

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”, “Health Plan” or “Plan”) in effect as of May 1, 2013. This SPD constitutes the Fund’s Plan document and supercedes all prior SPDs, plan rules and other notices for health coverage rendered or received on or after May 1, 2013. As such, this handbook 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 May 1, 2013, please refer to the Fund’s prior SPD, notices and documents for the applicable period. The SPD (and prior SPD and correspondence about the Fund) is also available on the Fund’s Website at www.wgaplans.org.

We encourage you to review this handbook carefully so that you are aware of all the benefits to which you are entitled, as well as some important restrictions and responsibilities. In its preparation, our goal has been 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 124 of this handbook.

Periodically, changes are made to the Health Plan. As a participant, you are notified through a Summary of Material Modification (“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 in the front pocket of this handbook.

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 Administrative Office are there to assist you, but have no authority to alter those benefits or eligibility rules. Any interpretations or opinions given by employees of the Administrative 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 decide on a participant’s entitlement to or application for benefits under the Health Plan, and any such decision of the Trustees or the Benefits Committee is final and binding upon all affected parties. The Trustees and the Benefits Committee are authorized and empowered generally to do all things, execute all such agreements, adopt and promulgate all such reasonable rules and regulations, take all such proceedings and exercise all such rights and privileges as are necessary in the establishment, maintenance and administration of the Health Plan.

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.

The benefits described in this handbook may be reduced, modified or discontinued by action of the Trustees (or their authorized designee) at any time. These benefits and eligibility to receive these benefits are not guaranteed and may be changed at any time.

If you have any questions about any terms of your coverage in general, please call the Administrative Office at **(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 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 “Union”), which are separate entities). Accordingly, if you have a question regarding your benefits under the Fund, please do not contact the Union. Instead, all questions concerning the Fund should be directed to the 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. 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 Union 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 CBS Broadcasting Inc. (“CBS Staff Group”).* 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.

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 5:00 p.m. Hora estándar del Este, o visite una de las oficinas de Writers’ Guild-Industry Health Fund:

Writers’ Guild-Industry Health Fund
1015 North Hollywood Way
Burbank, CA 91505
8:30 a.m. a 5:00 p.m.
Hora estándar del Pacífico

*The CBS Staff Group includes both regular full-time staff and temporary employees of CBS Broadcasting Inc., who meet the requirements of Article II, Section 1(e)(2) of the Pension Plan and participate in the Writers’ Guild-Industry Health Fund. The CBS Staff Group is a “Named Employer” pursuant to a Collective Bargaining Agreement.

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HANDBOOK SUMMARY



YOUR HEALTH AND LIFE BENEFITS ARE AN IMPORTANT PART OF THE ADVANTAGES OF WORKING IN COVERED EMPLOYMENT. TO MAKE THE MOST OF THESE BENEFITS, YOU NEED TO UNDERSTAND HOW THEY WORK AND HOW TO USE THEM.

THAT'S WHERE THIS HANDBOOK CAN HELP. IT CONTAINS INFORMATION YOU NEED TO KNOW ABOUT YOUR HEALTH CARE AND LIFE INSURANCE BENEFITS.

SECTION 1

SUMMARY OF BENEFITS

This section provides you with a guide to the medical, mental health and chemical dependency, vision, prescription drug and dental benefits available to eligible participants in the Writers' Guild-Industry Health Fund and the plan contact information. **Starting on page 6.**

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 17.**

SECTION 3

MEDICAL, CHEMICAL DEPENDENCY, VISION, AND PRESCRIPTION DRUG BENEFITS

This section explains the benefits available for the PPO and the Low Option Plans. The section is filled with tips to help you get the most from the plan and displays a comprehensive listing of what's covered and what's not covered under the Health Plan. **Starting on page 40.**

SECTION 4

DENTAL BENEFITS

This section explains the dental benefits available under the PPO and HMO plans (the Dental HMO is available in California only), which expenses are covered and which are not. **Starting on page 78.**

SECTION 5

WHAT ELSE YOU SHOULD KNOW ABOUT YOUR HEALTH CARE PLANS

This section explains legal provisions describing certain rights you have to benefits under the Federal Law. **Starting on page 94.**

SECTION 6

PROTECTION BENEFITS

This section explains life and accidental death and dismemberment benefits. **Starting on page 98.**

SECTION 7

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 101.**

SECTION 8

OTHER RESOURCES

This section contains answers to Frequently Asked Questions (FAQ). **Starting on page 122.**

SECTION 9

GLOSSARY

This section contains the glossary of plan language terms. **Starting on page 124.**

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Starting on page 132.

SUMMARY of Benefits

The Summary Plan Description (“SPD”) along with this **Summary of Benefits** (“SOB”), will serve as your guide to the medical, vision, prescription drug, dental, mental health and chemical benefits available to eligible participants in the Writers’ Guild-Industry Health Fund (“Fund”). The SOB contains details about (1) your earnings requirement, (2) dependent coverage premiums, (3) benefit levels for each plan, and (4) plan contact information.

The SOB does not serve as a guarantee of benefits. Services are either subject to preauthorization or medical necessity review. The benefits outlined may change from time to time. Terms not specifically defined herein shall have the meaning assigned to them in the SPD. The Trustees reserve the right to terminate or change any part or all of any of the health plans offered under the Fund at any time. Benefit changes will periodically be communicated to you by letter, SMM, newsletter, or our website at www.wgaplans.org, between publications of updates of this SOB.

	MEDICAL, MENTAL HEALTH AND CHEMICAL DEPENDENCY				
	PPO PLAN			LOW OPTION PLAN ¹	
	NETWORK PROVIDER ²	NON-NETWORK PROVIDER ³	OUT OF AREA (For participants who live over 25 miles outside the PPO service area of 2 providers) ^{3,4}	NETWORK PROVIDER ²	NON-NETWORK PROVIDER ³
PLAN FEATURES					
Calendar-Year Deductible ⁵	\$300/person; \$900/family	\$300/person; \$900/family	\$300/person; \$900/family	\$750/person; \$2,250/family	\$750/person; \$2,250/family
Out-of-Pocket Maximum ^{6,7,8}	\$1,000/person	\$2,500/person	\$1,000/person	\$4,500/person	\$6,000/person
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

IMPORTANT!

Note: All services are subject to medical necessity review at the time of payment.

- ¹ For COBRA participants and Extended Coverage participants only.
- ² Benefits for services received from a network provider will be paid based on the contracted rate.
- ³ Benefits for services received from non-network and out-of-area providers will be paid based on reasonable and customary (R&C) allowances. The participant is responsible for any amount over the R&C.
- ⁴ The participant must contact the Fund office to determine if the provider qualifies for the out-of-area benefit. If the provider is approved, the participant is responsible for filing claims with the Fund to receive benefit reimbursement.
- ⁵ All plan benefits are paid after the deductible, unless otherwise noted.
- ⁶ Calendar-year deductible, office visit and hospital copays do not apply toward the out-of-pocket maximum. When the out-of-pocket maximum is reached, benefits are payable at 100% of R&C allowances or the contracted rate (whichever applies) for the rest of the calendar year.
- ⁷ The out-of-pocket maximum (after deductible) for Medicare-eligible Certified Retirees who retired prior to March 1, 1997, and are receiving a benefit from the Producer Writers Guild of America Pension Plan of less than \$800 per month, is \$400 for network providers (with coverage at 85%) and \$600 for non-network providers (with coverage at 70%).
- ⁸ Both network and non-network charges apply toward your out-of-pocket maximum, unless otherwise noted.

SUMMARY OF BENEFITS

Eligibility Earnings Minimum (effective 7/1/10):	\$32,700 (One hour network prime-time story and teleplay)
Eligibility Earnings Minimum (effective 7/1/11):	\$34,355 (One hour network prime-time story and teleplay)
Eligibility Earnings Minimum (effective 7/1/12):	\$34,956 (One hour network prime-time story and teleplay)
Eligibility Earnings Minimum (effective 7/1/13):*	\$35,568 (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

*Subject to increase or decrease, not to exceed 0.5% to the Health Fund.

	MEDICAL, MENTAL HEALTH AND CHEMICAL DEPENDENCY				
	PPO PLAN			LOW OPTION PLAN ¹	
	NETWORK PROVIDER ²	NON-NETWORK PROVIDER ³	OUT OF AREA (For participants who live over 25 miles outside the PPO service area of 2 providers) ^{3,4}	NETWORK PROVIDER ²	NON-NETWORK PROVIDER ³
PHYSICIAN SERVICES					
Doctor's Office Visit ⁹	85% ¹¹	70%	80%	70% ¹¹	60%
Periodic Health Assessment	Covered under Wellness Benefits ^{10,11}	Covered under Wellness Benefits ¹⁰	Covered under Wellness Benefits ¹⁰	Not covered ¹¹	Not covered
Well Baby Care	85% ¹¹	70%	80%	70% ¹¹	60%
Childhood Wellness Visits, including Immunizations					
• Through age 6	85% ¹¹	70%	80%	70%	60%
• Ages 7 and older	Covered under Wellness Benefits ^{10,11}	Covered under Wellness Benefits ¹⁰	Covered under Wellness Benefits ¹⁰	Not covered ¹¹	Not covered
Adult Immunizations	Covered under Wellness Benefits ^{10,11}	Covered under Wellness Benefits ¹⁰	Covered under Wellness Benefits ¹⁰	Not covered ¹¹	Not covered

⁹ Includes lab work and X-rays.

¹⁰ See Wellness Benefits, page 12.

¹¹ See Preventive Care Benefits Services, page 10. Some or all of the services in this section may be covered under the Preventive Care Service Benefits, payable at 100%, no deductible, when seen by a network provider.

	MEDICAL, MENTAL HEALTH AND CHEMICAL DEPENDENCY				
	PPO PLAN			LOW OPTION PLAN	
	NETWORK PROVIDER ²	NON-NETWORK PROVIDER ³	OUT OF AREA (For participants who live over 25 miles outside the PPO service area of 2 providers) ^{3,4}	NETWORK PROVIDER ³	NON-NETWORK PROVIDER ³
PHYSICIAN SERVICES					
Maternity Care ¹²	85% ¹¹	70%	80%	70% ¹¹	60%
Inpatient / Outpatient Physician Services	85% ¹³	70%	80%	70% ¹³	60%
Inpatient Routine Nursery Visits and Room and Board ¹⁴	85%	70%	80%	70%	60%
Other Physician Services	85% ¹¹	70%	80%	70% ¹¹	60%
Surgery ¹⁵	85%	70%	80%	70%	60%
HOSPITAL SERVICES					
Emergency Room	85% after \$50 copay (copay is waived if admitted; hospital admission copay applies)	70% ¹⁸ after \$50 copay (copay is waived if admitted; hospital admission copay applies)	80% ¹⁸ 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)	60% ¹⁸ after \$50 copay (copay is waived if admitted; hospital admission copay applies)
Inpatient Services ^{16, 17}	85% after \$100 copay/admission	70% after \$100 copay/admission	80% after \$100 copay/admission	70% after \$100 copay/admission	60% after \$100 copay/admission
Outpatient Services ^{11, 17}	85% ¹¹	70%	80%	70% ¹¹	60%
Outpatient Lab Work and X-rays	85% ¹¹	70%	80%	70% ¹¹	60%
Skilled Nursing Facility ^{17, 23}	85% after \$100 copay/admission	70% after \$100 copay/admission	80% after \$100 copay/admission	70% after \$100 copay/admission	60% after \$100 copay/admission

¹² Includes prenatal care, delivery and postnatal care of a physician-delivered baby.

¹³ Non-network anesthesiologists, radiologists and pathologists are payable at 85% of R&C under the PPO plan or 70% of R&C under the Low Option plan, if services are rendered at a network facility by a network physician.

¹⁴ Inpatient hospital copay applies to the facility fees associated with the baby's facility charges.

¹⁵ Assistant surgeons will be considered at a reduced benefit level that is equal to 20% of the surgeon's contract or R&C allowances.

¹⁶ Includes semi-private room and board within plan limits and ancillary services.

¹⁷ Preauthorization review is required for all inpatient and outpatient treatment facilities, such as partial hospitalization, residential day treatment and intensive outpatient programs.

¹⁸ Emergency room services may qualify for network coinsurance if emergency care definition is met. See SPD page 48 for definition.

SUMMARY OF BENEFITS

	MEDICAL, MENTAL HEALTH AND CHEMICAL DEPENDENCY				
	PPO PLAN			LOW OPTION PLAN ¹	
	NETWORK PROVIDER ²	NON-NETWORK PROVIDER ³	OUT OF AREA (For participants who live over 25 miles outside the PPO service area of 2 providers) ^{3, 4}	NETWORK PROVIDER ²	NON-NETWORK PROVIDER ³
OTHER MEDICAL SERVICES					
Alternative Medicine <ul style="list-style-type: none"> • Acupuncture¹⁹ • Biofeedback²⁰ • Chiropractic²¹ • Lymphedema Therapy²⁰ • Occupational Therapy²⁰ • Osteopathic Manipulative Treatment • Outpatient Physical Therapy²⁰ • Orthoptic Training 	85% of \$60 allowable/visit; one monthly re-exam to monitor progress	70% of \$60 allowable/visit; one monthly re-exam to monitor progress	80% of \$60 allowable/visit; one monthly re-exam to monitor progress	70% of \$60 allowable/visit; one monthly re-exam to monitor progress	60% of \$60 allowable/visit; one monthly re-exam to monitor progress
Ambulance	80%	80%	80%	70%	60%
Air or Sea Ambulance	85% \$5,000/incident maximum	70% \$5,000/incident maximum	80% \$5,000/incident maximum	70% \$5,000/incident maximum	60% \$5,000/incident maximum
Ambulatory Surgery Center	85%	70% \$1,500/ incident maximum	80% \$1,500/ incident maximum	70%	60% \$1,500/ incident maximum
Electro-Convulsive Therapy (ECT)	85%	70%	80%	70%	60%

IMPORTANT!

