Fund will generally be presumed to be mentally and physically competent and of age. However, if the Plan Administrator (or its designee) determines that a person entitled to receive benefits hereunder is a minor, or is physically or mentally incompetent to receive the payment or to give a valid release for benefits, the Fund may issue payments to the person's legally appointed guardian, committee or representative (upon proof of the appointment) or, if none, to another person or entity that the Trustees determine appropriate in their sole and absolute discretion. Any payment made in accordance with this provision will entirely discharge the obligation of the Fund.

**SOCIAL SECURITY NUMBERS NEEDED**

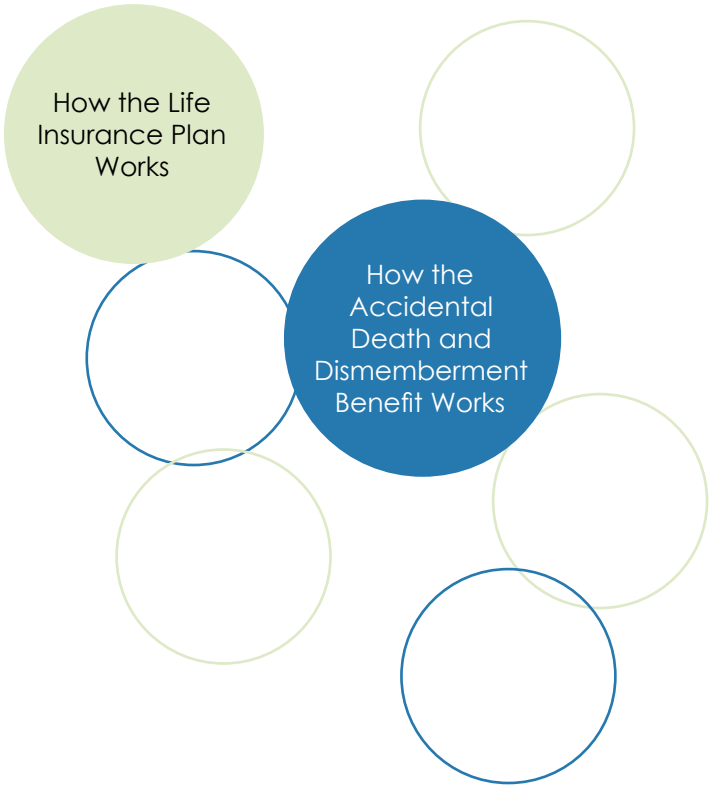
To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number of your eligible dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such 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.

If a dependent does not yet have a Social Security Number, you can go to this website to complete a form to request a Social Security No.: socialsecurity.gov/online/ss-5.pdf. Applying for a Social Security Number is free.

Failure to provide the Social Security Number or failure to complete the CMS model form (HICNSSN Form No. 081809, available from the Fund Office or at CMS.gov) means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

The Fund automatically provides you with basic life insurance coverage, including separate accidental death and dismemberment (AD&D) coverage, if you experience certain injuries or loss as the result of an accident. This coverage is included with your Health Plan coverage at no additional cost.

In the next few pages we'll take a closer look at your life and AD&D coverages to help you understand the protection benefits available to you through the Fund.




**MAJOR TOPICS IN THE PROTECTION BENEFITS SECTION**

# HOW THE LIFE INSURANCE PLAN WORKS

The Fund provides you with a life insurance benefit of $5,000 when you die from any cause, either on or off the job. You will automatically be enrolled in life insurance coverage if you are enrolled in the PPO Plan. The Fund pays the entire cost of life insurance coverage for eligible Participants only (earned, extended coverage, excess earnings extension, and Certified Retiree coverage).

Life insurance benefits are not available if you are enrolled in COBRA Continuation Coverage or the Low Option Plan. Also note that these protection benefits are provided only to Participants, and not their covered dependents.

## SUB-TOPICS:



## PAYING BENEFITS

If you die while you have the Plan's life insurance coverage, benefits will be paid as a lump sum to the beneficiary you have on file with the Fund Office.

You may choose anyone you wish to be your designated beneficiary by completing the appropriate beneficiary designated form and returning it to the Fund Office. You may also change your designation at any time. If you have not named a beneficiary, or if your beneficiary doesn't survive you, your life insurance benefit may pay:

- Up to $500 of your benefit toward any party responsible for your burial expenses;
- The executors or administrators of your estate; or
- Your surviving relatives in the following order: your spouse, your children, or your parents.

If your designated beneficiary is a minor without a legal guardian, the benefit may be paid to the person who is caring for and supporting him/her. If the beneficiary is deceased or there is no beneficiary selected, the surviving relative (spouse, children, or parents) must fill out a Preference Beneficiary Affidavit form to receive the $5,000 benefit.

## IF YOU BECOME DISABLED

If you become totally disabled while you have the Plan's life insurance coverage, and you are under age 60, your life insurance coverage will remain in effect, and you will not have to pay additional premiums. Your beneficiary will receive the full amount of your insurance if your total disability continues until the date of your death.

Within one year of the end of coverage, you must submit proof that the total disability began while you were covered. You will also have to submit proof of continued disability annually.

**NOTE:** If the person is no longer totally disabled, this benefit will no longer apply.

### REQUESTING BENEFITS

Upon notification of your death or receipt of your death certificate, the Fund will process the necessary paperwork. Benefits are insured and administered by Hartford Life Insurance. The Fund is responsible for validating coverage and submitting the appropriate paperwork to the beneficiary and Hartford Life Insurance. (For more information about filing claims, see Claims and Appeals Rules on pages 192-206.)

# HOW THE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT WORKS

In addition to the life insurance benefit, the Fund provides you with accidental death and dismemberment coverage in the amount of $5,000. You will automatically be provided with this coverage if you are enrolled in the PPO Plan. The Fund pays the entire cost of accidental death and dismemberment coverage for eligible Participants only, except those enrolled with COBRA Continuation Coverage or the Low Option Plan. Only Participants under the PPO Plan, and not their dependents, are eligible for accidental death and dismemberment coverage.

### SUB-TOPICS:

## UNDERSTANDING THE BENEFIT

If you have Health Plan coverage with the PPO Plan (and not COBRA Continuation Coverage or the Low Option Plan), you will receive an accidental death and dismemberment benefit if you suffer an accidental injury and a loss resulting directly from the injury, including an injury that occurs within 365 days of the accident.

The maximum accidental death and dismemberment benefit that will be paid for all losses resulting from one accident is $5,000. The amount you receive depends on the extent of the injury:

| FOR LOSS OF... | THE BENEFIT PAID IS... |
|---|---|
| Life | $5,000 |
| One hand | $2,500 |
| One foot | $2,500 |
| One eye | $2,500 |
| Speech or hearing | $2,500 |
| Thumb and index finger on either hand | $1,250 |
| Movement of both upper and both lower limbs (quadriplegia) | $5,000 |
| Movement of three limbs (triplegia) | $3,750 |
| Movement of both lower limbs (paraplegia) | $3,750 |
| Movement of both the upper and the lower limb on one side of the body (hemiplegia) | $1,250 |
| Movement of one limb (uniplegia) | $1,250 |
| More than one of the above, resulting from one accident | $5,000 or the sum of the benefits payable for each loss (whichever is less) |

## SEAT BELT BENEFIT

You may be eligible for a seat belt benefit if you suffer an accidental death or dismemberment while operating or riding as a passenger in an automobile. If you were wearing a seat belt at the time of the accident, your accidental death and dismemberment benefit will be paid at 110%. The police report must attest to the fact that you were wearing a seat belt at the time of the accident, or the additional 10% benefit will not be paid.

## AIR BAG BENEFIT

If you are eligible for a seat belt benefit, then an additional 5% of your accidental death and dismemberment benefit will also be paid if:

- You were in a seat that was equipped with a factory-installed air bag; and
- You were using your seat belt when the air bag inflated.

In addition, the police report must indicate that the air bag inflated properly upon impact, or the benefit will not be paid.

## KNOWING WHEN BENEFITS AREN'T PAID

The accidental death and dismemberment coverage pays a benefit for an accident or injuries that lead to the losses described in "Understanding The Benefit." Benefits will not be paid for a loss caused by or contributed to by:

- Illness;
- Disease;
- Any medical treatment for illness or disease;
- Any infection, except a pus-forming infection of an accidental cut or wound;
- War or any act of war, whether or not war is declared;
- Any injury received while you were in the armed service of a country that is at war or engaged in armed conflict;
- Any intentionally self-inflicted injury, suicide, or suicide attempt, whether you were sane or insane;
- Riding in, boarding, or alighting from any aircraft owned, operated, or leased by or on behalf of your employer or the Trustees of the Fund;
- Riding, boarding or alighting from any aircraft while you are a pilot or crew member of the aircraft; or
- Taking drugs, sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless prescribed or administered by a licensed.

## REQUESTING BENEFITS

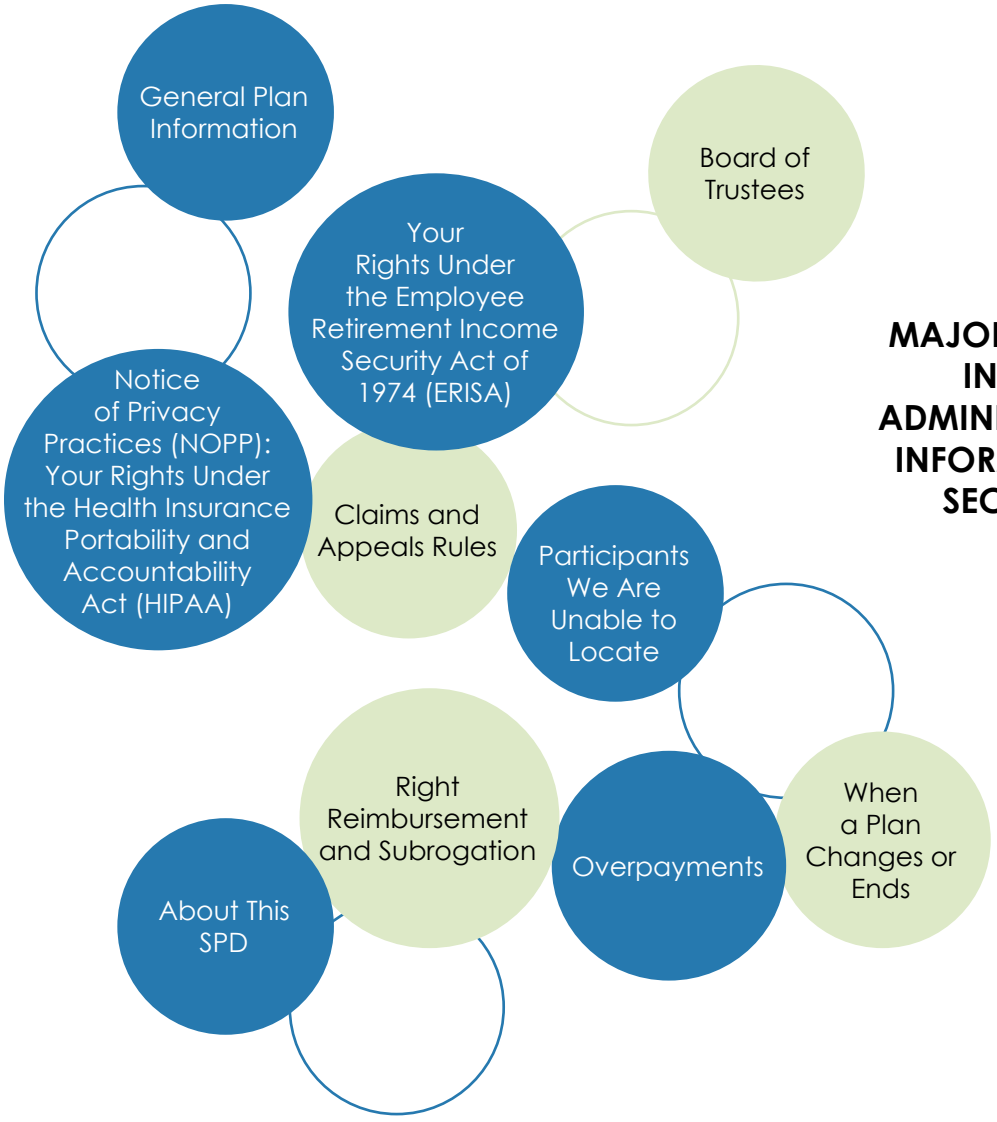
If the accidental injury you sustain results in your death, your benefits will be paid to the beneficiary you have on file with the Fund Office in accordance with the procedures for the payment of your life insurance benefit. (See Requesting Benefits on page 181 for more information.) Benefits for all other losses will be paid to you directly as a lump-sum payment.

To initiate a request for benefits, you or your beneficiary should call the Fund Office within 20 days after the accident occurs. If notice cannot be given within that time, it should be provided as soon as possible after that.

Within 15 days after receiving notice of a request for benefits, you or your beneficiary will receive forms to complete for proof of the loss. Satisfactory written proof must be submitted to the Fund within 90 days. (For more information about filing claims, see Claims and Appeals Rules on pages 192-206.)

## CONVERTING YOUR COVERAGE

You may not convert your accidental death and dismemberment coverage to an individual policy.




**MAJOR TOPICS IN THE ADMINISTRATIVE INFORMATION SECTION**

## PLAN INFORMATION — WRITERS' GUILD-INDUSTRY HEALTH FUND

**Employer Identification Number Plan Number** 23-7108536

**Plan Number** 501

**Plan Administrator** Board of Trustees

Writers' Guild-Industry Health Fund
2900 W. Alameda Ave.
Suite 1100
Burbank, CA 91505-4267
Telephone: (818) 846-1015
Outside area: (800) 227-7863

**Type of Plan** This Plan is an employee welfare benefit plan that provides medical, outpatient prescription drug, dental, vision, life insurance, and accidental death and dismemberment benefits.