Note: All services are subject to review for medical necessity at the time of payment.

¹⁹ For chronic pain control only.

²⁰ A referral is required from a doctor of medicine (M.D.).

²¹ Manipulation of the musculoskeletal system.

	MEDICAL, MENTAL HEALTH AND CHEMICAL DEPENDENCY				
	PPO PLAN			LOW OPTION PLAN ¹	
	NETWORK PROVIDER ²	NON-NETWORK PROVIDER ³	OUT OF AREA (For participants who live over 25 miles outside the PPO service area of 2 providers) ^{3,4}	NETWORK PROVIDER ²	NON-NETWORK PROVIDER ³
OTHER MEDICAL SERVICES					
Enhanced External Counterpulsation Therapy (EECP)	85%	70%	80%	70%	60%
Hearing Aids	50% ^{22, 27}	50% ^{22, 27}	50% ^{22, 27}	50% ^{22, 27}	50% ^{22, 27}
Home Health ²³ Care and Home Infusion Therapy	Preauthorization Required - 85%	Preauthorization Required - 70%	Preauthorization Required - 80%	Preauthorization Required - 70%	Preauthorization Required - 60%
Hospice Care ²³	Preauthorization Required - 85%	Preauthorization Required - 70%	Preauthorization Required - 80%	Preauthorization Required - 70%	Preauthorization Required - 60%
Infertility Treatment	Not covered	Not covered	Not covered	Not covered	Not covered
Inversion Device	85%; \$500 / per device and a Rx from an M.D. is required	70%; \$500 / per device and a Rx from an M.D. is required	80%; \$500 / per device and a Rx from an M.D. is required	70%; \$500 / per device and a Rx from an M.D. is required	60%; \$500 / per device and a Rx from an M.D. is required
Preventive Care Services	100% of certain Preventive charges as identified by Federal Law	Not available	Not available	100% of certain Preventive charges as identified by Federal Law	Not available
Routine Mammograms	Covered under Preventive Care ¹¹	Covered under Wellness Benefits ^{10, 24}	Covered under Wellness Benefits ^{10, 24}	Covered under Preventive Care ¹¹	60%
• Under 35	Not covered	Not covered	Not covered	Not covered	Not covered
• Ages 35-39	1 every 5 years	1 every 5 years	1 every 5 years	1 every 5 years	1 every 5 years
• Age 40 & Over	1 every year	1 every year	1 every year	1 every year	1 every year

IMPORTANT!

Inpatient, outpatient facility, Home Health Care, Hospice, Home Infusion Therapy, Skilled Nursing Facility and Transplant Services must be preauthorized through Anthem Blue Cross. Network services that are considered Preventive Care Services as identified by the Federal Law are not subject to a copay or annual deductible. Effective 1/1/13 this includes Women's Preventive Care: For additional details, see pages 69-72 or <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>.

²² Covers up to a maximum allowable charge of \$2,000 per device. A prescription from a doctor of medicine (M.D.) is required.

²³ Please have your provider contact the Fund's Utilization Administrator (Anthem Blue Cross) to facilitate your care through Case Management Intervention. On the backside of your Medical ID card, you will find the phone number for Preauthorization or Pre-Service Review.

²⁴ If the Wellness Benefit maximum is exhausted, wellness care expenses will be considered under the medical plan, subject to the annual deductible, medical necessity review and plan cost sharing requirements. (Doesn't apply to Low Option Plan and Preventive Care Service benefits.)

SUMMARY OF BENEFITS

	MEDICAL, MENTAL HEALTH AND CHEMICAL DEPENDENCY				
	PPO PLAN			LOW OPTION PLAN ¹	
	NETWORK PROVIDER ²	NON-NETWORK PROVIDER ³	OUT OF AREA (For participants who live over 25 miles outside the PPO service area of 2 providers) ^{3,4}	NETWORK PROVIDER ²	NON-NETWORK PROVIDER ³
OTHER MEDICAL SERVICES					
Speech Therapy (subject to plan restrictions) ²⁰	85% 100 visits/ calendar year 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.	70% 100 visits/ calendar year 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.	80% 100 visits/ calendar year 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.	70% 100 visits/ calendar year 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.	60% 100 visits/ calendar year 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.
Transplant Services ²³	Preauthorization Required - 85%	Preauthorization Required - 70%	Preauthorization Required - 80%	Preauthorization Required - 70%	Preauthorization Required - 60%
Treatment of TMJ Dysfunction	85% for X-rays and 6 physiotherapy visits	70% 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
Vision Benefits ²⁵	85% for exam, lenses, frames and contacts up to \$200/person/ calendar year ¹¹	85% for exam, lenses, frames and contacts up to \$200/person/ calendar year	85% for exam, lenses, frames and contacts up to \$200/person/ calendar year	Not covered ¹¹	Not covered

²⁵ The per-person annual dollar limit will not apply to essential pediatric vision care for dependent children under the age of 18.

	MEDICAL, MENTAL HEALTH AND CHEMICAL DEPENDENCY				
	PPO PLAN			LOW OPTION PLAN ¹	
	NETWORK PROVIDER ²	NON-NETWORK PROVIDER ³	OUT OF AREA (For participants who live over 25 miles outside the PPO service area of 2 providers) ^{3,4}	NETWORK PROVIDER ²	NON-NETWORK PROVIDER ³
OTHER MEDICAL SERVICES					
Wellness Benefits ^{24, 10} (Ages 7 and older; refer to SPD for covered services)	\$500/person or \$1,500/family/ calendar year for specific wellness care expenses covered at 100% up to this limit ¹¹	\$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 ¹¹	Not covered
PRESCRIPTION DRUGS^{26, 27}					
Retail (up to a 30-day supply)					
• Generic	\$10 copay ³¹	\$10 copay ²⁸	\$10 copay	Not covered ³¹	Not covered
• Preferred Brand	\$15 copay ³¹	\$15 copay ²⁸	\$15 copay		
• Non-Preferred Brand ^{29, 30}	\$25 copay ³¹	\$25 copay ²⁸	\$25 copay		
Mail Order (up to a 90-day supply) ³²					
• Generic	\$20 copay ³¹	\$20 copay ²⁸	\$20 copay	Not covered ³¹	Not covered
• Preferred Brand	\$30 copay ³¹	\$30 copay ²⁸	\$30 copay		
• Non-Preferred Brand ^{29, 30}	\$36 copay ³¹	\$36 copay ²⁸	\$36 copay		

IMPORTANT!

Services under the Wellness and Preventive Care Services Benefits are not subject to a copay or annual deductible.

²⁶ Subject to coordination of benefits provision.

²⁷ Does not count toward the out-of-pocket maximum.

²⁸ 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.

²⁹ Brand-name copay applies only when doctor specifies "Dispense As Written" (DAW) on the prescription and no generic equivalent is available.

³⁰ If a generic equivalent is available, patient pays generic copay plus the cost difference between generic drug and brand-name drug even if the doctor specifies "Dispense as Written" (DAW) on the prescription.

³¹ Over-the-counter drugs allowed under the Preventive Care Services Benefits are administered by Express Scripts. See list of eligible preventive care benefits, pages 70-72.

³² Using the mail-order service is mandatory for maintenance medications.

THE INDUSTRY HEALTH NETWORK

*Participants can take advantage of significant savings available to you when you use **The Motion Picture & Television Fund (MPTF) Health Centers (TIHN - The Industry Health Network)**, available only in Southern California. First, you must choose a primary care physician (PCP). Then, your PCP will treat you directly, coordinate your care and, if necessary, refer you to a TIHN specialist. Without a Primary Care Physician's referral, your standard Writers' Guild-Industry Health Fund (Fund) benefits will apply, including your deductible and co-insurance. No enrollment is required to use this benefit.*

- ▶ All TIHN benefits are subject to the maximums and limitations listed in this **Summary of Benefits** and your Health & Life Summary Plan Description.
- ▶ All claims from a TIHN specialist must be submitted with the referral number assigned by MPTF.
- ▶ The Preventive Care Services (pages 69-72) 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, they will provide you with a medical order³⁶ rather than a referral. At this time, behavioral health services will not be part of the TIHN referral program.
- ▶ Referral from a TIHN primary care physician does not guarantee payment. All services are subject to medical necessity.

PLAN BENEFITS	WHEN YOU USE THE INDUSTRY HEALTH NETWORK
PCP Office Visit ¹¹	\$10 copay
Specialist Office Visit ³³	\$10 copay
Periodic Physical Exam ^{11, 34}	No copay
Well Child Care/Pediatric Visit ^{11, 35}	\$10 copay
Lab Work/X-rays ^{11, 33}	100%
Physical Therapy ³³	\$10 copay
Hospitalization ³³	100% after \$100 copay/admission
Surgery ³³	100% after \$100 copay
Anesthesiology ³³	100%

³³ Requires a written referral from your PCP. (This only applies to specialist charges.)

³⁴ \$200 is applied to your Wellness Benefit. Wellness Benefit for over age 7 only.

³⁵ For children under the age of 13, the participant must call The Industry Health Network Customer Service Department at (800) 876-8320 for a referral to see a pediatric physician.

³⁶ A medical order is a treatment recommendation that requires self-referral to a behavioral physician.

DENTAL BENEFITS

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

	DELTA PREFERRED OPTION (DPO)			DELTACARE
	DPO PROVIDER	DELTA DENTAL PROVIDER (NOT PART OF DPO NETWORK)	NON-NETWORK PROVIDER	DHMO ^{37, 38} (APPLIES TO 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 Maximum • Diagnostic, Preventive, Basic and Major Services • Orthodontia	\$2,500/calendar year ³⁹ Coverage for children up to the age 19	\$2,500/calendar year ³⁹ Coverage for children up to the age 19	\$2,500/calendar year ³⁹ Coverage for children up to the age 19	None
PLAN BENEFITS				
Diagnostic and Preventive Benefits	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 ⁴⁰ (EOC) Schedule A for a description of benefits and copayments)
Basic and Major Benefits	80% of DPO-approved fee	70% of Delta-approved fee	70% of Delta-approved fee; you pay remaining 30% plus fees above approved amount	(See Delta Dental's Evidence of Coverage ⁴⁰ (EOC) Schedule A for a description of benefits and copayments)

IMPORTANT!

The following are covered under the Preventive Care Services benefit at 100%, with no deductible:

- Fluoride supplements for children without fluoride in their local water supply.
- Oral health risk assessment for young children

³⁷ Services received from a non-network dentist are not covered, except in an emergency if your DeltaCare dentist is unavailable or cannot see you within 24 hours of making contact or you believe your condition makes it dentally/medically inappropriate to travel to your contracted dentist to receive emergency services.

³⁸ The plan will reimburse up to \$100 of non-network emergency dental care per emergency, per enrollee, less any applicable copayment.

³⁹ Plan maximum annual dollar limit does not apply to dependent children under the age of 18.

⁴⁰ The Delta Dental EOC was distributed at the time of enrollment. If another copy is needed, contact DeltaCare USA Customer Relations at (800) 422-4234 or website, www.wgaplans.org.

DENTAL BENEFITS				
	DELTA PREFERRED OPTION (DPO)			DELTACARE
	DPO PROVIDER	DELTA DENTAL PROVIDER (NOT PART OF DPO NETWORK)	NON-NETWORK PROVIDER	DHMO ^{37, 38} (APPLIES TO CALIFORNIA)
PLAN BENEFITS				
Orthodontia Benefits	70% of DPO-approved fee (Coverage for children up to age 19) ⁴¹	70% of Delta-approved fee (Coverage for children up to age 19) ⁴¹	70% of Delta-approved fee (Coverage for children up to age 19) ⁴¹	<ul style="list-style-type: none"> 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) 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 ⁴²	Percentage of approved fee varies based on type of service	Percentage of approved fee varies based on type of service	Percentage of approved fee varies based on type of service	<p>Pedodontic referrals must be pre-authorized by DeltaCare.</p> <ul style="list-style-type: none"> Up to age 7: 100% less applicable co-payments 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.

⁴¹ Up to age 19 with a \$25 deductible.

⁴² A Pedodontist is a dentist who specializes in the growth and development of children's teeth.

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 1015 N. Hollywood Way Burbank, CA 91505	(818) 846-1015 or (800) 227-7863	www.wgaplans.org
PPO Plan and Low Option Plan Providers	Physician and Hospital Network in California: Anthem Blue Cross of California Physician and Hospital Network Outside California: BlueCard®	(800) 810-BLUE (2583)	www.wgaplans.org
Prescription Drug Benefits	Prescription Drug Network Nationwide: EXPRESS SCRIPTS	(800) 987-6551	www.express-scripts.com
The Industry Health Network	Motion Picture & Television Fund Customer Service (Available in Southern California Only)	(855) 760-6783	www.mptvfund.org
DPO Dental Plan	Delta Preferred (DPO) Customer Relations	(800) 765-6003	www.deltadentalca.org/deltacareusa
DeltaCare Dental HMO	DeltaCare USA Customer Relations (Available in California only)	(800) 422-4234	www.deltadentalca.org/deltacareusa

TIHN HEALTH CENTERS	LOCATION	PHONE NUMBER
Bob Hope Health Center	Los Angeles, Hollywood, Mid-City	(323) 634-3850
Glendale Health Center	Glendale on Central Avenue	(818) 876-4790
Jack H. Skirball Health Center	Woodland Hills	(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

ELIGIBILITY *and Enrollment*

The medical, mental health, chemical dependency, dental, vision, prescription drug, life and AD&D coverages are designed to help cover you and your family for the cost of routine care, as well as to provide some protection if catastrophic illness or injury strikes. In this section, you will learn how you become eligible for coverage, who's eligible and what happens if you lose your eligibility.

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 2011 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 Funds, 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 Administrative Office immediately to request an earnings review.

Eligibility rules for 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 the CBS Staff Group) require coverage (month-to-month) to commence on the first day of the month following a full month of staff employment and will continue until employment ends (subject to the payment of contributions).

COVERED EARNINGS MINIMUM

The accumulated covered earnings you need to earn and have reported by your employers in order to qualify for eligibility are equal to the Writers Guild of America minimum for a one-hour network prime-time story and teleplay. These earnings must be earned and reported during no more than four consecutive calendar quarters and, for eligibility purposes, will apply to the period in which the writing services are performed. (See "*When Coverage Begins*" on page 27.) The covered earnings minimum will increase with any subsequent increase in the minimum as stipulated in your MBA. (See the ***Summary of Benefits*** section on page 7 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.

IMPORTANT!

Earnings are allocated to the quarter in which they were earned, not when they’re paid by your employer. If you do not perform services but are paid compensation, the earnings will usually be allocated to the pay date. (Some situation-specific exceptions apply.)

EARNINGS NOT QUALIFYING FOR EMPLOYER CONTRIBUTIONS AND ELIGIBILITY

The following types of earnings (including but not limited to) do not qualify for employer contributions or eligibility:

- Compensation received where no employer/employee relationship existed or compensation received in excess of any applicable ceilings, as described in Article 17 of the MBA.

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, or a team comprised of Same-Sex Domestic Partners, would not earn Health Fund coverage if their earnings were allocated 50/50. This waiver must be requested from the Guild prior to employment. Please contact the WGA for more information.

IMPORTANT!

Examples of non-covered earnings include, but are not limited to:

Excerpts
Royalties
Character Payments
Separated Rights
Interest
Late Fees
Expenses
Publication Fees

10% OWNER REPORTING REQUIREMENTS

In order to curtail practices which appear to circumvent the intent of the Trust Agreement and create a drain on the assets of the Trusts, on January 1, 2001, the Board of Trustees adopted the following revised rules of the Trust governing eligibility for benefits thereunder:

- Contributions on the Writer’s compensation do not count toward the Writer’s eligibility for benefits when the Writer directly or indirectly owns ten percent (10%) or more of the equity of the contributing employer,* or where a contributing employer is a non-profit entity as defined under the Internal Revenue Code (IRS Code), for which a Writer is an officer, board member, director (or serves in another similar capacity of such non-profit), and the employer hires the Writer to perform only writing services unless an unrelated third party directly utilized and paid for the Writer’s services. In no event shall contributions be due on amounts in excess of the amounts paid by the third party to the contributing employer for covered services.
- Contributions on the Writer’s compensation do not count toward the Writer’s eligibility for benefits when the Writer directly or indirectly owns ten percent (10%) or more of the equity of the contributing employer,* and the Writer performs writing and other services (other than under Article 14 of the Basic Agreement). Contributions do not count toward eligibility under this provision even if the contributing employer is hired by an unrelated third party.

Notwithstanding the above, contributions will count toward eligibility for benefits if the contract with the unrelated third party specifically states the amount allocated for such Writer's covered writing services. In this case, contributions shall be due on the greater of the amount so specified or the Basic Agreement's minimum for such writing services.

In addition, if the contract with the unrelated third party does not specifically state the amount allocated for such Writer's covered writing services, contributions will count toward eligibility for benefits when contributions are based on the **lower** of one of the following:

- (a) Five percent (5%) of the total compensation the contributing employer received from the unrelated third party for producing **non-dramatic programming**** or ten percent (10%) of the total compensation the contributing employer received from the unrelated third party for producing **dramatic programming**; or
- (b) At least \$125,000.***

In either case (a) or (b), the employer must contribute on at least the collective bargaining agreement's minimum for writing services.

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, may need to be submitted for review:

- ▶ Proof of unrelated outside financing (check copies/wire transfer/bank statements);
- ▶ License agreement between signatory and Writer (license agreement should contain an allocation for the writing services, if not, see (a) and (b) above);
- ▶ Budget (with allocation for writing services and contributions);
- ▶ Evidence of payment to the Writer (copy of canceled check, wire transfer or bank statement); or
- ▶ Scripts and other literary material.

*The term "indirectly owns...the equity of the contributing employer," includes (a) equity ownership by the Writer's spouse (opposite or same-sex), 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, the Writer's (or spouse's) parent, sibling or lineal descendant.

**For this purpose, "non-dramatic programming" includes all types of programming other than those that are specifically dramatic in nature (e.g., comedy-variety, documentary, quiz and audience participation).

***The Fund's actuary estimated that contributions on reportable earnings in the amount of \$125,000 were the amount necessary in 2001 to pay the cost of the annual Health Fund coverage for an eligible active participant. Periodically, this figure will be adjusted to approximate the annual cost to the Health Fund for coverage.

Note – the compensation amount in 2010 was \$142,506.

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 cell phones and PDA's).

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.

OTHER REPORTING REQUIREMENTS

- ▶ Contributions on the Writer's compensation do not count toward the Writer's eligibility for benefits when the Writer is employed for writing and other services (other than under Article 14 of the Basic Agreement) and the Writer's contract does not separate writing compensation from compensation for other services unless the employer contributes on the lower of:

(a) One hundred percent (100%) of the Writers' total compensation under the contract; or

(b) \$125,000*

*The Fund's actuary estimated that contributions on reportable earnings in the amount of \$125,000 were the amount necessary in 2001 to pay the cost of the annual Health Fund coverage for an eligible active participant. Periodically, this figure will be adjusted to approximate the annual cost to the Health Fund of coverage. Note: the compensation amount in 2010 was \$142,506.

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.

IF ELIGIBILITY IS GRANTED IN ERROR

Contributions an employer pays 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.

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.

EMPLOYER CONTRIBUTIONS

The Fund is financed primarily by participating employers who are signatory to the Writers Guild of America MBA and who make contributions to the Fund. As of November 1, 2004, participating employers are required to contribute 8.5%* 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 November 1, 2004 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 Contribution and Eligibility*" on page 18.)

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

* In the second and/or third periods of the May 2, 2011 - May 1, 2014 MBA contract term, the Trustees have the discretion to increase or reduce the Health Fund contribution rate by up to 0.5%, in increments of not less than one-quarter (0.25%), by reducing or increasing minimums a corresponding percentage if they determine that additional contributions are needed/not needed to maintain the level of benefits in existence on May 2, 2011.

TERMINATION OF HEALTH COVERAGE FOR CAUSE - INCLUDING FRAUD OR INTENTIONAL MISREPRESENTATION

As always, the Fund reserves the right to terminate coverage for you and/or your dependent(s) if you and/or your 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 (within the meaning of PPACA) retroactively (as opposed to prospectively) except in the circumstances permitted by law, such as the failure to pay premiums or the commission of fraud or intentional misrepresentation (for example, in enrollment materials, a claim or appeal for benefits or in response to a question from the Fund Administrator or its delegates by you, your covered dependent(s), or someone seeking coverage on your behalf), or where not considered a rescission. In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon 30 days notice. Failure to promptly inform the Administrative Office that you or your dependent or spouse has become ineligible for coverage (e.g., divorce) or knowingly providing false information to obtain coverage for an ineligible dependent are examples of actions that constitute fraud or intentional misrepresentation.

WHO'S ELIGIBLE

Active Participants and Certified Retirees, as well as their spouses (opposite and same-sex) or Same-Sex Domestic Partners and dependent children, may be eligible for coverage. Once you are eligible, you are automatically enrolled in the Medical PPO plan with the Dental PPO plan, unless you reside in California and have elected to enroll in the Medical PPO with the Dental HMO coverage plan. This election is then effective and may not be changed until your next Open Enrollment period, unless you and your dependents qualify for Special Enrollment Rights outside the Open Enrollment period (See page 24).

As long as you are eligible for benefits, you will receive your own coverage at no charge. If you would like to cover your eligible dependents, you may enroll them, but you must pay a monthly dependent coverage premium, which is payable quarterly in advance. Dependent coverage premiums are not required for dependents of Certified Retirees age 65 and over who do not have active earned 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.

ACTIVE PARTICIPANTS

You are considered an Active Participant the first time the Fund receives a contribution on your behalf. (See "How to Become Eligible for Benefits" on page 17.)

YOUR ELIGIBLE DEPENDENTS

If you are eligible for benefits, you may enroll:

- Your legal spouse (opposite or same-sex) or Same-Sex Domestic Partner (for more information about enrolling a *Same-Sex Domestic Partner or Same-Sex Spouse*, see "Same-Sex Domestic Partners" on page 22).
- Your children younger than age 26, including:
 - Your natural child or stepchild;
 - Your adopted child or child placed for adoption with you (coverage begins on the date the child was placed for adoption with you or the date the adoption was final, whichever is earlier); or
 - Any other child who depends on you for support and lives with you in a parent-child relationship if you provide proof of these conditions (legal guardianship or foster children).

As such, 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 below), or any other factor other than the relationship between the child and the participant. If, however, your 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 such child will be secondary.

- Children age 26 or older who are incapable of self-sustaining employment because of mental retardation or physical handicap, as long as:
 - The mental retardation 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 you for support; and
 - You provide evidence of incapacity to the Fund within 31 days after the child reaches age 26. (The Fund may ask for proof of continuing incapacity at other times during the child's coverage.)

Note: *Your domestic partner's children are not eligible for coverage unless you have legally adopted them. In addition, if your dependent child is married, coverage will not be extended to your dependent's spouse or children.*

SAME-SEX DOMESTIC PARTNERS

You may enroll your Same-Sex Domestic Partner for coverage under the Fund's health plans. For purposes of the Fund's coverage, the Fund's definition of a domestic partnership is a committed same-sex relationship that:

- ▶ Has been in existence for at least six months;
- ▶ Includes financial interdependence; and
- ▶ Is intended by both partners to be permanent.

You must complete and notarize an Affidavit of Domestic Partnership and submit other documents to enroll your partner. If you live in a jurisdiction that allows you to register your partnership, you must do so and provide documentation of such. Contact the Administrative Office for a complete information package on Same-Sex Domestic Partner coverage, including an affidavit form. Same-Sex Domestic Partner coverage is different from spouse coverage. For instance:

- ▶ You are required to pay income taxes on the dollar value of the benefits provided to your domestic partner if your partner does not qualify as your "dependent" according to the IRS Code. You do this by paying the Fund the amount of any state and federal tax required to be withheld (as indicated on the invoice that you receive from the Administrative Office), in advance, on a quarterly basis. The tax amount will be based on the value of the coverage the Fund provides to your partner, less the amount of your quarterly dependent premium payment. If you do not pay the amount required by the Fund, your Domestic Partner will not be covered.
- ▶ Your application to cover your domestic partner is evidenced by the submission of a copy of the notarized Affidavit of Domestic Partnership and satisfactory completion of the "Affidavit of Dependency for Tax Purposes" (if applicable), and quarterly prepayment of the required taxes (if applicable). These documents should be received by the Administrative Office as soon as possible to assure Health Plan coverage for your Same-Sex Domestic Partner.
- ▶ If you do not enroll your Same-Sex Domestic Partner when he/she is first eligible, coverage for any pre-existing conditions* will be limited. Pre-existing conditions will not be covered until the calendar quarter beginning after the earlier of:
 - 90 days after your Domestic Partner was last treated for the condition; or
 - One year from the date your Domestic Partner could have first received coverage.
- ▶ Your Domestic Partner's children are **not** eligible for coverage, unless you have legally adopted them.
- ▶ COBRA continuation coverage is not available for your Domestic Partner.
- ▶ The extension of benefits due to a disability doesn't apply to Domestic Partners.

* This pre-existing condition exclusion period will be reduced on a day-for-day basis if your Domestic Partner provides a certificate of creditable coverage indicating that he/she didn't have a break in coverage of 63 days or more. Effective January 1, 2014, these pre-existing exclusions will be eliminated in accordance with the applicable requirements under the PPACA.

A pre-existing condition exclusion is an injury or illness for which your Domestic Partner has received treatment, incurred expenses or received a diagnosis within the 90 days before his/her enrollment date.