**Plan Administration** The Health Plan's benefits are self-funded and administered by the Board of Trustees with equal representation by contributing employers and the Union. Other benefits are provided through fully insured contracts, administrative services only contracts and network arrangements, as follows:

| INSURED CONTRACTS | SELF-FUNDED CONTRACTS (ADMINISTRATIVE SERVICES ONLY) | NETWORK ARRANGEMENTS |
|---|---|---|
| Hartford Life – Life and AD&D<br><br>DeltaCare USA – DHMO | Express Scripts – Outpatient Prescription Drugs<br><br>Delta Dental – DPO | The Industry Health Network (TIHN) – Southern California Only<br><br>Anthem BlueCross – PPO Network for PPO Plan and Low Option Plan in California<br><br>Blue Card – PPO Network for PPO Plan and Low Option Plan outside California |

**Agent for the Service of Legal Process**

Jim Hedges
Chief Executive Officer

Writers' Guild-Industry Health Fund
2900 W. Alameda Ave.
Suite 1100
Burbank, CA 91505-4267
Telephone: (818) 846-1015
Outside area: (800) 227-7863

Or

Robert M. Projansky
Proskauer Rose LLP
Eleven Times Square
New York, NY 10036

Or

George Kraw
Kraw Law Group, APC
605 Ellis Street
Suite 200
Mountain View, CA 94043
(650) 314-7800

Service of legal process by a court, upon a Trustee of the Fund in his/her capacity as such shall also constitute service upon the Fund.

**Sources of Funding**

The Fund maintains a Trust that includes all contributions to the Health Fund and investment income. All contributions to the Fund are made by employers in accordance with their collective bargaining agreements or participation agreements, and by Participants through premium payments. You may obtain information from the Fund as to whether a particular employer is contributing on behalf of Participants working under the collective bargaining agreement, as well as the address of any such employer or a list of all participating employers, by written request to the Fund's Employer Compliance Department.

**Collective Bargaining Agreement**

Contributions to the Fund are made on behalf of Participants in accordance with the collective bargaining agreements between Writers Guild of America, East, Inc., Writers Guild of America, West, Inc. and employers in the industry. The Administrative Office will provide you, upon written request, with copies of the collective bargaining agreements. The collective bargaining agreements are also available for examination at the Administrative Office.

**Trust**

Fund assets are held by the Northern Trust Company, as Trustee at 50 South LaSalle Street, Chicago, IL 60075.

**Plan Year**

The Plan Year ends on Dec. 31 each year. Records of the Plan are kept on a calendar-year basis.

**Principal Trustees**

To contact a Plan Trustee, send correspondence care of the Plan Administrator to the following address:

Writers' Guild-Industry Health Fund
2900 W. Alameda Ave.
Suite 1100
Burbank, CA 91505-4267

# BOARD OF DIRECTORS/TRUSTEES

## GUILD TRUSTEES

**Lise Anderson**
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

**John Auerbach**
WGA, East
250 Hudson St., Suite 700
New York, NY 10013

**Simran Baidwan**
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

**Geoff Betts**
WGA, East
250 Hudson St., Suite 700
New York, NY 10013

**Patti Carr**
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

**Stan Chervin**
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

**Yahlin Chang**
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

**Kathy Christovich**
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

**Zoanne Clack**
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

**Ken Hanes**
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

**Kate Purdy**
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

**Melissa Salmons**
WGA, East
250 Hudson St., Suite 700
New York, NY 10013

**Robert Schneider**
WGA, East
250 Hudson St., Suite 700
New York, NY 10013

**Charles Slocum**
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

**Ellen Stutzman**
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

**Tom Szentgyorgyi**
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

**David N. Weiss**
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

**Lisa Zwerling**
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

## PRODUCER TRUSTEES

**Shannon Aho**
Netflix
5808 Sunset Blvd.
Los Angeles, CA 90028

**Mark Badagliacca**
Paramount Picture Corp.
5555 Melrose Ave.
Redstone 136
Los Angeles, CA 90038

**Tracy Cahill**
AMPTP
15301 Ventura Blvd., Bldg. E
Sherman Oaks, CA 91403

**Katya Culberg**
Sony Pictures Entertainment
10202 W. Washington Blvd.
Jimmy Stewart 340N
Culver City, CA 90232

**Jim Gray**
Walt Disney Studios
500 Buena Vista St.
Burbank, CA 91521-6552

**Virginia Hoyt**
NBCUniversal
100 Universal City Plaza,
1280-3
Universal City, CA 91608

**Monica Jain**
Paramount Studios
5555 Melrose Ave.,
Zukor Bldg.
Los Angeles, CA 90038

**Grace Jun**
Walt Disney Television
2121 Avenue of the Stars,
Fox Plaza Bldg.
Los Angeles, CA 90067

**Hank Lachmund**
Warner Bros. Ind. Relations
4000 Warner Blvd.,
Building 137, #1009
Burbank, CA 91522

**Jane Lee**
Warner Bros. Pictures
4000 Warner Blvd.,
Bldg. 137, #1045
Burbank, CA 91522

**Carol Lombardini**
AMPTP
15301 Ventura Blvd., Bldg. E
Sherman Oaks, CA 91403

**Laura Beedy Ritchie**
CBS Studio Center
4024 Radford Ave.
Studio City, CA 91604

**Marc Sandman**
ABC, Inc.
500 S. Buena Vista St.
Burbank, CA 91521-4211

**Evan Sherman**
Warner Bros. Discovery
8900 Venice Blvd.
Culver City, CA 90232

**Mark Stubington**
Walt Disney Pictures and Television
500 Buena Vista St.
Burbank, CA 91521-7397

**Maria Truisi-Kenney**
CBS
51 West 52nd Street, 19th Floor
New York, NY 10019

| CHIEF EXECUTIVE OFFICER | LEGAL COUNSEL | CONSULTANTS | AUDITOR |
|---|---|---|---|
| **Jim Hedges** | **Kraw Law Group, APC**<br>**Proskauer Rose, LLP** | **The Segal Company**<br>**Milliman, Inc.** | **Withum** |

# YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a Participant in the Fund, you're entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan Participants are entitled to the following rights:

## RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Fund. These include insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You may also obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include 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.
- You may also receive a summary of the Fund'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

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

## PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

## ENFORCEMENT OF YOUR RIGHTS

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

Under ERISA, you may take certain steps to enforce the above rights, as described below.

1. For instance, if you request a copy of Fund documents or the latest annual report from the Fund and do not receive it 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 $184 a day not to exceed $1,846 per request (indexed for inflation) until you receive the materials, unless the materials were not sent due to reasons beyond the Plan Administrator's control.

2. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court within two years of the date the Plan Administrator notifies the claimant of a final adverse determination, provided that the Fund's claims and appeals processes were first fully exhausted. In addition, if you disagree with the Fund's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court.

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

## ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about the Fund, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
US Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline at (866) 444-3272 (EBSA) of the Employee Benefits Security Administration.

# CLAIMS AND APPEALS RULES

The claims and appeals rules apply to the benefits administered by the Fund and benefits administered for the Fund by third-party administrators.

A claim is a request for Plan benefit made in accordance with the Health Plan's procedures for filing such claims. A specific request for eligibility relating to a particular person or period is also considered a claim under these rules. Inquiries that are unrelated to a specific claim, such as inquiries regarding benefits available under the Fund, the circumstances under which benefits might be paid, or qualification for benefits, will not be treated as claims (except for pre-service claims as described below). In addition, a request for preauthorization or prior approval of a benefit that does not require prior approval under the Fund is considered an inquiry (e.g., a predetermination of service), and is not a claim for purposes of these procedures and the appeal procedures that follow.

In addition to special requirements as described below for pre-service claims and urgent care claims, a claim for health benefits under the Fund must include the following information, as applicable to health care related claims, in order to be considered for payment by the Health Plan:

- Plan Participant's name and address;
- Plan Participant's 12-character Participant ID No. (WRXA########);
- Patient's name and address (if different from the Participant's);
- Patient's date of birth;
- Provider's name and address;
- Provider's Federal Tax ID No.;
- Itemized provider bill, preferably in a standardized CMS-1500 or UB-04 format (non-standard billing formats can delay claim processing);
- Amount paid (if any);
- CPT (Current Procedural Terminology) procedure code(s);
- ICD-10 (International Classification of Diseases, Tenth Edition) diagnosis code(s);
- Date(s) of service; and
- Other information or proof reasonably required by the Fund.

You do not have to provide all of the information described above if your claim relates to an eligibility determination. A claim for eligibility should provide a written description of the circumstance surrounding your claim so that your claim may be adjudicated properly. Fund staff will contact you if we need additional information.

The scope of an adverse benefit determination or claim will include rescissions (within the meaning of PPACA) of coverage whether or not there is an immediate adverse effect on any particular benefit. As a result, rescissions of coverage are subject to the Fund's claims and appeal rules. The Fund's procedures for all Fund claims are described below.

You will find contact information for all Claims Administrators in the Summary of Benefits section starting on page 21.

SUB-TOPICS:

## FILING CLAIMS IN GENERAL

How claims are processed depends on the type of claim. Who processes the claim also depends on the type of claim. Certain claims must be submitted to the applicable third-party claims administrator. All other claims must be submitted to the Administrative Office. Each third-party administrator, as well as the Fund Office, is referred to as a "Claims Administrator." The chart below lists the Claims Administrator for each type of claim.

Generally, if you receive services from an in-network health care provider, the provider will submit the claim to the applicable Claims Administrator directly. If you receive services from an out-of-network provider, you or your provider will submit the claim to the applicable Claims Administrator. See pages 77-81 for details.

You may designate an authorized representative for assistance with respect to your claim for benefits. For more information, contact the Claims Administrator.

| CLAIM TYPE | SUBMIT/REFER TO |
|---|---|
| Medical and wellness claims | Administrative Office or BlueCross Blue Shield Global Core (see claim submission section) |
| Dental claims | Delta Dental (PPO) or DeltaCare USA (DHMO) |
| Outpatient prescription drug claims | Express Scripts |
| Life and accidental death and dismemberment claims | Administrative Office |
| Vision claims | VSP |
| Eligibility determinations | Administrative Office |
| Infertility treatment claims (See page 128) | Carrot |

## INITIAL CLAIM DETERMINATIONS

The Claims Administrator has full discretion to deny or grant a claim in whole or in part. Such decisions will be made in accordance with the governing Fund documents, and where appropriate, Fund provisions will be applied consistently with respect to similarly situated claimants in similar circumstances.

How and when claims are processed depends on the type of claim. Most claims under the Fund that are required to be submitted to the Administrative Office are post-service health care claims. Most other claims under the Fund will also be post-service claims.

## POST-SERVICE HEALTH CARE CLAIMS

A post-service claim is a claim for benefits after services or treatment have been provided. A claim regarding rescission of coverage will be treated as a post-service claim. The Claims Administrator will notify the claimant of a denial within a reasonable period of time but not later than 30 days after receipt of the claim, unless an extension of 15 days is necessary due to circumstances beyond the Fund's control. If the reason for the extension is because the Claims Administrator doesn't have enough information to decide the claim, the notice will describe the required information, and the claimant will have 45 days from the date he/she receives the notice to provide the necessary information.

After the claimant responds to this request for information (or at the end of the 45-day period, whichever comes first), the Fund will make a decision on your claim and notify you of the determination within 15 days. If the requested information is not provided within the time allowed, your claim will be considered denied.

For claims subject to No Surprises Act billing protections, the Claims Administrator will make an initial payment or notice of denial of payment for emergency services at out-of-network health care facilities, non-emergency services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services within 30 calendar days of receiving a claim from the out-of-network provider or facility that includes all necessary information to decide the claim.

## DENIAL NOTICES

Any notice of an adverse benefit decision will include the following:

- Identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
- The specific reason or reasons for the adverse determination;
- Reference to the Fund's provisions on which the determination was based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why the information is necessary;
- A description of the Fund's review procedures, the time limits applicable to such procedures, and the claimant's right, at no charge, to have reasonable access to and to obtain copies of all relevant documents upon request, and a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse determination on review;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that the rule, guideline, protocol, or other criterion was relied upon and will be provided free of charge upon request;
- If the determination is based on a Medical Necessity or experimental treatment or similar exclusion, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to the medical circumstances, or a statement that an explanation of the scientific or clinical judgment applied to make the determination will be provided free of charge upon request;
- If the determination affects a claim for urgent health care, a description of the expedited review process applicable to such claims;
- Information identifying the claim involved including the date of service, the health care provider, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The reason(s) for the adverse benefit determination including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used to deny the claim at issue, and, in the case of final adverse benefit determinations, the description of the discussion of the decision;
- A description of the available internal appeals and review processes, including information regarding how to initiate an appeal; and
- The contact information and availability of any applicable offices of health insurance consumer assistance or ombudsman established under PPACA to assist you with the internal claims and appeals processes.

**Note:** If you do not understand English and have questions about a claim denial, contact the Claims Administrator for assistance.

In addition, the Fund will provide you (free of charge) with any new or additional evidence that was considered, relied upon, or generated by the Fund or the Claims Administrator in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for you to respond to such new evidence or rationale before the Plan makes a final determination of the claim on review or appeal.

## APPEALING A DENIED CLAIM

If a claim is denied, the claimant will have 180 days from receipt of the denial to submit a written appeal. The appeals decision for any claims denied by the Claims Administrator will be conducted by the Fund's Benefits Committee. However, the Benefits Committee may delegate this power to an authorized designee. The authorized designee for claims denied by Anthem Blue Cross is typically the Administrative Office, but the Benefits Committee reserves the right to designate any entity or person to hear appeals as it deems appropriate. Any authorized designee shall not be the same individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

The claimant may submit written comments and other information relating to the claim for consideration on appeal. The claimant will be provided, upon request and free of charge, other information relevant to the claimant's claim, including the identity of any medical consultant who reviewed the initial claim without regard to whether the advice was relied upon in making the initial claim. The appeals decision will not afford deference to the initial adverse determination and will be conducted by an individual or individuals who are neither the individual who made the initial determination nor his/her subordinate.

## ELIGIBILITY APPEALS

Health Fund eligibility appeals (i.e., appeals not related to a specific medical claim) must be submitted in writing to the Eligibility Department, and to the attention of the Eligibility Manager. The appeal will be heard by the Benefits Committee at its next regularly scheduled quarterly meeting. If any appeal is received by the Eligibility Department within 30 days before the meeting, the review will be delayed until the next scheduled quarterly meeting.

## DECISIONS ON APPEAL

The Appeals Reviewer (either the Benefits Committee or its authorized designee) will take into account all comments, documents, records, and other information submitted as part of its review, regardless of whether the information was previously considered on initial review. The Appeals Reviewer will have discretion to deny or grant the appeal in whole or part. Such decisions will be made in accordance with the governing Fund documents and, where appropriate, Fund provisions will be applied consistently with respect to similarly situated claimants in similar circumstances. The Appeals Reviewer will have discretion to determine which claimants are similarly situated in similar circumstances. If the decision to deny the claim was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Appeals Reviewer will consult with a health care professional who has experience and training in the relevant field and who was not involved in the initial determination and was not the subordinate of the health care professional involved in the initial determination. Identification of any such health care professional will be provided to the claimant upon request and free of charge without regard to whether the advice was relied upon in making the initial determination.