SAME-SEX SPOUSES

In 2009, the Trustees decided to allow Same-Sex Spouses to be added to the Health Fund using the procedures currently in place for Same-Sex Domestic Partners, with some modifications to the list of documents that would otherwise be required to be submitted to the Health Fund to establish eligibility for coverage. Same-Sex Spouses will also be treated like Same-Sex Domestic Partners for purposes of other plan requirements, including the payment of taxes on the value of coverage (unless your Same-Sex Spouse qualifies as your tax dependent).

Please note the following important information:

- ▶ If you were legally married in a state or country legalizing Same-Sex Marriage, and you have a certified marriage certificate,* the following are not required:
 - An Affidavit of Domestic Partnership;

- Proof that you registered your domestic partnership with the State of California (or any other jurisdiction which allows you to register your partnership); and
- Provide 3 pieces of documentation to prove your relationship has been in existence for at least 6 months.

However you must:

- Submit a copy of your marriage certificate to the Administrative Office;
- Pay the required quarterly Domestic Partner taxes (unless you submit the Fund’s Tax Affidavit declaring that your Same-Sex Spouse is your dependent under Federal and State tax law for health coverage purposes); and
- Pay the applicable quarterly dependent premium (if you are not doing so already).

**Note: This applies to the states that have legalized same-sex marriages.*

Like a Same-Sex Domestic Partner, if your Same-Sex Spouse does not qualify as a “dependent” according to the IRS Code, the Fund will be required to collect from you and pay state and federal tax withholdings based on the value of the coverage being provided to your Same-Sex Spouse. You must pay all State and Federal tax required to be withheld (as indicated on the invoice that you receive from the Administrative Office), in advance, on a quarterly basis. The tax amount will be based on the value of the coverage the Fund provides to your spouse, less the amount of your quarterly dependent premium payment.

For California Residents: California law provides that if a domestic partnership is registered with the state, the Domestic Partner shall be treated the same as a spouse for certain State tax purposes applying to health care benefits. Accordingly, when calculating your income subject to California State tax, the value of your Same-Sex Spouse’s health care would not be included. In order to ensure compliance with the new tax provision, the Fund will consider the certified copy of your marriage certificate to be the equivalent to the Declaration of Domestic Partnership you would have filed with the Secretary of State had you not gotten married.

Your application to cover your Same-Sex Spouse is evidenced by the submission of a copy of your certified marriage certificate and satisfactory completion of the Affidavit of “Dependency” for Tax Purposes (if applicable), and quarterly prepayment of the required taxes (if applicable). All should be received by the Administrative Office as soon as possible to assure Health Plan coverage for your Same-Sex Spouse.

IMPORTANT: Like a Same-Sex Domestic Partner, if you do not enroll your Same-Sex Spouse when he or she is first eligible for enrollment, coverage of pre-existing conditions* will be subject to certain limitations. Late enrollment means that your Same-Sex Spouse will not be eligible for coverage for a pre-existing health condition until the calendar quarter beginning after the earlier of:

- ▶ **90 days after your Same-Sex Spouse was last treated for the pre-existing condition*;** or
- ▶ **One year from the date your Same-Sex Spouse first could have received coverage.**

** This pre-existing condition exclusion period will be reduced on a day-for-day basis if your partner provides a certificate of creditable coverage indicating that he/she didn’t have a break in coverage of 63 days or more. Effective January 1, 2014, these pre-existing exclusions will be eliminated in accordance with the applicable requirements under PPACA.*

We urge you to consider enrolling your Same-Sex Spouse immediately upon becoming eligible.

Note: You must notify the Administrative Office of a divorce, legal separation or (if applicable, termination of a domestic partnership) within 60 days after the date of the event. COBRA Continuation Coverage is not available to Same-Sex Spouses or Same-Sex Domestic Partners.

For more information regarding adding your Same-Sex Spouse or Same-Sex Domestic Partner, please contact the Eligibility Department of the Administrative Office.

ENROLLING YOUR DEPENDENTS

To enroll your dependents, you must submit to the Fund a completed enrollment form, along with your premium payment and all required documentation, generally within 30 days of the date you become eligible. If you do not enroll your dependent within this 30-day period, you will not be able to enroll them until the next Open Enrollment period unless you experience a Life Event that qualifies you to Special Enroll your dependents in the Fund as described below.

IMPORTANT!

If you choose to cover your dependents and you fail to make a premium payment by the due date, coverage for your dependents will be terminated. Coverage will be reinstated during the next Open Enrollment period, effective January 1, provided you prepay the premium for the first quarter (Jan 1 to March 31).

TO ENROLL...	YOU WILL NEED...
Your spouse (opposite or same-sex)	A copy of your certified marriage license/certificate
Your Same-Sex Spouse	A copy of your certified marriage license/certificate. (See qualifying marriage criteria on page 22 & 23)
Your Same-Sex Domestic Partner	A signed Affidavit of Domestic Partnership and any additional documents requested by the Fund
Your child	His/her birth certificate (for newborns, since official birth certificates often are not available within 30 days of a birth, 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) along with your completed Dependent Enrollment Form to add a new child to coverage)
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, foster placement, guardianship or placement documents
All of the Above	Important: you must provide the Social Security number for each dependent you are enrolling, unless they are not a citizen of the United States. If adding a newborn please submit the Social Security number to the Administrative Office once it is received by you.

Additionally, if you decline coverage for your dependents because they have other health insurance coverage, and your dependents then lose that coverage (or if their employer stops contributing toward your dependents' other health coverage), you have the right to Special Enroll your dependents in the Fund. In order to do so, you must request and submit a Dependent Enrollment Form to the Administrative Office within 30 days after the other coverage ends (or after the employer stops contributing towards your dependent's other health coverage), and provide proof of the termination from the other health insurance plan. If a Special Enroll request is made due to marriage, your spouse's (opposite or same-sex) coverage will be backdated to the date of your marriage. However, due to the fact that there is no daily proration of dependent premiums, you may instruct the Fund to make your spouse's (opposite or same-sex) coverage effective on the 1st day of the month after your date of marriage.

If your dependent’s Medicaid or State Children’s Health Insurance Program (“CHIP”) coverage is terminated due to 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 Fund within 60 days of such event. Coverage will become effective the date after the Medicaid or CHIP coverage ends, or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP provided that the request for enrollment, the required documentation and the dependent premium, if applicable, is received by the Administrative Office within 60 days of the termination of Medicaid or CHIP coverage.

If you and/or your dependents experience a Life Event (See “*Life Events*,” page 27, for more information), you have the right to Special Enroll your dependents in any benefit option for which you are eligible under the Fund. (For example, if you reside in California and are enrolled in the Medical PPO Plan and the Dental PPO and subsequently obtain a new dependent, you have the option of enrolling your dependent in the Plan in which you are currently enrolled.)

To enroll your dependents, you will need to provide the following documentation:

DEPENDENT TYPE	REQUIRED DOCUMENT
Dependent children younger than age 26	His/her birth certificate
Other dependents	A copy of the adoption/release, foster placement, guardianship or placement documents
Mentally retarded or physically handicapped dependents over age 26	Proof of incapacity, medical records and proof that you’re providing support

If you’re **re-enrolling** a dependent, have previously submitted the appropriate documentation, have not been asked to supply additional or modified information and have not been advised that your dependent(s) is not eligible to enroll, then all you need to do is complete a “Dependent Reinstatement Form” (located on our website: www.wgaplans.org) and pay the dependent coverage premium, if applicable.

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 (opposite or same-sex), or Same-Sex Domestic Partner; and
- ▶ All eligible dependent children.

(See “*Your Eligible Dependents*” on page 21 for the definition of “eligible dependents.”)

This premium covers all eligible dependents in your household whom you enroll for medical, mental health, chemical dependency, dental, prescription drug and vision benefits. Your own coverage, which you receive when you meet the eligibility earnings requirement, doesn’t require a premium payment. The dependent premium amount is listed in the **Summary of Benefits** section, page 7, of this SPD.

Plan Participants (not including employees of “Named Employer”) pay dependent premiums on a quarterly basis, in advance, based on invoices issued by the Fund. Only the dependents you have enrolled will be covered. To enroll dependents, you must complete and submit a “Dependent Enrollment Form” (including all required documentation, if applicable) to the Fund office. If the Fund does not receive the required premiums by the due date, dependent coverage will be terminated, and you will not have another opportunity to enroll your dependents, unless you or your dependents experience a Life Event that allows you to Special Enroll, or until the next Open Enrollment period, with coverage taking effect the following January 1. (See “*Life Events*,” page 27, for more information.)

Newborns of participants who have earned coverage or coverage through any of our COBRA plans 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 you have already paid the dependent premium for your existing dependents, you do not need to submit an additional premium for the newborn.

HEALTH COVERAGE FOR CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer (which includes coverage provided through plans sponsored by unions and employers, like the Fund), but 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 CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. These are existing state programs and are not related to the Health Care Reform Act.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state that offers this program, you can 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, you can contact your state Medicaid or CHIP office or dial *1-877-KIDSNOW*, or go to www.insuredkidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined by the State that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan - as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "Special Enrollment" opportunity, and you must request coverage from the plan within 60 days of being determined eligible for such premium assistance.

If you would like to request that you be provided with this Special Enrollment opportunity from the Fund, please contact the Eligibility Department at (818) 846-1015 or (800) 227-7863 to request the necessary forms.

To determine which states have added a premium assistance program or to obtain more information on Special Enrollment rights, you can contact either:

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

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

GRANTING RETROACTIVE OR TERMINATING PROSPECTIVE COVERAGE

Sometimes Employer Compliance audits uncover cases in which a participant gains or loses eligibility due to misreported earnings and was unaware of his/her correct status. The Fund then makes the appropriate adjustments:

- ▶ Retroactive eligibility will be granted for the period in which you would have been eligible if earnings were accurately reported.

Note: you may submit claims for all medical, mental health and chemical dependency, hospital, vision, dental and pharmaceutical expenses that you incurred during the period of retroactive eligibility.

- ▶ If you're awarded retroactive eligibility and want dependent coverage, you will have to pay monthly premiums retroactively for the number of consecutive quarters for which you want dependent coverage.
- ▶ If the Fund determines that current coverage was granted in error, your 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 15th, your coverage will terminate April 30th.

The collection of any delinquent contributions may result in the granting of retroactive eligibility for coverage. Should retroactive eligibility be granted, you will be notified by the Administrative Office of:

- ▶ Your new eligibility period; and
- ▶ The process for submitting receipts for retroactive medical, mental health and chemical dependency, dental, vision and prescription claims. **Please save your receipts!**

LIFE EVENTS

If you experience one of the following **Life Events**, you will be allowed to Special Enroll or drop dependent coverage during the year provided you have notified the Fund within 30 days of the Life Event:

- ▶ Marriage, divorce or legal separation (in the instance of a divorce the Fund must be notified within 60 days of the event);
- ▶ 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 (opposite or same-sex), Same-Sex Domestic Partner or dependent;
- ▶ Any change in a spouse's (opposite or same-sex), Same-Sex Domestic Partner's or dependent's employment status that results in a significant change to benefits, such as the start or end of employment, change from full-time to part-time employment, or start or end of an unpaid leave of absence;
- ▶ Termination of Medicaid or CHIP coverage (Fund notification within 60 days is required);
- ▶ Unmarried dependent's (up to age 26) loss of health insurance benefits provided by their employer; or
- ▶ Change in work-site or residence for the participant or his/her spouse (opposite or same-sex), Same-Sex Domestic Partner or dependent if that change affects benefits.

Note: If you timely request to special enroll in the Health Plan due to birth, adoption or placement for adoption of a dependent child, coverage will become effective as of the date the event occurred.

Other status changes, such as a change in a family member's coverage, may apply. For example, if your spouse (opposite or same-sex) elects family coverage during his/her open enrollment period, you may be allowed to drop dependent coverage. You may contact the Eligibility Department at the Administrative Office if you have questions about any of the Life Events described in this section.

You will not have to pay the entire quarterly premium if your Life Event takes place during the quarter. Instead, your premium will be prorated to the first day of the month in which the most recent Life Event takes place. If you **do not** make a premium payment at the time of a Life Event, or if you do not make your request to Special Enroll a dependent within 30 days of a qualified Life Event, you will not be able to enroll your dependents until the next annual Open Enrollment period.

WHEN COVERAGE BEGINS *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 CBS Staff group).*

To accommodate necessary administrative processes, your coverage will take effect one calendar quarter after the quarter in which you satisfy the eligibility earnings requirement. (See chart below or the **Summary of Benefits**, page 6 for more details.) Your coverage will begin on the first day of the month after your one quarter administrative period and will continue for one year.

Once you have established eligibility, it is important to be aware of your personal earnings cycle (the period in which you must meet the Eligibility Earning requirement to continue uninterrupted coverage).

The chart below provides some examples:*

IF YOU SATISFY THE ELIGIBILITY EARNINGS REQUIREMENT IN	YOUR COVERAGE PERIOD WILL BE	THE EARNINGS CYCLE FOR CONTINUED COVERAGE WILL BE
October 1 – December 31	April 1 – March 31	January 1 – December 31
January 1 – March 31	July 1 – June 30	April 1 – March 31
April 1 – June 30	October 1 – September 30	July 1 – June 30
July 1 – September 31	January 1 – December 31	October 1 – September 30

**For example, if a writer is hired on March 15, 2013 for a covered writing project and thereafter meets the eligibility earnings requirements by June 15, 2013, his/her coverage cycle will begin October 1, 2013 and run through September 30, 2014. To qualify for another year of coverage, he/she must earn the applicable eligibility earnings requirement in the period July 1, 2013 through June 30, 2014. If the earnings requirement is not met in this period, earned coverage under the Fund will end. He/she may regain earned coverage when the eligibility earnings requirement is met in a subsequent four-quarter earnings period.*

WHEN COVERAGE ENDS *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 CBS Staff group).*

If you continue to meet the eligibility earning requirement, coverage for you and your eligible dependents will continue uninterrupted. If you do not meet the eligibility earnings requirement during your personal earning cycle, your employer-paid coverage will end on the last day of your 12-month coverage cycle.

Your coverage will end if:

- ▶ The Health Fund is modified to terminate coverage for your class of participants; or
- ▶ The Plan ends.

Your dependents' coverage generally ends when your coverage ends. Additionally, dependent coverage will end if:

- ▶ You do not pay the dependent premium by the due date;
- ▶ On the last day of the month that a dependent child reaches age 26 (in the case of a covered child who is mentally or physically disabled who had extended coverage beyond age 26, the last day of the month that such child no longer to have such disability);
- ▶ Your mentally or physically disabled dependent child over the age of 26 loses total disability certification because he/she no longer meets the Fund's definition of total disability (coverage will end on the last day of the month in which the child loses certification); or
- ▶ Your dependent child enters full-time military service.

If you become legally separated or divorced, coverage for your spouse (opposite or same sex) will end on the last day of the month in which:

- ▶ You were legally separated; or
- ▶ Your divorce was final.

Your Same-Sex Domestic Partner's coverage will end on the last day of the month in which:

- ▶ You fail to pay the required taxes to the Fund by the due date;
- ▶ You fail to pay the required dependent premium to the Fund by the due date; or
- ▶ The partnership ends.

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you or your dependent's health coverage ends under the Fund, you and your dependents are entitled by law to, and will be provided with, a "Certificate of Creditable Coverage." Certificates of Creditable Coverage indicate the period of time you and/or your dependents were covered under the Fund (including COBRA coverage), as well as certain additional information required by law. A Certificate of Creditable Coverage may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy within 63 days after your coverage under this Fund ends (including COBRA coverage, not applicable to Same-Sex Domestic Partners). A Certificate of Creditable Coverage is necessary as it may reduce any exclusion for preexisting coverage periods that may apply to you and/or your dependents under the new group health plan or health insurance policy.

A Certificate of Creditable Coverage will be provided to you, upon request, up to 24 months after your coverage ends; when you are entitled to elect COBRA; when your coverage terminates (even if you are not entitled to COBRA); or when your COBRA coverage ends. Certificates of Creditable Coverage should be kept as proof of prior coverage for you or your dependent's new health plan. To request a Certificate of Creditable Coverage, please contact the Administrative Office.

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 Producer-Writers Guild of America Pension Plan. This certificate can be obtained by contacting the Administrative Office.

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

- ▶ Retired under the Producer-Writers Guild of America 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 3 qualified years after December 31, 1954.

If you retired on or after January 1, 1997, you're considered a Certified Retiree if you:

- ▶ Are at least 60 years old; and
- ▶ Retired under the Producer-Writers Guild of America Pension Plan; and
- ▶ 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 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.

***Definitions of "qualified years" and "credited weeks" are included in the Producer-Writers Guild of America Pension Plan Summary Plan Description.*

WHEN CERTIFIED RETIREE COVERAGE BEGINS

If you still have employer-paid coverage when you retire, that coverage will continue until your employer-paid eligibility period ends. At that point, your Certified Retiree Health Coverage begins.

If you're younger than 60 years old and you have at least 68 qualified quarters when you retire, your Certified Retiree Health Coverage will begin on the first day of the month after you turn 60 (provided you are not on employer-paid coverage when you turn 60).

If you return to work after your Certified Retiree Health Coverage begins, and you regain employer-paid coverage by meeting the eligibility earnings minimum requirement, you will be considered an Active Participant on earned coverage and will be required to pay the premium for dependent 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 51.)

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.

IMPORTANT!

When you are on Extended Coverage or COBRA you are not earning qualified quarters toward 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 "Plan Changes or Termination" on page 120.

MEDICARE PARTS A AND B

Medicare is a two-part program. Part A covers hospitalization and certain follow up services, which is at no cost to you 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. In order for you to receive optimum coverage and reimbursement for your hospital and doctor bills, it is important that you enroll in Part A and Part B of Medicare.

Please note: Medicare coverage will be the primary plan when you turn age 65 and on Certified Retiree Health Coverage. If Medicare enrollment has not occurred, the Fund will pay benefits as if you are enrolled in both Part A and Part B, and will coordinate benefits as if you had received reimbursement for your medical expenses from Medicare. (The Fund will pay 20% of the eligible medical expenses after the deductible is satisfied.)

You (and your dependents) may become eligible for Medicare upon turning 65, 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”).

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

MEDICARE PART D

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set 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, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you enroll in the Medicare drug program, 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 prescription drug benefit, provided that you continue to qualify for those benefits. Your eligible covered dependents who have not enrolled in a Medicare drug program will continue to receive prescription drug coverage under the Fund.

If you decide to join a Medicare drug plan and drop your prescription drug coverage under the Fund, be aware that you will not be able to reinstate your prescription drug coverage under the Fund until the next annual open enrollment period. (Plan changes to the Fund’s prescription drug benefits that are adopted during open enrollment generally become effective January 1st of the following year.)

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 www.medicare.gov;
- ▶ Call your State Health Insurance Assistance Program for personalized help; or
- ▶ Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 www.ssa.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

MEDICARE PRIVATE CONTRACT

Under the law, you are entitled to enter into a Medicare private contract with certain health care practitioners under which you agree that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If you enter into such a contract, the Fund will pay a portion of the benefits for health care services and/or supplies you receive pursuant to it, but those benefits will be subject to all of the Plan's terms and provisions, including those relating to exclusions, medical necessity, reasonable and customary charges, and utilization management. Specifically, the Fund will pay 20% of the eligible medical expenses after the deductible is satisfied, and you are responsible for the rest.

WHEN YOU LOSE ELIGIBILITY

If you lose Health Fund coverage, you may be able to temporarily extend your coverage. The diagram below shows the options (should you qualify) to extend coverage, which are described in more detail in this section:



**These extended coverage programs are not available 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 CBS Staff group).*

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 CBS Staff group).*

WRITER'S POINT SYSTEM

You can extend your own coverage at no charge through the Extended Coverage Program. This is a program in which points are awarded to you based on your meeting the reportable compensation minimum to qualify for eligibility in your four-quarter personal earnings cycle in order to be eligible for employer-paid coverage. (See **Summary of Benefits** section, page 6, for more details.)

You may accumulate up to 50 points to use toward future Fund coverage. The chart on the following page shows how points are awarded. For each four-quarter earnings cycle in which you earn employer-paid eligibility, you have the potential to be awarded up to three points.

If you have met the covered required minimum earnings for one (1) year of employer-paid Fund coverage during any earnings cycle ending on or after September 30, 1989, you:

- ▶ Get 1 point;
- ▶ Get a second point if you earned at least the applicable required second point covered during that earnings cycle; and
- ▶ Get a third point if you earned at least the applicable required third point covered earnings minimum cumulative during that earnings cycle.

EARNINGS MINIMUM FOR SECOND POINT	EARNINGS MINIMUM FOR THIRD POINT	EARNINGS CYCLE EFFECTIVE DATE BEGINNING ON	EARNINGS CYCLE EFFECTIVE DATE BEGINNING ON	EARNINGS CYCLE EFFECTIVE DATE BEGINNING ON	EARNINGS CYCLE EFFECTIVE DATE BEGINNING ON
1 point for each four-quarter earnings cycle in which you have covered earnings of at least:	Plus, 1 point awarded for each four-quarter earnings cycle in which you have covered earnings of at least:				
\$100,000*	\$200,000*		04/01/00	07/01/00	10/01/00
\$103,252	\$200,000	01/01/01	04/01/01	07/01/01	10/01/01
\$106,089	\$200,000	01/01/02	04/01/02	07/01/02	10/01/02
\$108,741	\$200,000	01/01/03	04/01/03	07/01/03	10/01/03
\$111,460	\$200,000	01/01/04	04/01/04	07/01/04	10/01/04
\$113,968	\$204,500	01/01/05	04/01/05	07/01/05	10/01/05
\$116,534	\$209,101	01/01/06	04/01/06	07/01/06	10/01/06
\$119,156	\$213,806	01/01/07	04/01/07	07/01/07	10/01/07, 01/01/08
\$122,731	\$220,220	04/01/08	07/01/08	10/01/08	01/01/09
\$126,413	\$226,827	07/01/09	10/01/09	01/01/10	04/01/10
\$130,205	\$233,631	07/01/10	10/01/10	01/01/11	04/01/11
\$132,809	\$238,304	07/01/11	10/01/11	01/01/12	04/01/12
\$135,133	\$242,474	07/01/12	10/01/12	01/01/13	04/01/13
\$137,498	\$246,717	07/01/13	10/01/13	01/01/14	04/01/14

*The four-quarter earning cycle must end on or after September 30, 1989 and before January 1, 2001.

Note: The covered earnings minimum on which the 2nd and 3rd points are awarded will periodically increase by a proportionate amount equal to any increase in the MBA minimum.

Currently the minimum for awarding the 2nd and 3rd point is based on the percentage increase per year in the MBA for a one-hour network prime time story & teleplay.

Points are awarded based on your personal earnings cycle and may not be carried over to the next earning cycle.

You have to accumulate at least 10 points to qualify for benefits under the point system. If you have accumulated at least 10 points and subsequently lose employer-paid eligibility, you will be notified that you have been automatically placed in the Extended Coverage Program. The Fund will send you a statement indicating the number of points you've accumulated, the number of points you've used and the number of points remaining available to you. Your coverage will be extended by using your points as follows:

- ▶ 10 points for 4 quarters of PPO Plan coverage (total points reduced by 2½ points per quarter). Coverage includes mental health and chemical dependency, medical, hospital, prescription, vision, wellness, dental, life insurance and accidental death and dismemberment insurance (AD&D); or
- ▶ 6 points for 4 quarters of Low Option Plan coverage (total points reduced by 1½ points per quarter). Coverage includes mental health and chemical dependency, medical and hospital benefits only, with higher out-of-pocket costs.

(See the **Summary of Benefits**, starting on page 6, for specific information about your medical plan options.)

Applicable points will be deducted for each quarter you receive benefits until:

- You are once again eligible for employer-paid Fund coverage;
- You become eligible for Certified Retiree Health Coverage (See page 29 for a definition of “*Certified Retiree*”); or
- You do not have enough points to continue extending your coverage.

Note: *If eligible, you are automatically placed on the Extended Coverage Program even if you qualify for other coverage. You may not waive participation in the Extended Coverage Program.*

If you die, your surviving spouse (opposite or same-sex), Same-Sex Domestic Partner and/or covered dependent children can use your remaining points to extend their coverage. If you become eligible for Certified Retiree Health coverage, your points will be forfeited.

If you have exhausted your points under the Extended Coverage Program, you will be offered the option of purchasing COBRA continuation coverage. (For information about COBRA, see “*COBRA Continuation Coverage*” on page 35.)

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 can not 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 and 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

The \$250,000 extension provision also applies to bona fide two-person writing teams that meet the covered earnings requirement. Income earned as part of the team — not individual earnings — will be considered for eligibility. Team writers who do not earn equal amounts of covered compensation will not qualify for the extension unless their reportable amount divided between two years is equal to or greater than the amount required to qualify for coverage in each year.

This extension is not automatic. You must contact the Eligibility Department if you believe you qualify for the extension.

OTHER EXTENSIONS OF COVERAGE

After you or your dependents lose eligibility for the Fund's health plans, there may be other options for extending coverage. For example, when your adult dependent child turns age 26, the Fund will send your dependent a notification of termination of coverage that will contain information about their individual right to elect:

- ▶ **COBRA continuation coverage.**

TOTAL DISABILITY

If, at the time coverage ends, you or a dependent — excluding Same-Sex Spouses and Same-Sex Domestic Partners — are totally disabled, that person may receive extended benefits through the total disability extension offered by the Fund or through COBRA.

The Total Disability Application and Attending Physician Statement must be submitted within 30 days before coverage would otherwise end.

A Disabled Participant:

- ▶ After being deemed eligible for a disability extension of coverage, the totally disabled participant and his/her covered dependents are entitled to full medical and dental benefits for 6 months from the date coverage would otherwise end.
- ▶ If, at the end of the 6 month extension of coverage, the participant remains disabled, he/she will be entitled to elect an additional 12 months of “comprehensive medical coverage” (out-patient mental health and chemical dependency, medical, vision and prescription benefits only), or COBRA. If the participant elects the 12 months of comprehensive medical coverage, their dependents will not be eligible for coverage. The dependents will be offered COBRA. Their COBRA entitlement will be offset by the 6 months of disability extension previously received.
- ▶ If, after the first 6 month extension of coverage, the participant elects COBRA, the COBRA entitlement will be offset by the 6 month extension previously received. If the 12 month comprehensive medical coverage extension is elected, COBRA will not be offered at the termination of this extension.