**IMPORTANT!**

Neither the Participant, eligible dependents, health care providers, nor their individual representatives, may appear in person before the Benefits Committee.

Reviews of denied claims which are heard by the Benefits Committee (and not by its authorized designee) will be heard at the Benefits Committee's next regularly scheduled quarterly meeting. However, if an appeal is received within 30 days before the meeting, the review will be delayed until the next meeting. In addition, if special circumstances require further extension of time, the review may be delayed to the following meeting. Once the benefit determination is made, the claimant will be notified as soon as possible, but not later than five days after the determination.

For reviews of claims denied by a party other than the Benefits Committee, the claimant will be notified of the determination within a reasonable period of time, but not later than 60 days after receipt of the request for review.

The Appeals Reviewer will notify you of its decision for urgent care claims as soon as possible but no later than 72 hours after the receipt of such claim, provided that you provide the Appeals Reviewer with sufficient information for it to determine whether and to what extent benefits are covered under the Fund under such circumstances. If the Appeals Reviewer requires additional information from you in order to make a determination for an urgent care claim, you will have not less than 48 hours to provide the Fund with the requested information. The determination as to whether a claim involves urgent care is determined by the attending provider and the Appeals Reviewer will defer to such determination.

**NOTE:** Throughout this section, "claimant" will be used interchangeably with "Participant" and "dependent."

## NOTICE OF DECISION ON APPEAL

Any notice of an adverse determination will include the following:

- The specific reason or reasons for the adverse determination;
- Reference to the Fund's provisions on which the determination was based;

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents and other information relevant to the claimant's claim;
- A statement describing the claimant's right to bring an action under ERISA Section 502(a);
- If the determination is based on a Medical Necessity or experimental exclusion, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to the medical circumstances, or a statement that an explanation of the scientific or clinical judgment applied to make the determination will be provided free of charge upon request;
- If an internal rule or guideline was applied in making the determination, either the specific rule or guideline or a statement that the rule will be provided free of charge upon request;
- Information identifying the claim involved including the date of service, the health care provider, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The reason(s) for the adverse benefit determination including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used to deny the claim at issue, and, in the case of final adverse benefit determinations, the description of the discussion of the decision;
- A description of the available internal appeals and review processes, including information regarding how to initiate an appeal;
- The contact information and availability of any applicable offices of health insurance consumer assistance or ombudsman established under PPACA to assist you with the internal claims and appeals processes; and A statement describing the Plan's voluntary appeal procedures and the claimant's right to obtain information about the voluntary appeal process.

If you do not understand English and have questions about a claim denial, contact the Claims Administrator for assistance.

You may not sue with respect to Fund benefits (including without limit any action to recover benefits, to enforce your rights under the Plan or to clarify your right to future benefits under the Plan) until the Plan's administrative procedures have been fully exhausted. Additionally, you may not bring a lawsuit more than two years following the date the Appeals Reviewer notifies the claimant of a final adverse determination.

## VOLUNTARY APPEAL TO BENEFITS COMMITTEE

Following an adverse determination on appeal by a party other than the Benefits Committee (i.e., a third party claims administrator or an authorized designee of the Benefits Committee), the claimant may submit a voluntary appeal to the Benefits Committee. While this voluntary appeal is being processed, the limitations period for filing a lawsuit described below is tolled. While the claimant may not bring a lawsuit regarding a claim without first exhausting the Fund's claims and appeal procedures, the claimant is not required to first submit a voluntary appeal.

## EXTERNAL REVIEW PROCESS

If, after exhausting the Fund's internal appeals process, you are not satisfied with the final determination, you may choose to participate in the external review process. This process only applies if the adverse benefit determination is based on:

- Clinical reasons (e.g., Medical Necessity);
- A rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time;
- The exclusions for experimental or investigational services or unproven services;
- Non-quantitative treatment limitations that apply to the provision of medical benefits;
- Compliance with surprise billing and cost-sharing protections under the No Surprises Act; or
- As otherwise required by applicable law.

This external review process does not pertain to claims for life/death benefits, AD&D, disability, or the dental or vision plans.

The external review process offers an independent review of the denied requested service or procedure, or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the Fund's internal appeals process, and receiving a final adverse benefit determination from the Fund on your internal appeal (your "Internal Appeal Denial.") You may request an external review by an Independent Review Organization (IRO) within four months of the notice of the Internal Appeal Denial.[30] Please note: claims involving eligibility determinations are not subject to external review.

The Fund's internal appeal denial notice will inform you of your right to request an external review, your external review rights, and your right to file suit in federal court under ERISA. See pages 196-198 of the SPD for details regarding the internal appeals process.

The external review will be performed by an independent physician of like specialty, or by a physician who is qualified to decide whether the requested service or procedure is a covered health service under the Fund. The IRO has been contracted by the Fund and has no material affiliation with or interest in the Fund. The Fund will choose the IRO based on a rotating list of approved IROs. In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO. Within applicable timeframes of the Fund's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by the Fund in making a decision; and
- All other information or evidence that you or your physician have already submitted to the Fund.

If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include this information with the request

[30] If there is no corresponding date four months after the date of your receipt of the internal appeal denial notice, you must then file the request for an external review by the first day of the fifth month following your receipt of such notice. For example, if the date of your receipt of the Fund's internal appeal benefit denial notice is Oct. 30, because there is no Feb. 30, the request must be filed by March 1. In addition, if the last filing date would fall on a weekend or federal holiday, the last filing date to request an external review is extended to the next day that is not a Saturday, Sunday, or federal holiday.

for an independent review, and the Fund will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an Expedited External Review as defined by applicable law.

## PRELIMINARY REVIEW BY THE PLAN

Within five business days following the date of the Fund's receipt of your request for an external review, the Claims Administrator will complete a preliminary review to determine whether your request is complete and eligible for an external review. Specifically, that preliminary review will determine whether:

- You were covered under the Fund at the time the health care item or service was requested or, in the case of a retrospective review, provided;
- The final denial of your appeal relates to your failure to meet the Fund's eligibility requirements;
- You exhausted the Fund's internal appeal process (or are not required to exhaust the process); and
- You have provided all the information and forms required by the Fund to process an external review.

Within one business day after the Claims Administrator completes his/her preliminary review, he/she will issue you a written notification of its determination. If your request is complete, but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If your request is not complete, the notification will describe the information or materials needed to make the request complete and you will be allowed to perfect your request for an external review within the original four-month filing period or, if later, the 48-hour period following your receipt of the notification.

## REVIEW BY THE IRO

If the Claims Administrator approves your request for an external review, the Fund will assign a qualified IRO to conduct the review. Within five business days after making the assignment, the Fund will provide the assigned IRO with the documents and information that the Claims Administrator considered in making its final adverse benefit determination.

The Fund will also notify you of this assignment. Upon receiving such notice, you will have 10 business days to submit additional information to the IRO. If you submit additional information, within one day after receiving such information, the IRO will send such information to the Fund so it may reconsider its determination.

If the Fund decides to reverse its decision based on its review of this new information, it will provide a written notice of its decision to you and the IRO within one business day after reaching that favorable decision, and the IRO will terminate the external review upon receipt of the Fund's notice.

If, however, the Fund does not reverse its determination, the IRO will conduct a review of all of the information and documents that it received from the Fund or you, and will not be bound by any decisions or conclusions reached by the Claims Administrator during the Fund's internal claim and appeal process. The IRO, at its discretion, may also consider the following in reaching its decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from the appropriate health care professionals and other documents submitted by the Claims Administrator, you or your treating provider;
- The terms of the Fund, to ensure that the IRO's decision is not contrary to the terms of the Fund;
- Appropriate practice guidelines;
- Any applicable clinical review criteria developed and used by the Fund; and
- The opinion of the IRO's clinical reviewer(s).

The IRO will provide written notice to you and the Claims Administrator of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO's notice will contain, to the extent required by law, the following information:

- A general description of the reason for the Request for External Review including, if applicable, information sufficient to identify the claim, the amount of the claim, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial;
- The date the IRO received the assignment from the Fund to conduct the external review and the date of the IRO's decision;
- References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Fund or you;
- A statement that judicial review may be available to you; and
- If applicable, the current contact information for any applicable office of Health Insurance Consumer Assistance or Ombudsman.

## OVERVIEW OF THE EXPEDITED EXTERNAL REVIEW PROCEDURES

Under the following circumstances, you may be eligible to file for an expedited external review:

If you:

- Receive an adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal with the Claims Administrator would seriously jeopardize your life or health, or that would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- Receive a final adverse benefit determination from the Claims Administrator;

and:

- You have a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or
- If the final adverse benefit determination concerns an admission, availability of care, continued stay, or a health care item or service for which you have received emergency services but have not been discharged from a facility.

## EXPEDITED PRELIMINARY REVIEW BY THE FUND

Immediately upon receipt of the request for an expedited external review, the Claims Administrator will conduct a preliminary review of your request and determine whether you are eligible for such a review. Immediately after completion of this preliminary review, the Claims Administrator will issue you a written notification of its determination. If your request is complete but is not found to be eligible for an expedited external review, the notice will include the reasons for ineligibility. If your request is incomplete, the notice will describe the information or materials needed to perfect the request.

## EXPEDITED REVIEW BY THE IRO

Upon a determination that a request is eligible for an expedited external review, the Claims Administrator will assign an IRO to review it and will transmit all necessary documents and information to the IRO in accordance with the above-discussed "standard" external review rules. The IRO will provide a written notice of its final decision to you and the Claims Administrator as expeditiously as possible, but in no event later than 72 hours (24 hours for reviews involving urgent claims) after the IRO receives the request for the expedited external review. If notice is not in writing, within 48 hours of providing that notice, the IRO shall provide written notice to you and the Claims Administrator of its final decision.

## PRE-SERVICE CLAIMS

While most claims for benefits under the Fund are post-service claims subject to the rules described above, some claims require pre-approval and are considered pre-service claims. A claim is a pre-service claim only if failure to obtain approval before care is received results in a reduction or denial of benefits that would otherwise be covered. Claims requiring pre-approval include certain dental claims (these are submitted to Delta Dental), and certain prescription drugs (these are submitted to Express Scripts).

There are three types of pre-service claims: urgent care claims, non-urgent care claims and concurrent care claims. The rules described above apply to pre-service claims, except as described below:

- If a claim is a pre-service claim but is not a claim for urgent care, the Claims Administrator will notify the claimant of a denial within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receiving the claim, unless an extension of 15 days is necessary due to circumstances beyond the Fund's control. If the reason for the extension is because the Claims Administrator doesn't have enough information to decide the claim, the notice will describe the required information and the claimant will have 45 days from the date the notice is received to provide the necessary information.

- If the claim is a pre-service claim for urgent care, the Claims Administrator will notify the claimant of the determination as soon as possible, but not later than 72 hours after receipt of the claim. If the claimant fails to provide sufficient information for determination, the claimant will be notified of the missing information as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will have a reasonable period of time (at least 48 hours) to provide the missing information. The claimant will then receive a determination not later than 48 hours after the earlier of (1) the Fund's receipt of the missing information, or (2) the end of the period provided for the claimant to submit the missing information, provided the Claims Administrator is not required to provide a determination before the original 72 hour period expires. If the requested information is not provided within this time frame, your claim will be considered denied.

- Special rules apply for concurrent care decisions. These are decisions involving an approved ongoing course of treatment, either for a specific period of time or for a specific number of treatments. A reduction or termination of the course of treatment before the approved time period or number of treatments will be considered a claim denial. If this occurs, the Participant will be notified sufficiently in advance in order to appeal the decision before the benefit is reduced or terminated.

- On the other hand, claimants may request an extension of the course of treatment beyond the approved time period or number of treatments. If such a concurrent care claim involves urgent care, the Claims Administrator will provide notice of the determination within 24 hours of receiving the request, as long as the request is made at least 24 hours before the approved time period or number of treatments expires. If the request doesn't involve urgent care, the normal pre-service claim rules apply.

- If a claimant fails to follow the Fund's claim procedures for filing a pre-service claim, the claimant will be notified of the failure and of the proper procedures to follow in filing a claim for benefits. The notice will be provided not later than 5 days (or 24 hours for an urgent care claim) after receipt of the claim. This provision applies only if the claim was received by a person customarily responsible for handling Fund benefit matters and includes the name of the claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

- If a pre-service claim for urgent care is denied on appeal, the claimant will be notified of the eligibility determination as soon as possible, but not later than 72 hours after receipt of the request for review.

- If a pre-service claim for benefits that doesn't involve urgent health care is denied on appeal, the claimant will be notified of the determination within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the request for review.

## PREDETERMINATION

A request for prior approval of a benefit that does not require prior approval under the Fund is considered a predetermination, and not a claim; it is similar to pre-authorization as it allows services or treatment to be reviewed for Medical Necessity. In this process, benefit coverage is predetermined before services are rendered and any limitation under the Plan can be addressed before services are provided.

## DISABILITY CLAIMS

If a claim is for disability benefits, the claims and appeals rules described in this section apply, except as follows: The Claims Administrator will notify the claimant of the Fund's decision within a reasonable period of time but not later than 45 days after receipt of the claim, unless the Claims Administrator notifies the claimant that an extension of 30 days is necessary due to circumstances beyond the Fund's control. This initial 30-day extension may be extended another 30 days if the Claims Administrator determines that an extension is needed due to circumstances beyond the Fund's control and the Claims Administrator notifies the claimant of the extension, including the unresolved issues and any additional information needed.

**Written Notice of Denial:** If you make a claim that requires a disability determination and the claim is denied, the written notice of denial will include the following information, in addition to the information otherwise required to be provided with the written notice of denial by the claims and appeals rules:

1. The internal rule, guideline, protocol, or other similar criterion of the Plan, if any, that was relied upon in making the adverse determination, or a statement that such rules, guidelines, protocols, standards, or similar criteria of the Plan do not exist.
2. A discussion of the decision, including an explanation of the reasons for disagreeing with or not following:
    a) The views of health care professionals treating you and vocational professionals who evaluated you, as presented in your claim for benefits;
    b) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    c) A disability determination made by the Social Security Administration, as presented in your claim for benefits.

**Opportunity to Review New Information:** Before issuing an adverse decision on your appeal, the Claims Administrator will provide the following information to you (if applicable):

1. Any new or additional evidence considered, relied upon, or generated by or at the direction of the Claims Administrator or its designee, and
2. Any new or additional rationale upon which an adverse decision is based.

This information will be provided to you free of charge and sufficiently in advance of the decision to provide you with a reasonable opportunity to respond.

**Notice of Determination on Appeal:** If your appeal of a claim requiring a disability determination is denied, the written notice will include the following information, in addition to the information otherwise required to be provided with your notice of determination on appeal by the claims and appeals rules:

1. The internal rule, guideline, protocol, or other similar criterion of the Plan, if any, that was relied upon in making the adverse determination, or a statement that such rules, guidelines, protocols, standards or similar criteria of the Plan do not exist.

2. A description of any applicable contractual limitations period that applies to your right to file the claim in court, including the date on which the contractual limitations period expires for the claim.

3. A discussion of the decision, including an explanation of the reasons for disagreeing with or not following:

   a) The views of health care professionals treating you and vocational professionals who evaluated you, as presented in your claim for benefits.

   b) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

   c) A disability determination made by the Social Security Administration, as presented in your claim for benefits.

## OTHER CLAIMS – LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT, AND ELIGIBILITY CLAIMS

If the claim is for benefits other than health care or disability benefits (such as protection benefits described on pages 179-184), the claims and appeals rules described in this section apply, except as described below:

- The Claims Administrator will notify the claimant of its decision within a reasonable time but not later than 90 days after receipt of the claim, unless the Claims Administrator determines that special circumstances require an extension of up to an additional 90 days. If the claim is denied, the claimant will have 60 days from receipt of notification to appeal the determination; and

- If an audit discovers that the employer has mistakenly reported earnings to the Fund, or if it is discovered that earnings were reported in an incorrect time period that results in the rescission of coverage, the Participant may ask the Audit & Delinquency Committee to review the Administrator's decision, if they feel the decision was reached erroneously.

## PLAN INTERPRETATIONS

The Trustees and their duly authorized designee(s) have the exclusive right, power, and authority, in their sole and absolute discretion, to administer, apply, and interpret the Fund, including this SPD, the Trust Agreement, and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Fund. Without limiting the generality of the foregoing, the Trustees and/or its duly authorized designee(s) shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to an individual's eligibility for, and the amount of, benefits payable under the Fund;

- Formulate, interpret and apply rules, regulations, and policies necessary to administer the Fund in accordance with its terms;
- Decide questions, including legal or factual questions, relating to eligibility for benefits and the calculation and payment of benefits under the Fund;
- Resolve and/or clarify any ambiguities, inconsistencies, and omissions arising under the Plan and the Plan documents, including but not limited to this SPD and all modifying updates or the Trust Agreement;
- Process and approve or deny benefit claims; and
- Determine the standard of proof required in any case.

All determinations and interpretations made by the Trustees and/or its duly authorized designee(s) shall be final and binding upon all Participants, beneficiaries, and any other individuals claiming benefits under the Health Plan.

No individual other than the Trustees or their duly authorized designee(s) has any authority to make any representations or promises to you about the Fund or your benefits under the Health Plan, or to change the provisions of the Health Plan.

# HIPAA NOTICE OF PRIVACY PRACTICES (NOPP)

**THIS NOPP DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY. THIS NOPP ALSO APPLIES TO YOUR SPOUSE AND OTHER QUALIFIED DEPENDENTS. PLEASE SHARE THIS WITH THEM.**

The Fund is committed to maintaining the confidentiality of your private information.

This NOPP describes our efforts to safeguard your protected health information (PHI) from impermissible use or disclosure. As a group health plan, the Fund is a covered entity under HIPAA. HIPAA requires that we provide you with notice of our legal duties and privacy practices with respect to PHI. PHI includes any individually identifiable health information that relates to your past, present, or future physical or mental health, the provision of health care to you, or the past, present or future benefit payments for your health care, including your name, address, date of birth, and Social Security No.

We are legally required to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. The primary purpose of this NOPP is to describe the legally permitted uses and disclosures of PHI, even though some may not apply to this Fund in practice. This NOPP also describes your right to access and control your PHI.

We are required to abide by the terms of this NOPP currently in effect. We reserve the right to change the terms of this or any subsequent NOPP at any time. If we make a change, the revised NOPP will be effective for all PHI that we maintain at that time, even if we received the PHI before the change, as well as any PHI that we may receive in the future. Within 60 days of any material revision of our privacy practices, we will distribute a new NOPP. Additionally, you may contact the Fund directly at any time to obtain a copy of the most recent NOPP, or visit wgaplans.org to view or download the current NOPP.

## PERMITTED USES AND DISCLOSURES OF PHI

The following sets forth various ways in which, under HIPAA, we may use and disclose your PHI without your specific authorization. In addition to the situations set forth below, we may also disclose your PHI to anyone that you authorize. Contact the Fund Office at (818) 846-1015 or visit wgaplans.org to obtain a copy of the appropriate form to authorize the people who may receive this information.

Generally, we will limit the use, disclosure or request for PHI to a "limited data set" as defined under HIPAA, to the extent practicable. Otherwise, we make every effort to use and disclose only the minimum necessary amount of PHI to achieve the intended purpose of the use or disclosure.

## TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Under HIPAA, we may use and disclose your PHI in connection with your receiving treatment, our payment for such treatment and for health care operations.

- **Treatment:** Treatment means the provision, coordination, or management of your health care. As a health plan, while we do not provide treatment, we may use or disclose your PHI to support the provision, coordination, or management of your care. For example, we may disclose your PHI to a health care provider responsible for coordinating your health care.
- **Payment:** Payment means activities in connection with processing claims for your health care. We may need to use or disclose your PHI to determine qualification for coverage, for Medical Necessity, and for utilization review activities. For example, we could disclose your PHI to physicians engaged by the Fund for their medical expertise in order to help us make claims decisions based upon Medical Necessity.

We may also disclose your PHI and your dependents' PHI, on Explanations of Benefit (EOB) forms and other payment-related correspondence, such as pre-authorizations, which are sent to you.

If you appeal a benefit determination on behalf of a qualified dependent, or if a close family member appeals a determination on behalf of you or one of your qualified dependents, we may disclose PHI related to that appeal to you or that close family member. If you appeal a benefit determination and you designate an authorized representative to act on your behalf, we will disclose PHI related to that appeal to that designated representative.

- **Health Care Operations:** Health care operations mean administrative and business functions that the Fund must perform to operate as a health plan. For example, we may need to review your PHI to conduct data analyses for cost control or planning purposes.

There are other ways in which we may use and disclose your PHI as part of our payment and health care operations. For example, we may disclose your PHI to third parties who are known as Business Associates that perform various activities (e.g., hospital preauthorization, case management) for us. We will have written contracts with our Business Associates, which require each of the Business Associates to protect the privacy of your PHI.

We may disclose your PHI to the Union(s) (i.e., Writers Guild of America, West, Inc. or Writers Guild of America, East, Inc.) and the Union(s) may use or disclose PHI to assist the Fund in the performance of payment activities, such as collecting contributions and premiums to pay for Fund coverage, or to obtain or provide reimbursement for the provision of health care. We may also disclose your PHI, including your qualification for health benefits and specific claim information to other covered entities such as health plans in order for us to coordinate benefits between this Fund and another plan under which you may have coverage.

We may use your PHI to inform you about treatment alternatives or health-related benefits and services that may be of interest to you.

We may disclose your PHI to Trustees who serve on the Benefits Committee and to the Fund's IROs in connection with appeals that you file following a denial of a benefit claim or a partial payment, or other appeals. In addition, any Trustee may receive PHI if you request that Trustee to assist you in your filing or perfecting a claim for benefits under the Fund. Trustees may also receive PHI if necessary for them to fulfill their fiduciary duties with respect to the Fund. Such disclosures will be the minimum necessary to achieve the purpose of the use or disclosure. In accordance with the Fund documents, such Trustees must agree not to use or disclose PHI

other than as permitted in this NOPP or as required by law, not to use or disclose the PHI with respect to any employment-related actions or decisions, or with respect to any other benefit plan maintained by the Trustees.

## DISCLOSURE TO OTHERS INVOLVED IN YOUR CARE OR PAYMENT OF YOUR CARE

You may designate a manager, agent, accountant, personal assistant, or other third party to receive EOBs and other written communications from the Fund with respect to you and your qualified dependents. We will recognize your previous designation of such individuals and will continue to send EOBs and other communications from the Fund to such parties. If you do not want us to continue such communications, you must notify us in writing to such effect and give us an alternate address or third party, if any, to whom you would like us to send your information. In addition, we may disclose to your spouse or other members of your immediate family and the individuals you designate or have designated, as provided above, your PHI that is directly relevant to such individual's involvement in your health care or payment of your health care, unless you request us in writing not to do so. We may also disclose or use PHI to provide information concerning your location, your general medical condition or your death to a family member, your Personal Representative or another person responsible for your care.

## PERSONAL REPRESENTATIVES

We may disclose your PHI to your Personal Representative in accordance with applicable state law or the Privacy Rule. A Personal Representative is someone authorized by court order, power of attorney, or a parent of a child, in most cases. In addition, a Personal Representative can exercise your personal rights with respect to PHI. Generally, a parent is the Personal Representative of an unemancipated minor. However, it is the Fund's policy that we will not disclose PHI, other than payment information, to a parent with respect to a child age 12 or older, unless we receive a written request for such information from that child's parent. Upon receipt of such a request, we will review any applicable restrictions regarding the disclosure of medical information of minors and respond to the request.

## REQUIRED BY LAW

We may use or disclose your PHI to the extent that we are required to do so by federal, state, or local law. You will be notified, if required by law, of any such uses or disclosures.

## HEALTH OVERSIGHT

We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and legal actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

## FOOD AND DRUG ADMINISTRATION

Our Pharmacy Benefit Manager may disclose your PHI to a person or company subject to the jurisdiction of the Food and Drug Administration (FDA) with respect to an FDA-regulated product or activity for which that person has responsibility, for the purpose of activities related to the quality, safety, or effectiveness of such FDA-regulated product or activity.

## LEGAL PROCEEDINGS

We may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal. In addition, we may disclose your PHI under certain conditions in response to a subpoena, discovery request, or other lawful process, in which case, reasonable efforts must be undertaken by the party seeking the PHI to notify you and give you an opportunity to object to this disclosure.

## WORKERS' COMPENSATION

We may disclose your PHI to comply with workers' compensation laws and other similar legally established programs.

## REQUIRED USES AND DISCLOSURES

We must make disclosures to you and to the Secretary of the US Department of Health and Human Services to investigate or determine our compliance with the federal regulations regarding privacy.

## ABUSE OR NEGLECT

We may disclose your PHI to any public health authority authorized by law to receive reports of child abuse or neglect. In addition, if we reasonably believe that you have been a victim of abuse, neglect, or domestic violence, we may disclose your PHI to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

## DISASTER RELIEF

We may disclose your PHI to any authorized public or private entities assisting in disaster relief efforts.

## PUBLIC HEALTH

We may disclose your PHI for public health purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of preventing or controlling disease (including communicable diseases), injury, or disability. If directed by the public health authority, we may also disclose your PHI to a foreign government agency that is collaborating with the public health authority.

## CORONERS, FUNERAL DIRECTORS AND ORGAN DONATION

We may disclose your PHI to a coroner or medical examiner for identification purposes or determining a cause of death, or other duties authorized by law. We may also disclose your PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye, or tissue donation and transplant purposes.

## RESEARCH

We are permitted to disclose your PHI to researchers when their research has been approved by an institutional review board that has established protocols to ensure the privacy of your PHI and certain other requirements are met. However, the Fund does not routinely disclose PHI to researchers.

## CRIMINAL ACTIVITY

Consistent with applicable federal and state laws, we may disclose your PHI, if we believe in good faith that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. In certain circumstances, we may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

## MILITARY ACTIVITY AND NATIONAL SECURITY

When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel:

- For activities deemed necessary by military command authorities; or
- To a foreign military authority if you are a member of that foreign military service.

We may also disclose your PHI to authorized federal officials conducting national security and intelligence activities, including the protection of the president.

## INMATES

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your PHI to the institution or law enforcement official if the PHI is necessary for the institution to provide you with health care, to protect the health and safety of you or others, or for the security of the correctional institution.

## OTHER APPLICABLE LAWS

If a use or disclosure of PHI is prohibited or materially limited by other applicable state or federal law, it is the Fund's intention to meet the requirements of the more stringent law. For instance, special privacy protections may apply to certain sensitive information, HIV-related information, alcohol and substance abuse treatment information, and mental health information. If you would like more information, contact the Privacy Officer.

## AUTHORIZATION FOR OTHER USES AND DISCLOSURES OF YOUR PHI

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted by law. Further, uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI require your written authorization. If you authorize us to use or disclose your PHI for purposes other than set forth in the NOPP, you may revoke that authorization, in writing, at any time, except to the extent that we have already taken action based upon the authorization. Thereafter, we will no longer use or disclose your PHI for the reasons covered by your written authorization.

In no event will the Fund use or disclose your PHI that is genetic information for purposes that are not permitted under the Genetic Information Nondiscrimination Act of 2008. In other words, genetic information cannot be used or disclosed for underwriting purposes.

## YOUR RIGHTS

### RIGHT TO INSPECT AND COPY

As long as we maintain it, you may inspect and obtain a copy of your PHI that is contained in a Designated Record Set, which means a group of records that comprise the enrollment, payment, claims adjudication, case, or medical management record systems maintained by or for the Fund. If the Fund uses or maintains an electronic health record with respect to your PHI, you may request such PHI in an electronic format, and direct that such PHI be sent to another person or entity. Under federal law, however, you do not have the right to inspect or copy:

- Psychotherapy notes;
- Information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or
- Any information, including PHI, to which the law does not permit access.

We may also decide to deny access to your PHI if it is determined that the requested access is reasonably likely to endanger the life or physical safety of you or another individual, or to cause substantial harm to you or another individual, or if the records make reference to another person (other than a health care provider) and the requested access would likely cause substantial harm to the other person. In the event access is denied on this basis, that decision to deny access may be reviewable by a licensed health professional who was not involved in the initial denial of access and who has been designated by the Fund to act as a reviewing official.

To request access to inspect and/or obtain a copy of any of your PHI, you must submit your request in writing to our Privacy Officer at the address below indicating the specific information requested. If you request a copy, please indicate in which form you want to receive it (i.e., paper or electronic). We shall impose a fee to cover the costs of copying or scanning, and any postage costs.