A Disabled Spouse:

- ▶ If, at the time coverage would otherwise end (participant's coverage ends), and the covered spouse (opposite sex) is deemed eligible for a disability extension of coverage, the spouse (opposite sex) will be entitled to elect 12 months of comprehensive medical coverage or COBRA. If the 12 month extension is elected, COBRA will not be offered at the termination of the 12 month extension.

A Disabled Child:

- ▶ If, at the time coverage would otherwise end (earlier if participant's coverage ends or the dependent child turns 26), and the child is deemed eligible for a disability extension of coverage, the child will be entitled to elect 12 months of comprehensive medical coverage or COBRA. If the 12 month extension is elected, COBRA will not be offered at the termination of the 12-month extension.
- ▶ If a dependent child reaches age 26 and qualifies as “permanently disabled” by the Fund (as defined in the Your Eligible Dependents section*) the dependent child will be entitled to coverage as long as the participant is covered under the Fund. If the participant loses eligibility for Fund coverage, the disabled child's coverage would also end. Should the participant regain earned coverage at a later date, the “permanently disabled” child's coverage would resume. Recertification of your dependent's permanent disability is required every two years.

*Eligible dependent is defined on page 21, under the “Who's Eligible” section, sub-section “Your Eligible Dependents,” starting with the bullet titled: “Children age 26 or older who are incapable of self-sustaining employment because of mental retardation or physical handicap as long as:”

Note: *The Total Disability Application and Attending Physician Statement form is available on our website or contact the Eligibility Department at the Administrative Office. If these forms are not received within 30 days before coverage would otherwise end, coverage under this extension of coverage may not be granted.*

ACTIVE SURVIVOR COVERAGE

If you die while covered under the Fund, your covered surviving dependent(s) will be entitled to Extended Coverage with the Health Fund, if at the time of your death:

- You were an active participant under age 60;
- Accumulated at least 68 quarters of Health Fund coverage; and
- You were married (to an opposite or same-sex spouse) or in a Same-Sex Domestic Partnership for at least two years.

Your surviving dependent(s) can elect either of the following options:

- Five years of full medical and dental coverage; or
- Subject to the applicable rules under the Fund, lifetime full medical and dental coverage starting on the date you would have turned age 60.

***Note:** If the five-year coverage is elected, coverage will end if your Surviving Spouse (opposite or same-sex) remarries, your Same-Sex Domestic Partner enters into a new domestic partnership or any of your dependents becomes eligible for Medicare or any other group health plan. If the lifetime coverage is elected and your Surviving Spouse (opposite or same-sex) remarries or your Same-Sex Domestic Partner enters into a new domestic partnership, his/her coverage will end. If your Surviving Spouse (opposite or same-sex) or Same-Sex Domestic Partner becomes Medicare-eligible, the Plan's coverage will be secondary to Medicare. (See "Understanding Coordination of Benefits (COB) on page 51.)*

Your Surviving Spouse (opposite or same-sex) or Same-Sex Domestic Partner is required to immediately notify the Administrative Office if he/she remarries or enters into a new domestic partnership. Alternatively, your Surviving Spouse (opposite sex) can enroll for COBRA Continuation Coverage. This option for COBRA Continuation Coverage is not available to Same-Sex Spouses or Same-Sex Domestic Partners. (For information about COBRA, see "COBRA Continuation Coverage" below.)

CERTIFIED RETIREE SURVIVOR COVERAGE

If you're at least 60 years old when you die and you had accumulated at least 68 quarters of Health coverage; and

- You had been married (to an opposite or same-sex spouse) or in a Same-Sex Domestic Partnership for at least two years at the time of your death, your survivor will receive the same Certified Retiree Health benefits he/she would have received had you retired and died immediately thereafter; or
- You had been married (opposite or same-sex) or in the Same-Sex Domestic Partnership for less than two years at the time of your death, your survivor will be entitled to receive this coverage for six months.

COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a Federal Law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Health Plan when they would otherwise lose their group health coverage.

You're required to pay the full cost of coverage, plus an administrative fee of 2%, for continued mental health, chemical dependency, medical, vision, dental and prescription drug coverage for you and any eligible dependents you wish to cover when you lose eligibility for employer-paid coverage and are not eligible for any other form of extended coverage. The Administrative Office is responsible for administering COBRA Continuation Coverage. All COBRA election paperwork should be sent to the Administrative Office.

To continue coverage, you must pay the COBRA premium on a monthly basis. When you first enroll, you may choose a plan under COBRA other than the one in which you were enrolled when you lost Fund coverage, but once enrolled in a COBRA plan, you may only change your plan selection during an Open Enrollment period or following a Life Event. (See "Life Events," page 27, for more information.)

WHO'S ELIGIBLE FOR COBRA

COBRA Continuation Coverage is available to the following dependents:

- ▶ Dependents other than Same-Sex Spouses and Same-Sex Domestic Partners who were covered under the Health Plan before loss of coverage due to a qualifying event as described below; and
- ▶ A child who is born to, adopted by, placed for adoption or legal guardianship with you (the participant) while you're covered under COBRA. You must notify the Administrative Office within 30 days of the event. If you do not notify the Administrative Office within 30 days of these qualifying events, the child will lose the right to be covered under COBRA.

If you continue your own coverage under COBRA, you may also cover your Same-Sex Spouse or Same-Sex Domestic Partner as your dependent if you pay the required premiums. However, your Same-Sex Spouse or Same-Sex Domestic Partner will have no individual COBRA rights under this coverage.

When your adult dependent child turns age 26, the Fund will send your dependent a Notice of Termination of Coverage offering him/her the option to purchase COBRA Continuation Coverage. Children of your Same-Sex Domestic Partners are not eligible for COBRA Continuation Coverage unless you (the participant) have legally adopted them prior to the qualifying event.

QUALIFYING EVENTS

The following chart shows who is eligible for COBRA Continuation Coverage, under what circumstances (also known as qualifying events), and how long COBRA Continuation Coverage will last. **You must notify the Administrative Office of a divorce, legal separation or a child's loss of dependent status within 60 days after the date of the qualifying event. If you do not, your qualified dependent(s) will lose their right to elect COBRA Continuation Coverage.**

WHO	QUALIFYING EVENT	WHO IS ELIGIBLE FOR COBRA CONTINUATION COVERAGE	DURATION OF COBRA CONTINUATION COVERAGE
You	Have a reduction in earnings below the level required for eligibility (and have exhausted any extended eligibility under the Extended Coverage Program or other coverage extension options)	You and your covered dependents, excluding your Same-Sex Spouse or Same-Sex Domestic Partner	18 months*
	Are disabled at the time you become eligible for COBRA or you become disabled within the first 60 days after COBRA Continuation Coverage begins	You and your covered dependents, excluding your Same-Sex Spouse or Same-Sex Domestic Partner	29 months**
	Die	Your covered dependents, excluding your Same-Sex Spouse or Same-Sex Domestic Partner	36 months
	Become divorced or legally separated	Your covered spouse, excluding your Same-Sex Spouse	36 months
Your Spouse and/or Dependent Child	Is no longer an eligible dependent (due to age limit, divorce or legal separation)	Your covered dependents, excluding your Same-Sex Spouse or Same-Sex Domestic Partner	36 months
	Is no longer an eligible dependent because of your death	Your covered dependents, excluding your Same-Sex Spouse or Same-Sex Domestic Partner	36 months
	Is disabled at the time COBRA Continuation Coverage begins or within the first 60 days after COBRA Continuation Coverage begins	Your covered dependents, excluding your Same-Sex Spouse or Same-Sex Domestic Partner	29 months

**24 months if, as an active participant, you've had at least two years of earned eligibility in the last five years.*

Excludes Same-Sex Domestic Partner's children unless you have legally adopted them prior to the date of the qualifying event.

***You are required to provide proof of eligibility for Social Security disability benefits for COBRA Continuation of Coverage for the additional 11 months.*

Once a qualifying event occurs and you notify the Administrative Office, you will receive full details about COBRA Continuation Coverage, including the cost and duration of coverage. If you decide to elect COBRA Continuation Coverage, you must notify the Administrative Office within 60 days of the notice date or the date coverage ended, whichever is later. Once you elect COBRA Continuation Coverage, you will have 45 days from the date you decided to elect COBRA Continuation Coverage to pay the initial monthly premium, 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. If you fail to pay your premium within 30 days of the due date, your COBRA Continuation Coverage will be terminated and 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 you do not respond to the initial COBRA notice within 60 days, you will no longer be eligible for COBRA Continuation Coverage.

Disability Extension of 18-Month Period of COBRA Continuation of Coverage

If you, your covered spouse or dependent children are determined to be “disabled” by the Social Security Administration at any time during the first 60 days of COBRA Continuation Coverage and you notify the Administrative Office in a timely fashion, you, your covered spouse or dependent children 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.

You must notify the Administrative Office of Social Security's decision within 60 days of the date of the determination but before the end of the 18-month period of COBRA Continuation Coverage. If you fail to provide such notice within this timeframe, you will not be eligible for the disability extension. This notice should be sent to the Eligibility Department of the Administrative Office. The monthly premium must continue to be paid during the disability extension period. This extension is not available to Same-Sex Spouses or Same-Sex Domestic Partners.

Second Qualifying Event Extension of 18-Month Period of COBRA Continuation Coverage

If you, your spouse (opposite sex) or dependent children experience another qualifying event during your COBRA Continuation Coverage period, your spouse (opposite sex) and dependent children can get additional months of COBRA Continuation Coverage, up to a maximum of 36 months reduced by the number of months they were previously covered under your COBRA event. This extension is available to your spouse and dependent children if you die, divorce, legally separate or enroll in Medicare (Part A, Part B or both) after your COBRA Continuation Coverage has commenced.

IMPORTANT!

All extensions of coverage and survivor coverage not specifically required by law, like all Fund benefits, are subject to amendment or termination by the Fund's Board of Trustees and do not entitle your surviving dependents to a guarantee or vested rights to the Fund's benefits program.

IMPORTANT!

Life insurance and accidental death and dismemberment benefits are not provided under COBRA Continuation Coverage.

The extension is not available to Same-Sex Spouses or Same-Sex Domestic Partners. The extension is available to a dependent child until they turn 26 and stop being eligible as your dependent.

Note: *In all of these cases, you must make sure that the Administrative Office is notified 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 the 60 day period, coverage won't continue beyond the 18 month period.*

COVERAGE OPTIONS

You can choose from a number of plans if you elect COBRA Continuation Coverage. These are the same health plans that are available to you as an Active Participant, but some offer special plan options — for example, one with no dental coverage — or one with a lower level of benefits to reduce your cost. The plan options range from the least comprehensive, for which the premiums are lowest, to the most comprehensive, for which you pay the most. You will receive complete information about your plan options and costs when you lose employer-paid coverage under the Health Fund.

When you elect COBRA Continuation Coverage, your premiums will be based on the coverage option you select.

These premiums are divided into three rate levels:

- ▶ Single coverage;
- ▶ Two-party coverage (you and one dependent); or
- ▶ Family coverage (you and two or more dependents).

In addition to your premium payments, you will also pay any applicable deductibles, coinsurance or copays. (See the *Summary of Benefits*, starting on page 6 for details.)

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;
- ▶ You fail to pay subsequent premiums within 30 days of the due date;
- ▶ The 18-month, 24 month, 29-month or 36-month continuation period ends;
- ▶ With respect to the extension for “disability”, the date the COBRA disability 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, provided the other plan doesn't impose any pre-existing condition exclusions on you or your qualified dependent(s);
- ▶ After electing COBRA Continuation Coverage, the date you or your dependents enroll in Medicare (Part A, Part B or both); or
- ▶ The Fund no longer provides group health care coverage.

If you have questions about your COBRA Continuation Coverage, contact the Eligibility Department at the Administrative Office, 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 through their website at www.dol.gov/ebsa.

In order to protect you and your covered dependent(s) rights to elect COBRA Continuation Coverage, you should inform the Administrative Office of any address changes for you or them. Address changes must be submitted in writing or through our website. You should keep a copy of any notices you send to and received from the Administrative Office, as well as the name of any person you speak with.

The California Continuation Benefits Replacement Act (“Cal-COBRA”)

Cal-COBRA generally requires California employers (with 2 to 19 employees) that provide insured health benefits to provide up to 36 months of continuation coverage to electing individuals who lose group health coverage due to a qualifying event. In addition, Cal-COBRA also requires employers subject to Federal COBRA Continuation Coverage (20 or more employees) that provide insured health benefits to provide extended continuation coverage to electing individuals who exhaust their

Federal COBRA Continuation Coverage for up to 36 months from the date that individual’s Federal COBRA Continuation Coverage began.

Please note that Cal-COBRA only applies to insured health plans (such as HMOs or insured PPOs). Cal-COBRA does not apply to self-insured employee benefit plans such as this Fund. Although the Fund is subject to Federal COBRA Continuation Coverage and provides Federal COBRA Continuation Coverage to participants, the Fund does not offer any type of insured benefits, except for the Dental HMO. Accordingly, Cal-COBRA is not offered to Fund participants who exhaust their Federal COBRA Continuation Coverage.