### RIGHT TO REQUEST A RESTRICTION OF YOUR PHI

You may ask us not to use or disclose any part of your PHI for the foregoing purposes. You may also request that we not disclose your PHI to your spouse, immediate family members, or other third parties as described above. If you request that we restrict disclosure to another health plan for purposes of carrying out payment or health care operations activities and the PHI you want to restrict relates solely to a health care item or service for which the health provider involved was paid out-of-pocket in full, we are required to comply with your request. With respect to all other requests, however, we are not required to agree to a restriction that you may request. If we do agree to the request, we will not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment or we terminate the restriction with or without your agreement. If you do not agree to the termination, the restriction will continue to apply to PHI created or received prior to our notice to you of our termination of the restriction.

To request a restriction, you must write to our Privacy Official at the address below indicating what information you want to restrict, whether you want to restrict use, disclosure, or both, and to whom you want the restriction to apply.

## RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

As described above, you may designate certain third parties to receive communications from the Health Fund on your behalf. In addition, you may request in writing and we must accommodate your reasonable requests, to receive communications of PHI from us by alternative means or at alternative locations, if you believe that disclosure of the information could endanger you. Contact the Privacy Officer to obtain the appropriate form.

## RIGHT TO AMEND YOUR PHI

You have the right to request an amendment of your PHI if you believe the information maintained by the Fund about you is incorrect or incomplete. You have this right as long as the Fund maintains your PHI in a Designated Record Set. We will make an amendment to PHI we created or PHI we did not create if you demonstrate that the person or entity that created the PHI is no longer available to make the amendment.

However, we cannot amend PHI that we determine is accurate and complete. You may submit a written request for amendment to the Privacy Official at the Fund at the address listed below. Please specify the PHI to be amended, the change you request, and the reason for the amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Did not originate with us, unless the person or entity that originated the PHI is no longer available to make the amendment;
- Is not contained in the records maintained by the Fund;
- Is not part of the information which you would be legally permitted to inspect and copy; and
- Is accurate and complete.

If we deny your request, you have the right to file a written statement of disagreement with us, or you can request us to include your request for amendment along with the information sought to be amended if and when we disclose it in the future. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

## RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to request a list of disclosures of your PHI made by the Fund or its Business Associates. We are required to comply with your request except with respect to disclosures:

- Made in connection with your receiving treatment, our payment for such treatment and for health care operations;
- Made to you regarding your own PHI;
- Pursuant to your written authorization;

- To a person involved in your care or for other permitted notification purposes;
- For national security or intelligence purposes;
- Incident to a use or disclosure permitted or required by law;
- That are part of a limited data set; or
- To correctional institutions or law enforcement officials.

To request an accounting of disclosures, you must submit your request in writing to our Privacy Official. You have the right to receive an accounting of disclosures of PHI made within six years (or less) from the date on which the accounting is requested. Your request should indicate the form in which you want the list (e.g., paper or electronic). The first request within a 12-month period will be free of charge. For additional requests within the 12-month period, we will charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any cost is incurred.

## RIGHT TO RECEIVE NOTICE OF CERTAIN BREACHES OF PHI

If your "unsecured" PHI is accessed, acquired, used, or disclosed in a manner that is not permitted under the HIPAA privacy rules and that compromises the security or privacy of the PHI, such that it constitutes a "breach" as defined under HIPAA, the Plan must take specified steps to notify you within 60 days of discovery of such breach.

## RIGHT TO OBTAIN A PAPER COPY OF THIS NOPP

You may request a paper copy of our NOPP at any time, even if you have previously agreed to accept this NOPP electronically. Additionally, you may visit our website at wgaplans.org to view or download the current NOPP.

## COMPLAINTS

If you believe that your privacy rights have been violated, you should let us know immediately. We will take appropriate steps to remedy any violations of the Fund's privacy policies. You may file a formal complaint with us and/or with the Secretary of the US Department of Health and Human Services. To file a complaint with us, you must submit your complaint in writing to our Privacy Official at the address below. We will not retaliate against you for filing a complaint.

## FOR QUESTIONS OR REQUESTS

If you have any questions regarding this NOPP or would like to submit a written request as described above, please contact:

Writers' Guild-Industry Health Fund
Attn: Privacy Official
2900 W. Alameda Ave. Suite 1100
Burbank, CA 91505-4267
(818) 846-1015

HIPAA privacy practices and applicable forms are also available on the Fund's website at wgaplans.org.

# PARTICIPANTS WE ARE UNABLE TO LOCATE

If a benefit payment under the Fund cannot be made because the Fund's records do not include the individual's current address, or the individual does not cash the check from the Fund by the last day of the Plan Year following the year the claim was incurred, then the Fund will consider the benefit forfeited. The Fund will reinstate the benefit of any individual who presents himself or herself to the Fund after such forfeiture has occurred. However, such reinstatement will not include any adjustment for increases or decreases in the benefit for the period between the date of forfeiture and the date of reimbursement.

# THE FUND'S RIGHT OF REIMBURSEMENT AND SUBROGATION

The Fund has the right, whether by subrogation or reimbursement, or any other equitable or legal relief available under state or federal law, to recover from you, your dependents, or any other person or trust in possession of such monies sought by the Fund, all benefits paid by the Fund on your right or behalf (or your dependents') for injuries or disabilities that you or your dependents have suffered as a result of the negligence or wrongdoing of others for which you receive a "Recovery." Recovery includes without limitation, any amount awarded to or received by way of court judgment, arbitration award, settlement, or any other arrangement, from any third party or third-party insurer, or from your uninsured or underinsured motorist, homeowners' or other insurance coverage, related to the illness or injury, without reduction for any attorneys' fees paid or owed by you or on your behalf, and without regard to whether you or your dependent have been "made whole" by the Recovery. Accordingly, the Fund does not recognize the "Make Whole Doctrine." In addition, the Fund's right of first reimbursement shall not be affected, reduced, or eliminated by the comparative fault or regulatory diligence doctrines.

The Recovery also includes all monies received, regardless of how held, and includes monies directly received by the Participant or eligible dependent, as well as any monies held in any account or trust on their behalf, such as an attorney-client trust account and any monies paid to their estate or beneficiaries.

If you and/or your dependents are injured as a result of the negligence or other wrongful acts of a third party and you/your dependents apply to the Fund for benefits and receive such benefits, the Fund shall then have a first-priority lien on any Recovery for the full amount of the benefits that are paid to you and/or your dependents or paid on your behalf or on the behalf of your dependents. In addition, in the event you and/or your dependents fail to seek to recover any monies from the third party that caused the injuries, the Fund shall be subrogated to your right of recovery against that third party. You and your eligible dependents are responsible for all expenses incurred to obtain payment for third parties, including attorney fees, which amounts will not reduce the amount due to the Fund as restitution. Accordingly, the Fund expressly rejects the "Common Fund" doctrine with respect to the payment of attorney fees.

No benefits will be paid unless you sign an agreement to the subrogation rules as follows:

If you or a dependent's injury or illness was, in any way, caused by a third party who may be legally liable or responsible for the injury or illness, no benefits will be payable nor paid under

any coverage of the Fund unless you contractually agree in writing, in a form satisfactory to the Fund, to do all of the following:

- Provide the Fund with a written notice of any claim made against the third party for damages as a result of the injury or illness;
- Agree to reimburse the Fund for benefits paid by the Fund from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party or from your own uninsured or underinsured motorist, homeowners, or other insurance coverage;
- Agree that the Fund has established a lien on any Recovery, which will be kept separate from and not comingled with any other funds, and further agree that the portion of any Recovery required to satisfy the lien of the Fund shall be held in trust for the sole benefit of the Fund until such time as it is conveyed to the Fund;
- Execute a lien in favor of the Fund for the full amount of the Recovery which is due for benefits paid by the Fund;
- Periodically respond to information requests regarding the status of the claim against the third party, and notify the Fund, in writing, within 10 days after any Recovery has been obtained;
- Direct any legal counsel retained by you, or any other person acting on your behalf, to hold that portion of the Recovery to which the Fund is entitled in trust for the sole benefit of the Fund, and to comply with and facilitate the reimbursement to the Fund of the monies owed to it (as described and defined below);
- Assign, upon the Fund's request, any right or cause of action to the Fund;
- Fully cooperate with the Plan Administrator in all respects in the Fund's enforcement of its equitable (or other) rights to restitution and keep the Fund informed of any important developments in your action;
- Not settle, without the prior written consent of the Plan Administrator, any claim that you or your eligible dependents may have against a third party, including an insurance carrier;
- Agree to the entry of judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the costs of such collection, including but not limited to the Fund's attorney fees and costs; and
- Take all other action as may be necessary to protect the interests of the Fund.

If you or your dependents fail to comply with any of the requirements listed above, no benefits will be paid with respect to the injury or illness. If benefits have already been paid, they may be recouped by the Fund.

We strongly recommend that, if you are injured as a result of the negligence or wrongful act of a third party, you contact your attorney for advice and counsel. However, the Fund cannot and does not pay for the fees your attorney might charge. Should you seek to recover any monies from any third party that caused your injuries, it is the Fund's rule that you must give notice of same to the Fund Office within 10 days after either you or your attorney first attempts to recover said monies, and if litigation is commenced, you are required to give notice to the Fund of any pre-trial conferences within five days of the same. Representatives of the Fund reserve the right to attend such pre-trial conference.

The Fund's lien is contractual and is a lien on the proceeds of any compromise, settlement, judgment, and/or verdict received from either the third party or his insurance carrier. By applying for and receiving benefits from the Fund in such third-party situations, you must reimburse the Fund the full amount of the benefits that are paid to you and/or your dependents from the proceeds of any such compromise, settlement, judgment and/or verdict, to the extent permitted by law. By applying for benefits, you agree that the proceeds of any Recovery, if paid directly to you, will be held by you separate from and not commingled with any other funds, in constructive trust for the Fund.

By accepting benefits, you agree that the proceeds of any Recovery paid to any other person or entity other than you, including but not limited to, a trust, an attorney, or any agent thereof, shall be held by such other person, entity, or trust in constructive trust for the Fund. The Fund reserves the right to seek recovery from such person, entity, or trust and to name such person, entity, or trust as a defendant in any litigation arising out of the Fund's subrogation or restitution rights. By applying for benefits, you agree that, except where mandated by statute, any lien the Fund may seek will not be reduced by any attorney fees, court costs, or disbursements that you might incur in your action to recover from the third party, and these expenses may not be used to offset your obligation to reimburse the Fund for the full amount of the lien. Further, you agree that any Recovery will not be reduced by and is not subject to the application of the "Common Fund" doctrine theory for the recovery of attorney fees.

Remember, the Fund does not require you to seek any recovery whatsoever against the third party, and if you do not receive any recovery from the party, you are not obligated in any way to reimburse the Fund for any of the benefits that you applied for and accepted. However, the Fund is entitled to obtain restitution of any amounts owed to it either from third-party funds received by you or your eligible dependents, regardless of whether you or your eligible dependents have been fully restituted for losses sustained at the hands of the third party. Accordingly, in the event that you do not pursue any and all third parties and responsible sources, the Fund is authorized to pursue, sue, compromise, or settle (at the Board's discretion) any such claims on your behalf and you agree to execute any and all documents necessary to pursue said claims and, furthermore, to fully cooperate with the Fund in the prosecution of such claims. In accordance with this authority, a Fund representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Fund's equitable (or other) right to obtain restitution. To this end, by participating in the Fund, you and your eligible dependents acknowledge and agree to the terms of the Fund's equitable (or other) rights to full restitution. You and your eligible dependents also agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Plan Administrator, including the signing of any documents or agreements necessary for the Fund to obtain full restitution.

In the event you fail to notify the Fund as provided for above, and/or fail to reimburse the Fund as provided for above, the Fund reserves the right, in addition to all other remedies available to it by law or equity, to withhold any other monies that might be due you from the Fund for either past or future claims, until such time as the Fund's lien is discharged.

Any amounts received from a third party by judgment, settlement, or otherwise must be applied first to reimburse the Fund for the amount of medical expenses paid on behalf of a Participant or beneficiary. The Fund's lien is a lien of first priority. Where the recovery from the third party is partial or incomplete, the Fund's right to reimbursement takes priority over the Participant's or beneficiary's right of recovery, regardless of whether or not the Participant or beneficiary has been made whole for his/ her injuries or losses.

# FILING AN ACCIDENT-RELATED CLAIM

If your medical claim is the result of injuries suffered in an accident, you must submit details concerning the accident with the accident-related claim. (If the accident or injury is the result of a third party, you must submit a completed Accident Details/Lien and Reimbursement Agreement form (visit wgaplans.org "Forms").

# OVERPAYMENTS

If for any reason payment of benefits to an individual under the Plan exceeds the amount of benefits that should have been paid, the Trustees are entitled to take any and all actions necessary and appropriate to recover the overpayment from the Participant, dependents, and any individual. This may include withholding of future payments for the Participant and any dependents or requiring the individual to repay the overpaid benefits.

# WHEN A PLAN CHANGES OR ENDS – PLAN CHANGES OR TERMINATION

The Trustees intend to continue the benefits described in this SPD indefinitely. However, the Trustees reserve the right, in their sole and absolute discretion, to terminate the Fund in whole or in part at any time; to modify or amend the Fund in whole or in part; and to change or discontinue the type and amounts of benefits offered by the Fund and the respective eligibility rules.

You should also know the following about the benefits and eligibility rules for active, extended, retired, or disabled Health Plan Participants:

- They are not guaranteed or vested;
- They may be changed or discontinued by the Trustees;
- They are subject to the rules and regulations adopted by the Trustees;
- They are subject to the Agreement and Declaration of Trust that establishes and governs Fund operations; and
- They are subject to the provisions of any group insurance policies purchased by the Trustees.

The nature and amount of Fund benefits are always subject to the actual terms of the Fund as it exists at the time a claim occurs. If the Fund is amended or terminated, it will not affect your right to receive reimbursement for eligible expenses that you have incurred prior to the date of termination or amendment.

## AUTHENTICITY AUDITS

As set forth in the Eligibility section of this SPD (see pages 22-36), qualification for Active Coverage under the Fund is based on attaining and maintaining a specified level of covered earnings for work performed under a collective bargaining agreement with the Guild. To qualify as covered earnings, the compensation reported to the Fund must have been paid

to a covered Participant for work that constitutes paid, covered work under a collective bargaining agreement between the Guild and a valid contributing employer.

The Trustees regularly conduct authenticity audits to detect and prevent fraud, including intentional misrepresentation, and to ensure that earnings are reported and contributions are made to the Fund in accordance with the Trust Agreement, the law, and applicable collective bargaining agreements. As a part of this effort, the Trustees may review any Participant's reported earnings to confirm that they are covered earnings which should be considered in determining qualification for coverage under the Fund. Therefore, please note that the Fund may require you and your employer(s) to submit information to verify reported earnings for a specific period or periods of time. As part of such a review, the Fund may request documents including (but not limited to) copies of:

- Applicable contracts for work performed;
- Forms;
- W-2 or 1099 tax forms;
- Payment documentation for the covered work;
- Royalty agreements;
- Product; and/or work product such as scripts, including rewritten versions; or
- Documentation to verify the production, sales, or release of covered work, depending on the type of work.

If you receive a request to provide information in connection with a review and you have any questions, please contact the Fund Office at (818) 846-1015.

# ABOUT THIS SPD

This handbook serves as your guide to the medical, dental, prescription drug, vision, life insurance, and accidental death and dismemberment benefits available to eligible Plan Participants. It is your responsibility to read this handbook thoroughly.

If there is any discrepancy between the descriptions in this handbook and the official Plan documents, the official Plan documents will always govern.

If you have any questions about the information provided in this handbook, contact the Fund Office.

# CONTACT INFORMATION

| FOR INFORMATION ABOUT | CONTACT |
|---|---|
| Health Fund Eligibility<br>Dependent Enrollment<br>COBRA Continuation Coverage<br>Premium Payments (COBRA and Dependent)<br>Extended Coverage Program<br>Two-Party Team Extensions<br>Prescription Benefits<br>Dental Benefits (PPO and HMO) | **Eligibility Department**<br><br>(818) 846-1015 / (800) 227-7863<br>(Press 1, then press 2)<br><br>Email:<br>Eligibility@wgaplans.org<br><br>Fax: (818) 526-3180 |
| **FOR INFORMATION ABOUT** | **CONTACT** |
| Medical Claims Status<br>Plan Benefits<br>Coordination of Benefits<br>Life Insurance<br>Accidental Death and Dismemberment Benefits<br>Disability Extension Benefit | **Participant Services**<br><br>(818) 846-1015 / (800) 227-7863<br><br>(Press 1, then press 1)<br><br>Email:<br>ParticipantServices@wgaplans.org<br><br>Fax: (818) 566-8445 |
| **FOR INFORMATION ABOUT** | **CONTACT** |
| Pension Plan Status<br>Retirement<br>Pension Statement<br>Pension Payments<br>Tax Withholding<br>Direct Deposit of Pension<br>Reporting Death of Participant | **Pension Benefits**<br><br>(818) 846-1015 / (800) 227-7863<br>(Press 1, then press 4)<br><br>Email:<br>PensionBenefits@wgaplans.org<br><br>Fax: (818) 526-6571 |
| **FOR INFORMATION ABOUT** | **CONTACT** |
| Contributions reported on your behalf<br>(by a signatory employer)<br><br>Discrepancies<br>(missing earnings, incorrect work periods, etc.)<br><br>Contract Questions<br>(what is subject to contributions, residuals, 10% ownership, etc.) | **Employer Compliance**<br><br>(818) 846-1015 / (800) 227-7863<br>(Press 1, then press 3, then press 1)<br><br>Email:<br>EmployerCompliance@wgaplans.org<br><br>Fax: (818) 526-3197 |

| ADDITIONAL INFORMATION | |
|---|---|
| **Anthem Blue Cross – Participants residing in California**<br><br>To Locate an In-Network Provider (Participants residing in California):<br>wgaplans.org/health/providers/find_participating_providers.html<br>or<br>anthem.com/ca/health-insurance/provider-directory/searchcriteria?branding=ABC&alphaprefix=WRX<br><br>Customer Service Phone: (800) 810-2583<br><br>**For Services Received Outside Californi**<br><br>Blue Cross Blue Shield Global Core<br>(Formerly known as BlueCard Worldwide)<br><br>To Locate an In-Network Provider (outside of California):<br>bcbsglobalcore.com<br><br>Customer Service Phone: (800) 810-2583 | **Delta Dental PPO & HMO Plans**<br><br>To Locate an In-Network Provider:<br><br>Delta Dental PPO and DeltaCare HMO Plans<br><br>deltadentalins.com/directory/<br><br>Customer Service Phone:<br>(800) 765-6003<br><br>PPO Group Number: 0825 |
| **UCLA Health/TIHN Network – California only**<br><br>For Locations and Provider Information:<br><br>UCLA Health (formerly The Industry Health Network or TIHN — see page 73 for TIHN locations and phone numbers)<br><br>uclahealth.org/MPTF/ | **VSP – Vision Benefit**<br><br>To Locate an In-Network Provider & More:<br><br>vsp.com<br><br>Customer Service Phone:<br>(800) 877-7195 |
| **Express Scripts – Prescription Drug Benefit**<br><br>Pharmacy Directory, Refills, Forms, Specialty Rx & More:<br><br>wgaplans.org/health/SPD/prescription_drug_benefits_S3.html<br>or<br>express-scripts.com<br><br>Customer Service Phone: (800) 987-6551 | |

# FREQUENTLY ASKED QUESTIONS

**Q: HOW WILL A WRITER KNOW WHEN HE/SHE HAS MET THE ELIGIBILITY REQUIREMENT?**

A: The Fund Office encourages all Writers to contact the Eligibility Department to check to see if employer contributions have been reported on their behalf. We strongly suggest that the Writer ask the Fund representative for his/her "Unique Participant ID No." With this number, you can visit wgaplans.org and register with our site. Once registered, you can view reported employer contributions, update your demographic information, view the Health Fund SPD, and more.

Once a Writer qualifies (and provides the Fund Office with a current mailing address), the Eligibility Department will send the Writer an Eligibility Packet approximately 30 days before coverage begins. The Eligibility Packet will include a Notice of Eligibility which outlines the Participant's eligibility period, a set of Health Fund ID Cards, and other important information. If a Writer believes he/she has met the eligibility earnings requirement but has not received an Eligibility Packet, the Writer should contact the Eligibility Department at the Fund Office.

**Q: What about the 2023 Writer's Strike? Are there special health coverage provisions because of it and who qualifies for it?**

A: The WGA and the AMPTP agreed to extend health coverage by one quarter as part of the strike settlement terms, and the Board of Trustees has approved the request. Participants who are qualified receive an additional quarter of coverage and an additional three months added to their earnings cycle. This document will explain how the extension will work, and how it might affect writers and their dependents.

FAQ for Health Coverage Extension | PWGA Pension & Health (wgaplans.org)

**Q: CAN A WRITER MAKE UP THE DIFFERENCE IN CASH BETWEEN WHAT HE/SHE EARNED AND THE COVERED EARNINGS MINIMUM REQUIREMENT TO QUALIFY FOR BENEFITS? FOR EXAMPLE, IF A WRITER IS SHORT OF MEETING THE COVERED EARNINGS MINIMUM BY $1,000, CAN THE WRITER PAY THE $1,000 TO QUALIFY?**

A: No. The covered earnings minimum is based solely on employment covered by the collective bargaining agreement. A Writer cannot pay the Fund to make up for any shortage in order to satisfy the covered earnings minimum.

**Q: DOES A WRITER HAVE TO ACCEPT OR USE THIS COVERAGE?**

A: When a Writer has met the covered earnings minimum requirement, Health Fund coverage is automatically awarded as part of the Collective Bargaining Agreement. The covered Participant is not required to use the coverage provided by the Fund. However, if the Participant has other insurance coverage, that insurance company may require information about the Plan coverage in order to coordinate benefits.

**Q: DOES PWGA HEALTH CARE COVERAGE INCLUDE MY FAMILY?**

A: It can, but the Participant must pay the additional dependent premium ($150 per quarter). Plan coverage is only automatic for the Participant. If a Participant wants to cover his/her eligible dependents, he/she must complete a dependent enrollment form, attach copies of all required documentation, and pay the required applicable quarterly dependent coverage premium as indicated above. The only exception to the requirement for the dependent premium occurs when a Writer achieves Certified Retiree status, does not have active earned coverage, and is 65 or older.

**Q: If A PARTICIPANT PLANS ON ADOPTING, WHAT IS REQUIRED TO ADD THE ADOPTED CHILD TO PLAN COVERAGE?**

A: A Participant must take advantage of the special enrollment opportunity to enroll a newly adopted child within 30 days following the adoption or placement for adoption. Please refer to the section entitled Enrolling Dependents on page 28 for more information on how to add an adopted child.

**Q: IF A WRITER'S SPOUSE HAS COVERAGE THROUGH WORK, CAN THE SPOUSE BE COVERED UNDER THE FUND AS WELL?**

A: Yes. If you cover your spouse, you will have to pay a dependent coverage premium. Then, your spouse's coverage under the Fund can coordinate benefits after your spouse's primary health plan has paid.

**Q: CAN A PARTICIPANT COVER HIS/HER FIANCÉ?**

A: No, only a legal spouse and dependent children (including step-children, adopted children, foster children, and children under a legal guardianship) are considered eligible dependents. Please refer to the section entitled Enrolling Dependents on page 28 for more information.

**Q: HOW CAN A PARTICIPANT PAY HIS/HER DEPENDENT OR COBRA PREMIUMS?**

A: Participants have four payment options:

- Pay online at wgaplans.org.
- Pay using the PWGA App, including enrolling in AutoPay.
- Mail in a check or money order with the bottom portion of their premium invoice.
- Bring the payment to the Fund Office (check or money order only) during normal business hours.

**Q: AT WHAT AGE ARE DEPENDENT CHILDREN NO LONGER ELIGIBLE FOR COVERAGE?**

A: Dependent children will be eligible for coverage until the last day of the month in which they turn 26. However, if the dependent child is totally disabled and receiving coverage prior to age 26, the dependent child may continue to be covered, provided he/she meets the eligibility requirements for coverage under the Plan, as defined in Eligible Dependents on page 28. Please refer to that sections, in addition to the Total Disability section on page 52, for more information.

**Q: DOES THE FUND OFFER A SENIOR RATE FOR HEALTH COVERAGE?**

A: No.

**Q: IS THERE A DIFFERENT RATE FOR COBRA CONTINUATION COVERAGE FOR ONE PERSON VERSUS A FAMILY?**

A: Yes. COBRA premiums are based on Single, Two-Party, and Family Coverage.

**Q: HOW DOES THE INDUSTRY HEALTH NETWORK (TIHN) WORK?**

A: If you live, are visiting, or are working in Southern California, you can use The Industry Health Network (TIHN), acquired by UCLA. TIHN offers a wide-ranging set of resources, including access to over 200 doctors and a hospital, and the ability to use the five UCLA Health/ Motion Picture & Television Health Centers, all at substantial savings to what Health Fund Participants would normally have to pay. If you're not using TIHN, you may be missing out

on significant savings as well as access to health care. TIHN's job is to get you the best care possible. (See How the Industry Health Network Works on page 72 for details.)

**Q: IS THERE A SEPARATE DEDUCTIBLE FOR THE PRESCRIPTION DRUG PROGRAM?**

A: No.

**Q: IS TELEMEDICINE AVAILABLE FOR MEDICAL SERVICES?**

A: Yes, through Anthem LiveHealth online. Anthem's service is available to all Participants and allows you to video chat with a doctor online for only $20. The doctor is licensed in whatever state you are contacting them from, and he/she has the ability to prescribe drugs (subject to some limitations on certain classes of drugs). You just need a phone, tablet, or computer equipped with video and an internet connection (See page 100.)

**Q: IS TELEMEDICINE AVAILABLE FOR MENTAL HEALTH SERVICES?**

A: Yes, through Anthem LiveHealth online. Anthem's service is available to all Participants and allows you to talk face-to-face with a licensed therapist, psychologist, or psychiatrist for only $10. It is easy to use, private, and convenient. You can get the care you need at home, at work, and when you are on the go. There are two separate practices under LHO Psychology that treat patients – one for patients who are 10-17 years old and one for patients who are 18 and above. (See page 100.)

**Q: HOW ARE MY CLAIMS PAID IF I ALSO HAVE COVERAGE WITH ANOTHER CARRIER?**

A: The Fund will coordinate benefits with other group coverage plans. This is called coordination of benefits (COB). Specific Plan rules determine which plan pays first or how much. You cannot decide which plan pays first or second. (See page 82.)

**Q: CAN I USE MY HEALTH COVERAGE IF I'M OUT OF THE COUNTRY?**

A: Yes. If you receive care outside the country, contact the BlueCross Blue Shield Global Core Service Center for access to medical assistance services and health care providers around the world. The phone number is listed under the title "BlueCard Worldwide" or "Blue Cross Blue Shield Global Core" on the back of your Medical ID Card. (See page 79 for details.)

**Q: I HAVE THE REGULAR PPO PLAN UNDER THE HEALTH FUND. HOW DOES THE INDUSTRY HEALTH NETWORK WORK FOR ME?**

A: In the Southern California area, all industry Participants have the opportunity to use The Industry Health Network at any time. You must contact The Industry Health Network directly to set up an appointment, and all applicable copayments and benefit limitations apply. You must ensure you or your provider has obtained the appropriate referral when receiving services outside of the UCLA Health/Motion Picture & Television Health Centers, otherwise you could be responsible for cost-sharing on these services. More information can be found here: mptf.com/healthcare (See page 15).

**Q: I AM A CERTIFIED RETIREE. I HAVE COVERAGE THROUGH THE FUND, AND I DO NOT WANT TO ENROLL IN MEDICARE PART B. DO I HAVE TO?**

A: If you fail to enroll, the Fund's payment of benefits will be processed assuming you have Medicare Part A and B benefits. Thus, it is greatly to your disadvantage if you fail to enroll in Medicare Part B once you reach age 65.

**Q: WHY AM I ASKED FOR ACCIDENT INJURY INFORMATION ON CERTAIN CLAIMS?**

A: If a claim has an accident or injury diagnosis, there may be another plan or entity that should legally provide benefits. For example, if the injury is the result of an automobile

accident, a third party may be liable. In this case, the Fund must coordinate benefit payments with the auto insurance company. If a third party were liable for the accident, the third party would be responsible for paying the costs incurred as a result of the accident. In these situations, the Fund needs information from you in order to determine how your medical expenses should be paid. (See pages 215-217.)

**Q: MY CERTIFIED RETIREE HEALTH FUND COVERAGE WILL BEGIN SOON; DO I HAVE TO ENROLL IN MEDICARE PART D?**

A: No. As a Certified Retiree, you continue to receive the Plan's prescription coverage. It is considered "creditable coverage," which means that on average for all Participants it is expected to pay out as much as the standard Part D coverage. That means that you can keep this coverage and not pay a higher premium if you later decide to enroll in Medicare Part D. However, it is worth noting that if you enroll in Medicare Part D, you will lose all Plan prescription coverage for the period Medicare Part D is in effect.