HOW TO CONVERT COVERAGE (CALIFORNIA RESIDENTS ONLY)

If your primary residence is in California, you may be able to apply for an individual medical plan policy with Anthem Blue Cross of California when the employer-paid coverage ends for you or any covered eligible dependent. To convert to an individual policy, you will not need to have a physical examination or provide other evidence of insurability if:

- ▶ You do not elect COBRA Continuation Coverage and you or your dependents apply for an individual policy within 31 days after your or your dependents’ group coverage ends; or
- ▶ You elect COBRA Continuation Coverage and you or your dependents apply for an individual policy within 180 days before but no later than 31 days after COBRA Continuation Coverage ends.

Keep in mind that the coverage and benefits under your individual policy will not be the same as those provided by the Fund’s medical plans, and the premiums will vary depending on your age and where you live.

Note: Information on this option is provided in the eligibility package mailed to you when your employer-paid coverage ends.

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 50% of their monthly COBRA premiums for a lifetime total of up to 12 months.

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 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 visit their website at www.dfs.ny.gov/consumer/cobra/cobra_entertainment.htm.

MEDICAL *Benefits*

You have health care benefits that allow you to receive health care depending on where you live and whether you're an active participant, have COBRA Continuation Coverage or are in the Extended Coverage Program.

If you live, 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 13, and for details on TIHN, see page 45.)

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

- *Medical, mental health and chemical dependency benefits;*
- *Vision benefits; and*
- *Prescription drug benefits.*

PAYING FOR YOUR CARE

Costs for your health care coverage are shared by both you and the Fund.

ELIGIBLE EXPENSES

“Eligible expenses” are the portion of expenses that the Fund says are covered for services that are covered by the Fund (i.e., for which it provides benefits).

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. Exceptions include prescription drug benefits, preventive and wellness benefits, many of which require copays but no deductibles. Deductibles apply to all plans except when you receive services from TIHN.

Here is the breakdown on deductibles:

- ▶ **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 count toward an individual’s deductible automatically counts toward the family deductible. Once three or more covered persons have met the combined deductible maximum, 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 for all family members involved will be applied to the eligible expenses resulting from the accident. 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 carry over 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.

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 your cost of care, up to certain maximums and limitations. Copays are required for specific benefits for all plans. Copays do not count toward your out-of-pocket maximums or deductible.

COINSURANCE

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

CONTRACTED RATES (NETWORK SERVICES)

“Contracted rates” are the rates that have been negotiated between the networks and their network providers. These rates apply only to network services. When you use a network provider, the provider should not “balance bill” or charge more than the negotiated fee. You are responsible for the non-covered expenses, any copays, the deductible and coinsurance amount. You are not responsible for the amount over the contracted rate, even if the provider bills a higher amount.

REASONABLE AND CUSTOMARY (R&C) LIMITS (NON-NETWORK SERVICES)

Anthem Blue Cross negotiates rates with doctors and other health care providers to help you save money. We refer to these providers as being “network.”

The Fund also pays for services from providers who are not in our network. Many of those plans pay for non-network services based on what is called the “reasonable,” “usual and customary” or “prevailing” charge. Here is how we figure out those charges:

We receive information from a not-for-profit company formed to create an independent database not owned by any health insurer. Health plans send this independent company copies of claims for services received from providers. The claims include the date and place of the service, the procedure code, and the provider's charge. This claim information is combined into databases that show the amount providers generally charge for just about any service in any zip code.

“Reasonable and Customary (R&C) limits” are the maximum dollar amount of a charge that a plan will consider (prior to application of a deductible, coinsurance or maximum) when determining benefits payable by the Fund. Currently, the Fund's determination of what is reasonable and customary is based on 80% of what providers in your geographic area charge (as determined by the Fund, in its sole discretion) for similar services or supplies. (A “geographic area” is an area grouped by several ZIP Codes.) Any amount above the R&C limit is not considered an eligible expense. R&C limits apply anytime you see a non-network provider. If you use a non-network provider, you are responsible for paying any amount over the R&C limit.

If you are contemplating incurring a major medical expense, you may want to find out whether your non-network provider's charges fall within R&C limits for that service. Before you receive care, call the Administrative Office for assistance. R&C limits are re-evaluated and changed periodically.

IMPORTANT!

Check out the **Summary of Benefits** (starting on page 6), 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); and
- Visits to an emergency room or urgent care facility (copays applies in addition to the deductible).

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.

* A “hospital admission” means being checked into a hospital. 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.

OUT-OF-POCKET MAXIMUM

The “out-of-pocket maximum” is the total amount of coinsurance you pay for eligible expenses during the year before the PPO and Low Cost plans begin paying 100% of most eligible expenses for the rest of the year. A new out-of-pocket maximum begins each calendar year. If you reach your out-of-pocket maximum, the plan begins paying 100% coinsurance of eligible expenses. Also keep in mind that eligible network **and** non-network expenses count toward the out-of-pocket maximum. (See the *Summary of Benefits* on page 6 for the separate out-of-pocket maximums.)

Even if you reach the out-of-pocket maximum, you must still pay copays for:

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

LIFETIME MAXIMUM BENEFIT

The “lifetime maximum benefit” is the maximum medical benefit payable for a covered person throughout his/her lifetime. Effective January 1, 2011, the Fund’s lifetime maximum benefit has been eliminated for all coverage options (PPO Plan and Low Option Plan, regardless of whether coverage is provided on an in-network or out-of-network basis) under the Health Plan.

Annual Dollar Limits:

In accordance with applicable law, none of the annual dollar limits set forth in this SPD shall apply to “essential health benefits” as such term is defined under Section 1302(b) of the Affordable Care Act. The law defines “essential health benefits” to include, at a minimum, items and services covered within certain categories, including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, and laboratory services, but currently provides little further information. Accordingly, a determination as to whether a benefit constitutes an “essential health benefit” will be based on a good faith interpretation by the Fund Administrator on the guidance available as of the date on which the determination is made. Additional information regarding the specific application of these rules may be furnished in a future communication as regulatory and other guidance governing the law is issued by the government.

IMPORTANT!

Check out the **Summary of Benefits** for specific out-of-pocket maximum amounts.

Some Certified Retirees, who are Medicare-eligible and their Medicare-eligible dependents, spouses (opposite and same-sex), or Same-Sex Domestic Partners have lower out-of-pocket maximums than do Active Participants. (See the **Summary of Benefits** page 6 for more information.)

IMPORTANT!

The out-of-pocket maximum doesn’t include any expenses related to Preventive Care Services, Wellness or Prescription Drugs benefits.

HOW THE PPO PLAN WORKS

*Preferred Provider Organization (PPO) Plan is a network-based medical plan that gives you a choice when it comes to getting health care. The PPO Plan is available in all states across the United States and is the plan in which you are automatically enrolled once you become eligible for the Fund's health care benefits. This is how it works. The network organization contracts with physicians, hospitals and other health care providers to provide services at a contracted rate. (See the **Summary of Benefits** section, starting on page 6, for benefit information.) Neither you nor the Fund are required to pay any amount over the contracted rate.*

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

- ▶ Any **network provider** and paying a smaller percentage of the contracted rate. This means less money out of your pocket; or
- ▶ Any **non-network provider** and paying a percentage of the R&C charge, plus any amount over the R&C limit. This means your out-of-pocket costs will be higher.

The Fund uses a single nationwide hospital and major medical network (Blue Cross/Blue Card) for all PPO and Low Cost Option participants, no matter where you live or travel. (For specific claim submission for services rendered outside of California, see the “*Filing A Claim*” section for medical claims on page 49.)

Whether you see a network provider or a non-network provider, the PPO Plan covers a broad range of medical services and supplies, including wellness benefits, hospital treatment, prescription drug benefits, and mental health and chemical dependency benefits. Keep in mind that you always have the freedom to choose your provider and the services he/she recommends.

Patient Protection Disclosure - If the non-grandfathered group health plan benefit option in which you are enrolled requires 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). For The Industry Health Network (TIHN), you can contact TIHN's Customer Service department at (800) 876-8320 or for the Blue Cross/Blue Card network at (800) 810-BLUE (2583) or you can access the network's provider listing through our website, www.wgaplans.org, “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 procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact TIHN's Customer Service department at (800) 876-8320 or the Blue Cross/Blue Card network, you can call (800) 810-BLUE (2583) or you can access the network's provider listing through our website at www.wgaplans.org, “Find A Participating Provider”.

IF YOU LIVE OUTSIDE THE PPO NETWORK AREA

Participants who live more than 25 miles from a minimum of two providers of any type who participate in the hospital/major medical network may be considered for out-of-area benefits. The PPO Plan's out-of-area option pays a percentage of the cost of eligible expenses, up to the Reasonable and Customary (R&C) limit, after you meet the calendar-year deductible. (See the **Summary of Benefits**, starting on page 6 for specific percentages.)

If you're traveling in an area where there are PPO 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 R&C limits.

If a participant, who lives in a network area, is being treated for a serious condition which requires care from a specialist and there are no network specialists in his or her area, the participant may be considered for out-of-area benefits for services rendered by a non-contracted specialist in his or 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 option covers the same medical services and supplies that are otherwise covered under the plan, including prescription drugs and mental health and chemical dependency treatment. You are responsible for contacting the Administrative Office to determine if your provider would qualify for out-of-area benefits.

GETTING THE MOST FROM YOUR PLAN

The PPO Plan gives you a choice when it comes to getting medical care. Depending on how you use the plan, you will pay more or less for your care. You will also spend more or less time filing claims.

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

If you go to a **network** provider:

- ▶ If you have not met your calendar-year deductible, you will pay the full amount of the provider's charge, up to the contracted rate, and 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.

If you go to a **non-network** provider:

- ▶ 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 a coinsurance percentage (higher than the network percentage) of the R&C charges, and a copay, if applicable.
- ▶ If the physician charges more than the R&C limits, you will also pay the full amount over the R&C limit.

Claim Example: The participant's wife, Lynn, has bronchitis and goes to a network doctor. She knows that for doctors' visits, she does not have to pay a copay, but she does have to pay the coinsurance. Let us assume that Lynn has already met her individual calendar-year deductible of \$300. Let us also assume that the Fund pays 85% of the contracted rate for network services, which makes her coinsurance 15%. The spouse's doctor sends a bill for \$120, but because his contracted rate is \$90 for that service, the spouse's share of the cost is 15% of \$90, or \$13.50.

The participant, Jimmy, needs to go to the doctor. Let us assume that Jimmy has already met his individual calendar-year deductible. He always lets his business manager worry about bills, so he does not try to find a network provider. Instead, he goes to a new doctor in Beverly Hills. The doctor charges \$300 for the visit and Jimmy has to pay it up-front. The Fund will pay a percentage of R&C charges for non-network services, and Jimmy is responsible for paying the balance. Assume that the R&C charge for that service is \$170:

PATIENTS	PHYSICIAN'S CHARGE	ALLOWED AMOUNT	% OF THE ALLOWED AMOUNT THE FUND PAYS	AMOUNT THE FUND PAYS	AMOUNT LYNN PAYS
Lynn (goes to a network provider)	\$120	\$90	85%*	\$90 x 85% = \$76.50	\$90 x 15% = \$13.50 (deductible was already met)
Jimmy (goes to a non-network provider)	\$300	\$170	70%**	\$170 x 70% = \$119	\$170 x 30% = \$51 (deductible was already met)

* The Fund's reimbursement for network providers is considered at 85% of the allowable charges/contract rate.

** The Fund's reimbursement for non-network providers is considered at 70% of the Reasonable and Customary charges.

Jimmy is responsible for \$51.

Note: Costs cited in this example are for illustrative purposes only. Your own costs may be different.

SAVINGS SYNOPSIS

If you use a non-network provider, the Plan pays a lower percentage of eligible expenses (which means you pay more), and you're responsible for any amount over the R&C limit. To keep your out-of-pocket expenses to a minimum, use network providers whenever possible.

How THE INDUSTRY HEALTH NETWORK WORKS

(For Southern California Area Only)

If you live or are visiting or working in Southern California, a special network that allows you to save on your health care costs is available to you. Here are the benefits of using The Industry Health Network (TIHN).

- ▶ TIHN has six Motion Picture & Television Fund (MPTF) Health Care Centers set up for the exclusive use of entertainment industry members and Health Fund participants. These centers are conveniently located in Los Angeles (two sites), Burbank, Woodland Hills, Glendale, and Valencia. (See contact information in the *Summary of Benefits*, page 16.)
- ▶ TIHN benefits range from hospitalization, surgery, anesthesia, primary care visits, laboratory, radiology services, and well-child care.*
- ▶ You pay no deductible when you use TIHN providers and facilities, however, copays applies. (See *Summary of Benefits*, page 13.)
- ▶ If you and your covered dependents use TIHN primary care physicians (PCPs), providers and health centers, you can potentially save hundreds of dollars a year because you pay only a copay for each visit. You do not have to meet a deductible or have a coinsurance to pay.
- ▶ You need to call for an appointment to see a PCP at one of the TIHN Centers. A written referral for outside services, such as specialty care requires a written referral authorization from your PCP.
- ▶ Without a written referral, your standard benefits for the PPO Plan (including deductibles) will apply.**
- ▶ TIHN benefits are subject to the standard maximums and limitations of the PPO Plan.