**Q: DOES A NEWBORN CHILD AUTOMATICALLY HAVE COVERAGE?**

A: A newborn child is automatically covered for 31 days after birth. However, to cover the child after that, the Participant must take advantage of the special enrollment opportunity to enroll the child by submitting a completed Dependent Enrollment Form, proof of birth, and payment of the dependent coverage premium (if applicable). If you don't provide the required documentation (see page 28 for permissible temporary documentation) and premium payment (if applicable) to the Fund office within this 31 day period, you will have to wait until the next Open Enrollment period to add the dependent child to your coverage.

The definitions in this section apply whether or not the defined words are first-capitalized, bolded, or italicized when used in this handbook.

## ACA (OR THE "PPACA" OR "HEALTH CARE REFORM ACT")

The Affordable Care Act actually refers to two separate pieces of legislation – The Patient Protection and Affordable Care Act (Pub. I.111-148) and The Health Care and Education Reconciliation Act (Pub I. 111-152) that, among other things, require group health plans like the Health Plan to meet certain minimum requirements.

## ACUPUNCTURE

The stimulation of a point or points on or near the surface of the body by the insertion of needles. The purpose of acupuncture treatment is to prevent or modify the patient's perception of pain or to control pain.

## ADMISSION

Being checked into a hospital or outpatient facility. If, after you are discharged, you are re-admitted within 30 days for the same injury or illness, that admittance is considered part of the initial admission.

## ALLOWED CHARGE

The Allowed Charge is the maximum dollar amount of a charge that the Health Fund will consider (prior to application of a deductible, coinsurance, or maximum) when determining benefits payable by the Fund for eligible Medically Necessary covered services and supplies.

## AMBULATORY SURGERY CENTER

A freestanding outpatient surgical facility. An ambulatory surgery center must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also be Medicare-approved or meet accreditation standards of the Joint Commission or the Accreditation Association of Ambulatory Health Care.

## APPEAL

An individual's request to have the Fund review an adverse decision for a benefit, payment, or eligibility provision.

## ASSIGNMENT OF BENEFITS

Refers to giving a health care provider your rights under the Health Plan, such as the right to submit benefit claims, rights to coverage, or other rights. The Plan prohibits all assignments and attempts to assign benefits claims, rights to coverage, or any other type of claims. If payment is made directly to a health care provider, this is done solely as a convenience. It does not constitute an assignment of any right under the Fund or under ERISA, and it is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Fund. It is not an assignment of rights respecting anyone's fiduciary duty, it is not an assignment of any legal or equitable right to institute any court proceeding against the Fund, and it in no way shall be construed or interpreted as a waiver on the Fund's prohibition on assignments.

## BALANCE BILLING

Occurs when a health care provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. If you use an out-of-network provider, you may be balance billed by that provider. However, you may not be balance billed by an out-of-network provider if you receive services under the following circumstances:

- Emergency services at an out-of-network health care facility (unless you consented to out-of-network billing rates for certain post-stabilization services, if applicable);
- Non-emergency services from an out-of-network provider at an in-network health care facility (unless you consented to out-of-network billing rates, if applicable); and
- Out-of-network air ambulance services. If you think you have received a balance bill from an out-of-network provider in error, you may contact the Fund Office at (818) 846-1015.

## BENEFICIARY

A person who is eligible to receive Plan benefits.

## BIRTHING CENTER

A medical facility, often associated with a hospital, that is designed to provide a comfortable, home-like setting during childbirth. A birthing center is generally less restrictive than a hospital in its regulations, such as in permitting midwifery or allowing family members or friends to attend the delivery.

## BRAND-NAME DRUG

A prescription drug that is patented and subject to an exclusivity agreement, which allows the patent owner to be the sole manufacturer of the drug for a certain number of years.

## CALENDAR-YEAR DEDUCTIBLE

The portion of eligible expenses you are responsible for paying each calendar year before the Fund begins to pay certain benefits.

## CASE MANAGEMENT

A program offered by the Fund through Anthem Blue Cross which provides Participants with assistance, coordination, and management of medical care and treatment.

## CERTIFIED RETIREE

A Participant who satisfies certain requirements is designated as a Certified Retiree. (See Certified Retirees on pages 36-38 for eligibility requirements.)

## CHIROPRACTIC CARE

Care that may be provided by chiropractors acting within the licensed scope of practice, except for:

- On-site calls; and
- Exercise at a gym or similar facility.

## COBRA

The acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985, including all subsequent amendments, which allows for the purchase of coverage after loss of eligibility due to certain qualifying events.

## COINSURANCE

The percentage of eligible expenses you are responsible for paying.

## COMPLICATIONS OF PREGNANCY

Conditions requiring hospitalization (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy, or are caused by pregnancy. Examples are acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity.

The following are not considered complications of pregnancy:

- False labor;
- Occasional spotting;
- Physician-prescribed rest during pregnancy;
- Morning sickness;
- Hyperemesis gravidarum;
- Pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy;
- Elective Caesarean section;
- Ectopic pregnancy that is terminated; or
- Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

The conditions defined above are covered under the Health Plan to the same extent as any other sickness.

## COMPREHENSIVE MEDICAL REHABILITATION HOSPITAL

Hospitals that are licensed and certified facilities that provide special rehabilitative health care services rather than general medical and surgical services. Rehabilitative therapy focuses on restoring physical function and abilities lost due to an acute debilitating condition. At the onset of therapy, it is assumed that there is a reasonable expectation of complete or partial

restoration of function. In order to clarify the standards governing such coverage, the Health Plan was amended as of April 1, 2002 to provide that coverage for an admission must meet the following requirements:

- The patient has a condition that has resulted in a significant decrease in functional ability;
- There is a reasonable expectation that the patient will improve in a reasonable and generally predictable period of time, and that such recovery will be aided by the inpatient rehabilitation care;
- The intensity of service required cannot be provided in the outpatient setting;
- The patient requires and will receive multidisciplinary team care, defined as at least two therapies (e.g., speech, occupational, physical, and/or respiratory therapies) provided on a daily basis (at least three hours per day, five days per week); and
- The patient's medical condition and treatment require physician supervision at least three times per week.

## CONTRACTED RATE

The fee that is negotiated between the Health Plan and its in-network health care providers. Contracted rate applies to in-network services only.

## CONTRACEPTION

Contraception (birth control) prevents pregnancy by interfering with the normal process of ovulation, fertilization, and implantation. There are different kinds of birth control that act at different points in the process.

## COORDINATION OF BENEFITS (COB)

The payment of health care benefits when a member is covered by two or more benefit plans. One of the health plans will be primary and the other secondary. The primary plan pays first, following its rules and schedule of benefits; then the payments under the secondary plan are coordinated so that combined plan payments do not exceed 100 percent of eligible expenses.

## COPAYMENT/COPAY

A fixed dollar amount you pay for an eligible expense at the time the service is provided.

## COSMETIC SURGERY

Procedures performed primarily to make an improvement in a person's appearance. Cosmetic surgery is performed to reshape normal structures of the body to improve the patient's appearance or self-esteem. Reconstructive surgery, unlike cosmetic surgery, is covered. Reconstructive surgery is performed on abnormal structures of the body, resulting from congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. Reconstructive surgery is generally performed to improve function, but it may also be done to approximate a normal appearance.

## COVERED EARNINGS

Income for writing services covered by a collective bargaining agreement that employers report and contribute to the Fund.

## CUSTODIAL CARE

Care designed to help a person with activities of daily living. Continuous attention by trained medical or paramedical personnel is not necessary. Such care may involve:

- Preparation of special diets;
- Supervision of medication that can be self-administered; and
- Helping the person get in or out of bed, walk, bathe, dress, eat, or use the toilet.

## DEDUCTIBLE

The deductible is the amount of eligible expenses the Participant must pay before the Health Plan will pay certain benefits. The deductible is applied on a calendar year basis.

## DEDUCTIBLE CARRYOVER

This is a special provision that applies to every covered family member. If your calendar-year deductible is satisfied in the fourth quarter (i.e., October, November, and December) of a given year, the deductible will be carried over and applied to the next calendar-year deductible.

## DENTIST

A doctor of dentistry who is licensed to practice dentistry at the time and place the particular dental procedure was rendered.

## DRUG FORMULARY

A list of outpatient prescription medications, including strength and dosages, both generic and brand name, compiled by a committee of physicians and pharmacists, that is used by the Health Plan to identify medications available for use by Plan participants. The formulary approval process considers factors such as a drug's safety, effectiveness, cost-effectiveness, side effects, and therapeutic outcome. Some medications may require prior authorization.

## DURABLE MEDICAL EQUIPMENT

Equipment that is:

- Ordered by your physician;
- Used primarily for medical purposes;
- Able to withstand repeated use;
- Generally not of use in the absence of sickness or injury; and
- Appropriate for use in the home.

## ELIGIBLE DEPENDENT

Any dependent of a Participant who meets the criteria for eligibility established by the Fund.

## ELIGIBLE EXPENSE

Any Allowed Charge for Medically Necessary services or supplies which is covered in full or in part by the Health Plan.

## EMERGENCY

A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the covered person (or, with respect to a pregnant person, the health of the person or their unborn child) in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of a body part.

## EMPLOYER CONTRIBUTIONS

Contributions employers pay to the Health Fund that are based on a percentage of a Participant's covered earnings.

## ERISA (THE EMPLOYEE RETIREMENT INCOME SECURITY ACT)

A federal act passed in 1974 that established new standards and reporting/disclosure requirements for employer-funded pension and health benefit programs. ERISA provides protection for individuals in these plans.

## EXPLANATION OF BENEFITS (EOB)

An explanation of benefits (EOB) is the insurance company's written explanation regarding a claim. It lists the health care provider's charges, what the Health Plan paid, what the Plan didn't pay (with an explanation why it was not paid), and what portion of the bill is the patient's responsibility, based on his/her deductible and out-of-pocket status.

## FAMILY DEDUCTIBLE

The family deductible is the amount of covered expenses the family must pay before the Health Plan will pay any benefits. The family deductible is considered "met" once three family members have satisfied their individual deductible. The deductible is applied on a calendar year basis.

## FILED FEE

Any procedure not listed in Delta Dental's Evidence of Coverage Booklet is considered not a covered benefit and you will be charged a "Filed Fee" for that service. This means the fee your contract dentist will charge you has been filed with Delta Dental and your dentist cannot charge you more than the "Filed Fee."

## FUND

The Writers' Guild-Industry Health Fund, sometimes referred to as the Producer-Writers Guild of America (PWGA) Health Plan.

## GENERIC DRUG

A prescription drug that has the same active ingredients as a brand-name drug and is subject to the same FDA standards for quality, strength, and purity as its brand-name counterpart – but is marketed with its chemical name and typically costs less. Not all brand-name drugs have generic equivalents.

## GUILD

"Guild" shall mean the Writers Guild of America, East, Inc., the Writers Guild of America, West, Inc., or both.

## HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)

HIPAA is the acronym for the Health Insurance Portability and Accountability Act that was passed by Congress in 1996. HIPAA does the following:

- Requires the protection and confidential handling, and security of protected health information by covered entities and their business associates;
- Reduces health care fraud and abuse; and
- Mandates industry-wide standards for electronic health care information on electronic billing and other processes.

## HOME HEALTH CARE

Care and treatment of a sick or injured person in that person's home by a home health care agency. Home health care must be ordered by the sick or injured person's attending physician and approved by case management intervention.

## HOME HEALTH CARE AGENCY

A hospital, service, or agency which holds a valid certificate of approval or license, authorizing it to provide home health care services, or any establishment approved as a home health agency by Medicare.

## HOME INFUSION THERAPY

Home infusion therapy includes the administration of medications or fluids delivered intravenously, intramuscularly, or subcutaneously. It also includes the infusion of enteral nutrition delivered through a gastrostomy or jejunostomy tube, usually via infusion pump.

## HOSPICE

An agency that provides health care services for palliative treatment and supportive care of terminally ill individuals. Services may include medical social services, skilled nursing visits, intermittent visits by a nursing assistant, all equipment needed for the comfort and care of the patient, pain management, and therapy needed to maintain function and pastoral counseling. The agency that provides this service must:

- Provide on-call coverage 24 hours a day, 7 days a week;
- Provide a program of services under direct supervision of a licensed health care practitioner;
- Maintain full and complete records of all services provided to all covered persons; and
- Be established and operated in accordance with the applicable laws or regulations of the jurisdiction in which it is located.

## HOSPITAL

A facility that provides diagnosis, treatment, and care of persons who need acute inpatient care under the supervision of physicians. A hospital must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of The Joint Commission (JCAHO).

A hospital also includes:

- Psychiatric health facilities, as defined in 250.2 of the California Health and Safety Code, when service is rendered there for psychiatric or mental conditions;
- Inpatient acute care facilities for mental health and substance abuse treatment that are licensed and operated according to state and local laws; and
- Outpatient centers as defined on page 237.

## ILLNESS

A sickness or disease that causes loss covered by the Health Plan. Pregnancy is considered a sickness with respect to a covered female Participant, spouse or dependent child. Pregnancy for dependent children isn't covered, except for complications of pregnancy, abortions, and certain preventive screenings required under the Affordable Care Act.

## IN-NETWORK PROVIDERS

A group of health care providers who agree to accept your insurance by providing services at pre-negotiated rates. A health care provider network includes doctors, labs, and hospitals. Health care providers in the network sign a contract with a health plan to provide services. Getting care from in-network providers is often a good way to get quality care at a more reasonable cost.

## INJURY

Bodily harm caused by an accident. For the purposes of accidental death and dismemberment coverage, the injury must also result, directly and independently of all other causes, in a loss covered by the Plan.

## INTENSIVE CARE UNIT

A section within a hospital which operates exclusively for the care of critically ill patients and which provides special supplies, equipment, and constant observation and care by registered nurses or other highly trained hospital personnel. It is not a hospital facility maintained for the purpose of providing normal post-operative recovery treatment.

## INVESTIGATIONAL/EXPERIMENTAL TREATMENT

A treatment that fails to meet specific criteria and, except in certain situations involving organ or tissue transplants, is not covered.

A procedure will be considered non-investigational or non-experimental (and thus eligible for coverage) if it meets all of the following criteria:

- The technology has final approval from the appropriate government regulatory bodies;
- The scientific evidence permits conclusions concerning the effect of the technology on health outcomes. The evidence must include appropriate studies in peer-reviewed journals;
- The technology improves the net health outcome. Its beneficial effects should outweigh any harmful effects;
- The technology is as beneficial and cost-efficient as any established alternatives; and
- The improvement is attainable outside the investigational setting (i.e., it is being performed in additional hospitals/facilities other than the hospitals/facilities doing the investigation). When used in the usual conditions of practice, the technology must satisfy the criteria of this bullet and the one above. When the application of a technology is limited to a tertiary care environment, that technology must be in regular use in tertiary care facilities and not restricted to a single center.

## LICENSED HEALTH CARE PROVIDER

Licensed health care providers include individuals who are specially trained and credentialed to provide essential services that promote health, prevent diseases, and deliver health care services. Licensed health care providers include, but are not limited to: licensed physicians (M.D. or D.O.) and other health care providers such as nursing professionals, dentists, pharmacists, and therapists who are legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered, and who act within the scope of his/her license and/or scope of practice. Licensed health care providers also include hospitals, ambulatory surgical facilities/ centers, birthing centers, home health care agencies, hospice care, and skilled nursing facilities, as those terms are defined in this Glossary.

## MAINTENANCE MEDICATIONS

Prescription drugs that are used on an ongoing basis (e.g., thyroid replacement, diabetes, or cardiac medications).

## MEDICALLY NECESSARY

Medical treatment that satisfies the definition of "necessary treatment."

## MEDICARE

The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future. Medicare is the federal government's health insurance program for those 65 and older, individuals that are totally disabled, and those with end-stage renal disease. The different parts of Medicare include:

- Part A, which covers inpatient hospitalizations, skilled nursing facilities (SNF), hospice care, and some home health care;
- Part B, which covers outpatient care, doctor's services, medical supplies, and preventive services; and
- Part D which covers medications.

Part A is premium-free, if you or your spouse paid Medicare taxes for a certain amount of time while working and meet certain requirements. Parts B and D have a premium that you must pay, which is calculated based on your income.

## MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Mental Health Parity and Addiction Equity Act of 2008, as amended (MHPAEA) generally requires group health plans and health insurance issuers to ensure that financial requirements (such as copays and deductibles) and treatment limitations (such as visit limits) applicable to mental health and chemical dependency use disorder (MH/SUD) benefits are comparable to and no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

## MINIMUM BASIC AGREEMENT (MBA)

The 2020 Writers Guild of America Theatrical and Television Minimum Basic Agreement ("MBA"), as may be amended by the bargaining parties.

## MORBID OBESITY

A body mass index in excess of 40 or a body mass index in excess of 35 with significant co-morbid conditions. Body mass index is calculated as the weight in kilograms divided by the square of height in meters.

## NAMED EMPLOYERS

The Writer's Guild-Industry Health Fund ("Health Fund"), the Producer-Writers Guild of America Pension Plan ("Pension Plan"), the Writers Guild of America East and West, the Writers Guild Foundation; and certain temporary employees of Audacy, Inc. ("Audacy Staff Group").

## NECESSARY TREATMENT

Provision of services or supplies that the Health Fund determines to be:

- Appropriate and necessary for the diagnosis or treatment of the medical or dental condition;
- Provided for the diagnosis or direct care and treatment of the medical or dental condition;

- Within standards of good medical or dental practice within the organized medical or dental community;
- Not primarily for the patient's convenience, or for the convenience of the physician or another health care provider; and
- The most appropriate supply or level of service that can safely be provided. For hospital stays, this means that acute care as an inpatient is needed due to the kind of services the patient is receiving or the severity of the patient's condition, and safe and adequate care cannot be received as an outpatient or in a less intense medical setting.

## NO SURPRISES ACT

A federal law that may protect you from receiving surprise bills for out-of-network services in three specific situations: (1) emergency services at an out-of-network health care facility (unless you consented in writing to out-of-network billing rates for certain post-stabilization services); (2) non-emergency services provided by an out-of-network provider during your visit to an in-network facility (unless you consented in writing to out-of-network billing rates, if applicable); and (3) out-of-network air ambulance services.

## NON-COVERED EXPENSES

Services, conditions, and supplies that are not covered by the Health Plan.

## OCCUPATIONAL THERAPY

The provision, by a person acting within the licensed scope of practice or state certification, of evaluation and training in self-care, work, and play activities to increase independent function, enhance development, and prevent disability. Services may include evaluation, individualized modifications, and training of patients to use adaptive equipment for activities of daily living.

Occupational therapy services may include evaluation or work in coordination with a physical therapy provider and/or speech therapy/pathology provider. Occupational therapy services may also include environmental assessment at home, work, or school, and in other community settings to identify how multiple settings may need modification to better match a patient's abilities.

## OPEN ENROLLMENT

The period during which a Participant may add coverages of dependents, drop coverages of dependents or, the annual time period in which Participants can select among the Plans offered. The Plan's annual Open Enrollment Period is described in the Eligibility and Enrollment section of this document beginning on page 39.

## OUT-OF-NETWORK PROVIDERS

Health care professionals, hospitals, clinics, and labs that do not belong to the Plan's network and do not necessarily agree to accept your insurance. The Plan provides coverage for services received from out-of-network health care professionals, but you will typically pay more and may have to file a separate claim for reimbursement.

## OUT-OF-POCKET LIMITS

For the Coinsurance Out-of-Pocket Limit, this is the maximum amount you pay in coinsurance each Plan Year for eligible medical expenses. There are separate In-Network and Out-of-Network Limits.

For the ACA Network Out-of-Pocket Limit, this is the maximum amount you pay for your deductible, copays, and coinsurance each Plan Year for in-network eligible medical expenses, and out-of-network eligible medical expenses required to be applied to your ACA Network Out-of-Pocket Limit under the No Surprises Act.

## OUTPATIENT CENTER

A freestanding center or entity within a hospital which is approved and licensed by the state to provide outpatient diagnostic services or surgical treatment of an illness or injury.

## PCP

The acronym for primary care physician.

## PEDIATRIC CARE

Treatment of a patient under the age of 18.

## PHYSICAL THERAPY

The provision, by a person acting within the licensed scope of practice, of evaluation and training in muscle strengthening, neuromuscular reeducation, and ambulation training. Services may include ambulation aids, such as walkers, wheelchairs, and devices to assist with transferring a patient, such as lifts. Services may also include therapeutic interventions related to strength and mobility; teaching of in-home exercises; use of modalities such as ultrasound, hot packs/cold packs, galvanic stimulation, and TENS units; and assessment of equipment needs.

## PLAN

The group of benefits provided by the Fund. The Plan is subject to change by the Trustees.

## PPO

An acronym for Preferred Provider Organization.

## PREAUTHORIZATION

Preauthorization, sometimes referred to as “precertification,” is the process used to confirm if a proposed service or procedure is a Medically Necessary health care service. Preauthorization, when required, should occur before treatment is received, except in an emergency.

## PREDETERMINATION OF BENEFITS

The process of obtaining certification or authorization from the Plan for a procedure before it is performed.

## PREFERRED PROVIDER ORGANIZATION (PPO)

A medical plan with a network of doctors, hospitals, and other health care providers who have agreed to provide their services at contracted rates. Each time you need medical care, you may go to an in-network or an out-of-network provider.

## PREVENTIVE MEDICINE

The ACA provides for preventive services with no shared costs for the Participant.

## PRIMARY CARE PHYSICIAN

A physician within the Plan's network who you've selected to coordinate all of your medical care. This includes providing routine medical services and referring you to a specialist, if necessary.

## QUALIFYING PAYMENT AMOUNT

Qualifying Payment Amount (QPA) means the Fund's median contracted rate for the item or service in the same geographic region, as adjusted under DOL Regulation 2590.716-6(c).

## REFERRAL

A recommendation from a licensed health care provider, acting within the scope of his/her license, for services to another licensed health care provider.

## SECOND OPINION

The evaluation by another qualified surgeon to obtain an opinion on the most appropriate course of treatment, following an initial surgery recommendation.

## SKILLED NURSING FACILITY

A facility that is certified by Medicare to provide 24-hour nursing care and rehabilitation services in addition to other medical services.

## SMART90

Smart90 is a maintenance medication program offered through ESI that allows you to fill a 90-day prescription (with up to three refills) at participating retail pharmacies (e.g., Walgreens, Duane Reade, and Happy Harry's) for maintenance medication(s) that would otherwise be filled through mail order.

## SPECIAL ENROLLMENT, SPECIAL ENROLLEE, OR SPECIAL ENROLLMENT RIGHT

The right you and/or your dependents have to enroll in the Fund outside the period when you and/or your dependents were initially eligible to participate and Open Enrollment period when certain life events occur. (Refer to the Life Events section on pages 32-34.)

## SPEECH THERAPY/SPEECH PATHOLOGY

The evaluation and treatment of communication and swallowing disorders by a person acting within the scope of licensed practice. Services provided may involve measurement, testing, identification, prognosis, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of identifying, preventing, and rehabilitating such disorders. Services may include evaluation of patients for augmentative/alternative communication systems, evaluation of verbal and written language reception and expression, and evaluation of cognitive processing of language.

## TOTAL DISABILITY

"Total disability," or "totally disabled" as used in Section Two: Eligibility and Enrollment, means:

- For an active Participant, the inability to perform the substantial and material duties of his/her occupation or employment. The inability must directly result from a non-occupational physical or mental injury or illness;
- For a Certified Retiree and for a dependent spouse, the inability to engage in the substantial and material activities engaged in before the start of the disability. The inability must directly result from a non-occupational physical or mental injury or illness; or
- For a dependent child, the inability of the covered dependent child to perform the normal activities or duties of a person of the same age and gender. The inability must directly result from a non-occupational physical or mental injury or illness.

"Total disability" or "totally disabled" as used in Section Ten: Protection Benefits, means the inability to engage in any occupation for wage or profit for which you are reasonably qualified by reason of education, training, or experience. The inability must be as a result of injury or sickness and must be verified by an attending physician's statement. A total disability may be a permanent disability or a temporary disability.

## UNION

"Union" shall mean the Writers Guild of America, East, Inc. or the Writers Guild of America, WestInc.

## URGENT CONDITION

A condition that is not as serious as an emergency medical condition, but that still requires immediate medical treatment, such as an ear infection, a sprain, a urinary tract infection, a simple bone break (e.g., toe, finger), a minor burn, or back pain.

## A



## B



## C



## D

## V



## W

# ADDITIONAL INFORMATION – CERTIFIED RETIREE BENEFITS FOR EMPLOYEES UNDER THE AUDACY STAFF GROUP EMPLOYEE AND KNX DAILY RATE EMPLOYEE AGREEMENT

## ADDITIONAL REQUIREMENTS FOR EMPLOYEES WORKING UNDER THE WGA-AUDACY NATIONAL AGREEMENT

The Board of Trustees of the Fund adopted a change to these rules solely for Participants who:

1. Were or are covered under the Fund on or after March 1, 2000 due to their employment as an Audacy staff employee covered under the 1999-2002 WGA-Audacy National Staff Agreement or any subsequent WGA-Audacy National Staff Agreement (a "Audacy Staff Employee"); or

2. Were or are covered under the Fund on or after July 1, 2007 due to their employment as a KNX Daily Rate Employee, as defined under Article XVII.C. of the 2005-2008 WGA-Audacy National Agreement or any successor of that Article in any subsequent WGA-Audacy National Agreement ("KNX Daily Rate Employee"); or

3. Were or are covered under the Fund on or after April 2, 1996 due to their employment as an Audacy temporary employee covered under the WGA-Audacy 1996-1999 National Agreement or any subsequent WGA-Audacy National Agreement (a "Audacy Temporary Employee")

If an individual was a Participant in the Fund due to their employment with Audacy as an (i) Audacy Staff Employee or KNX Daily Rate Employee on or after March 1, 2000; or (ii) KNX Daily Rate employee on or after July 1, 2007; or (iii) as an Audacy Temporary Employee on or after April 2, 1996, the following rules apply to determine whether such individual will be considered a Certified Retiree:

- Are at least 60 years old;
- Retired under the Producer-Writers Guild of America Pension Plan or retired from Audacy as evidenced by an affidavit filed with the Writers' Guild-Industry Health Fund;
- Accumulated at least 68 quarters of earned eligibility before your retirement, calculated as follows:
    - A Qualified Year under the Producer-Writers Guild of America Pension Plan for each year before 1988 equals four quarters of eligibility , provided, however, that you shall not be entitled to earned eligibility quarters for any Qualified Year you earned prior to 1988 based on employment with an employer who did not make contributions on your behalf to the Writers' Guild-Industry Health Fund and who appears on the following list of employers: American Broadcasting Corporation News, CBS TV Network News NY (Daily Temps), Metromedia Inc., RKO General Inc., United Stations Radio Network, WABC-AM Radio, Inc., WNYW-5 Fox TV, W.O.R. A.M. Radio, WWOR-TV Inc.;
    - Each year of eligibility earned under the Writers' Guild-Industry Health Fund during 1988 and every year thereafter (other than as an Audacy Staff Employee or a KNX Daily Rate Employee) equals four quarters of eligibility; and

- Each year of eligibility earned under the Writers' Guild-Industry Health Fund as an Audacy Staff Employee starting on March 1, 2000 and thereafter or as a KNX Daily Rate Employee starting July 1, 2007 and thereafter equals four quarters of eligibility. The following additional rule applies to Audacy Staff Employees and KNX Daily Rate Employees who, for any year on or after the relevant dates listed above, are eligible for less than a year of coverage under the Writers' Guild-Industry Health Fund due to employment as an Audacy Staff Employee or KNX Daily Rate Employee, and whose eligibility for coverage is not based on meeting a certain level of earnings: an individual who earns $5,000 of "gross compensation" in a year from employment as an Audacy Staff Employee or KNX Daily Rate Employee shall be deemed to earn a year of eligibility under the Writers' Guild-Industry Health Fund in accordance with the preceding sentence. For this purpose, "gross compensation" shall mean the amount of compensation upon which Employer Contributions are based, as set forth in the applicable collective bargaining agreement.

An Audacy Staff Employee, KNX Daily Rate Employee, or Audacy Temporary Employee who is eligible for Certified Retiree coverage, but is not retiring under the Producer-Writers Guild of America Pension Plan shall be required to file a fully completed application packet (on forms prepared by the Trustees of the Fund) with the Trustees at least thirty (30) days prior to the date selected by such Audacy Staff Employee, KNX Daily Rate Employee or Audacy Temporary Employee for such Certified Retiree coverage to commence.

**PWGA PENSION & HEALTH PLANS**
2900 W. Alameda Avenue, Suite 1100
Burbank, CA 91505-4267
(818) 846-1015 • (800) 227-7863
*wgaplans.org*