* Children up to age 13 are seen by contracting TIHN pediatric health centers.

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

To find out where TIHN Centers are located and what you need to pay for services, refer to the *Summary of Benefits*, page 16, or go to www.wgaplans.org. Then, go to the Find A Provider section to link to TIHN's website.

HOW THE LOW OPTION PLAN WORKS

(For COBRA Participants and Extended Coverage Participants Only)

Only COBRA 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, page 6, for benefit information.)*

The Low Option Plan 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. The Low Option Plan does not include benefits for wellness, vision, prescription drugs, dental care, life insurance, accidental death and dismemberment (AD&D) insurance, and it covers 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. The plan 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 network or non-network providers, it is important to know how to reduce your costs as much as possible.

Also keep in mind that separate out-of-pocket maximums apply to network and non-network providers.

Claim Example: Take Bobby, who enrolled in the Low Option Plan as an Extended Coverage Program participant, and Max, Bobby's Same-Sex Domestic Partner. Max has bunions and goes to a network doctor. He knows that for doctor visits, he has to pay the coinsurance. Let us assume that Max has met the individual calendar-year deductible of \$750. Let us also assume that the Fund pays 70% for network services, and that Max pays 30%. If his doctor's negotiated fee is \$90, Max's share of that cost is 30% of \$90, or \$27.

Bobby wants to see a doctor about a knee problem. He does not look for a network provider. He goes to the doctor he saw advertised in the trades, who is a non-network provider. The doctor's visit sets him back \$300, which he pays at the time, even though he has met his calendar-year deductible. When he sends in the bill for reimbursement, the Fund pays a smaller percentage, 60%, of R&C charges for non-network services, or a total of \$102.

PATIENTS	CALENDAR-YEAR DEDUCTIBLE	PHYSICIAN'S CHARGE	R&C LIMIT	% OF R&C CHARGES THE FUND PAYS	AMOUNT THE FUND PAYS	AMOUNT THE PATIENT PAYS
Max (goes to a network provider)	\$750	\$90*	N/A	70%	\$90 x 70% = \$63	\$90 x 30% = \$27 after deductible
Bobby (goes to a non-network provider)	\$750	\$300	\$170	60%	\$170 x 60% = \$102	\$170 x 40% = \$68 \$300 - \$170 = \$130 Total: \$198 after deductible

* This is the contracted rate. Otherwise, the charge would have been \$250.

Bobby is responsible for paying \$198, and Max has to pay just \$27.

Note: Costs cited in this example are for illustrative purposes only. Your own costs may be different.

HOW THE SPECIAL FEATURES OF THE PPO PLAN AND LOW OPTION PLAN WORK

SPECIAL RULES FOR USING CERTAIN NON-NETWORK PROVIDERS AT NETWORK FACILITIES

When you receive treatment at a network facility and your treating physician (that is, the physician who ordered your treatment at the facility) is a network provider, any eligible services you receive from non-network anesthesiologists, radiologists, pathologists and emergency room physicians will be paid at the network percentage of the “Reasonable and Customary (R&C) limit.” That means that once you have met the deductible, you will be responsible for the network coinsurance plus any amount over the R&C limit for each service.

However, if you go to a non-network facility, you may not take advantage of this special rule. That means you will be responsible for a higher percentage of the cost (the non-network coinsurance) and any amount over the R&C limit. Also, please see page 48 to find out what expenses and charges are covered for emergency care.

MANAGING YOUR CARE

In most health care scenarios, you can take the time to discover the most effective and efficient way to manage your care. The Fund’s Utilization Administrator can help facilitate your care through Case Management intervention to help you make those non-urgent decisions. In emergency situations, you will need to take immediate action.

IMPORTANT!

If you use a non-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 R&C limit. To keep your out-of-pocket expenses to a minimum, use network providers whenever possible.

EMERGENCY CARE

No matter where you are, if you have a medical emergency — that is, a sudden and, at that time, unexpected change in your physical or mental condition which, if not treated immediately, could result in a loss of life or limb, significant impairment of a bodily function or permanent dysfunction of a body part — it is recommended that you go to the nearest emergency room to get the care you need. Here are some examples of medical emergencies:

- ▶ Active labor;
- ▶ Stroke;
- ▶ Complex fractures;
- ▶ Poisoning;
- ▶ Seizure or loss of consciousness;
- ▶ Suspected medication overdose;
- ▶ Severe pain;
- ▶ Severe shortness of breath;
- ▶ Severe burns;
- ▶ Uncontrolled bleeding;
- ▶ Sudden paralysis or slurred speech; and
- ▶ Chest pains or a severe squeezing sensation in the chest.

If you are covered under the PPO Plan or Low Option Plan and incur charges as the result of a medical emergency, your reimbursement level will depend on whether you received care from network or non-network providers. If, as a result of an emergency, you did not have time to contact a network provider, the Fund may review and consider your non-network claim for network benefits, subject to the Reasonable and Customary limits. You are responsible for contacting the Administrative Office to determine if services qualify for network benefits.

Effective January 1, 2012, the Fund will charge you the same copayment or coinsurance for hospital emergency room services only, when you obtain those services from a network hospital or from a non-network hospital. Accordingly, emergency care provided in an emergency room by non-network provider will be considered at the network coinsurance level, or 85% for the PPO Plan and 70% for the Low Option Plan, subject to the Plan's \$50 copayment and the annual deductible. However, if you obtain those services from a non-network hospital, that hospital may bill you separately if the hospital's charges exceed the Plan's allowances for the services.

URGENT CARE

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

- ▶ Back pain;
- ▶ Ear infections;
- ▶ Minor burns;
- ▶ Simple bone breaks (e.g., toe, finger);
- ▶ Sprains; and
- ▶ Urinary tract infections.

If you are in a PPO network area and want to receive the higher, network level of benefits, you must seek urgent care from a network provider; otherwise, you will receive the lower, non-network level of benefits. Emergency room services for Urgent Care do not qualify for the higher network coinsurance.

FILING CLAIMS

Prescription drug and dental benefits are administered by Express Scripts and Delta Dental. (You will find the contact information for the Fund's Claims Administrators in the *Summary of Benefits* section, page 16.)

Each professional claim filed with the Fund should include the following information:

- ▶ Participant's Name
- ▶ Patient's Name
- ▶ Patient's Date of Birth
- ▶ Provider's Federal Tax ID Number
- ▶ Procedure Code (provided by doctor on bill)
- ▶ Diagnosis Code (provided by doctor on bill)
- ▶ Participant's Health Fund ID Number (as it appears on the Health Fund ID Card)
- ▶ Provider's Name
- ▶ Provider's Address
- ▶ Amount Paid (if any)

PROVIDER CLAIM SUBMISSION

If you use a network provider, you are not responsible to submit the claim. Your network doctor, hospital or other provider will automatically accept assignment of benefits and submit the claim on your behalf. All you have to do is pay the applicable co-insurance, copay and deductible, if any.

If you use a non-network 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 Administrative Office for details about what you need to do to designate a representative.

Provider claim submissions are required to be sent as follows:

California Provider Paper Submission

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

California Electronic Submission: Anthem's electronic claim submitter number: **47198**

Non-California Provider All Claim Submission

See our website* and click on the "Claim Submission" tab, then on the "Hospital Claim" or "Professional Claim" link to locate the local Blue Cross office in your state.

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 Card office, using a participant direct submission claim form. You can obtain a copy from our website at www.wgaplans.org, forms section. It is recommended that you retain copies of the claims you are submitting.

ALL California participant direct claim submissions, with the exception of the claims noted on the next page are required to be sent to Anthem Blue Cross, using a participant direct submission claim form.

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

See the next page for the non-California participant direct claim submission.

IMPORTANT! FOREIGN CLAIMS

If you receive medical treatment in a foreign country, you should first contact BlueCard World Service Center for access to medical assistance services and healthcare providers around the world. (On the backside of your Medical ID Card, the phone number is listed under the title "To Find a Blue Card Provider".)

For inpatient care at a BlueCard Worldwide® hospital that was arranged through BlueCard Worldwide Service Center, you only pay the provider the usual out-of-pocket expenses (non-covered services, deductible, co-payment and co-insurance) when cashless access is arranged. The provider files the claim for you.

For all outpatient and professional medical care (including inpatient services where cashless access is not arranged), you must pay the provider fees at the time of service. Then submit a claim, in English, with invoices, any applicable medical records, and a statement with U.S. currency and currency exchange rate at the time of payment, to the Administrative Office for consideration of benefits.

Claims can be submitted directly to the Worldwide Service Center who will convert and translate your claims in preparation for processing by the Administrative Office. See our website at www.wgaplans.org, forms section for a copy of the International Claim Form.

ALL non-California participant direct claim submissions, with the exception of the claims noted below, are required to be sent to your local Blue Card office using a participant direct submission claim form. Refer to our website at www.wgaplans.org to locate the address of your local Blue Card office.

To receive Plan benefits for non-network claims, you must submit your non-network claims to your local Blue Cross/Blue Card office 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 can be submitted directly to the Administrative Office at the following address:

Writers' Guild-Industry Health Fund
1015 N. Hollywood Way
Burbank, CA 95105

- ▶ **Routine Vision claims from Non-Traditional Vision Providers.**
Some examples of non-traditional vision providers are as follows:
 - Costco;
 - LensCrafters;
 - J.C. Penney; or
 - Walmart

- ▶ **Wellness claims from Non-Traditional Healthcare Providers.**
Some examples of wellness claims from non-traditional healthcare providers are as follows:
 - Receipt for a flu shot received at a drug store;
 - Invoice for a smoking cessation program;
 - Invoice from a weight-loss program; or
 - 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 BlueCard World Service Center for access to medical assistance services and healthcare providers around the world. (The phone number is listed under the title “BlueCard Worldwide” on the backside of your Medical ID Card). For in-patient care at a BlueCard Worldwide hospital arranged through the BlueCard Worldwide Service Center, you only pay the provider the usual out-of-pocket expenses (i.e., non-covered services, deductible and copayment expenses). 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 BlueCard Worldwide Service Center, you will need to pay the healthcare provider directly and submit a BlueCard Worldwide International claim form with original bills, your participant Health Fund ID Number (as it appears on the Health Fund ID Card) and receipts to the BlueCard Worldwide Service Center.

If you live in a foreign country, your claims can be submitted 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.

BlueCard Worldwide International claim forms are available on our website, www.wgaplans.org, under “Forms” or visit www.BCBS.com/bluecardworldwide. It is recommended that you always retain copies of the claim(s) you are submitting.

BlueCard Worldwide Service Center: P.O. Box 72017 Richmond, VA 23255-2017 or call 1-800-810-2583 or collect: 1-804-673-1177

ASSIGNMENT OF BENEFITS

“Assignment of Benefits” means that you’re authorizing the Fund to pay the provider directly rather than paying you. Benefits are assigned automatically to network providers based on their agreement with the PPO network. Benefits may also be assigned to a non-network provider if he/she allows it.

Notwithstanding the foregoing, no benefit payable under the terms of this Health Plan shall otherwise be subject to the debts, contracts or liabilities of any individual covered by this Fund.

TIMELY FILING RULES

In-network claims (Facility and Professional claims) are subject to *Blue Cross/BlueCard's network timely filing limitations*. Out-of-network claims (Facility and Professional claims) not filed within two years of the date of service will be denied.

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 118.)

CLAIM DETERMINATIONS

The Claims Administrator may deny or grant a claim, in whole or in part, at his/her discretion. The Fund's claims provisions will be applied consistently for claimants in similar circumstances who are similarly situated, as determined by the Claims Administrator. (See *Administrative Information*, page 105 for more information about your rights under the claims and appeal process. Network providers are subject to Blue Cross/BlueCard timely filing limitations.)

UNDERSTANDING COORDINATION OF BENEFITS (COB)

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

You or your eligible dependents may be covered by other group health plans, and this can result in duplicate coverage. The Administrative Office should be notified when you or your dependents are covered by another plan. 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. Examples of other plans include your spouse's (opposite or same-sex) or dependent child's medical plan or Medicare.* The COB rules ensure that a person is not reimbursed for **more than** the actual expense incurred for a medical service or supply.

The Fund's benefits were designed to help you pay your health care costs but not provide extra income through payments above your health care obligations. The goal is to cover your costs so that no more than the total of all services, subject to the R&C 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.

*Special rules apply when any covered individual is diagnosed with End Stage Renal Disease (ESRD) or other disabling condition eligible for Medicare benefits. See page 30 for additional information.

THE PRIMARY-SECONDARY RULE

The plan with the first obligation to pay the claim is called the primary plan, and the other plan is the secondary plan. Usually, the plan covering someone as a participant based on employment is the primary plan, and the plan covering someone as a dependent is the secondary plan.

Note: *The Fund only applies COB to group health plans, not to individual policies. However, a plan is primary if it doesn't have COB rules.*

INFORMATION REQUIRED

During the Open Enrollment period, the Administrative Office will ask you to update information about other group health coverage you and/or your covered dependents may have. A COB form will be included in the Open Enrollment package.

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 Coordination Overpayment Policy as stated on page 120.

IF YOUR CHILDREN ARE COVERED BY MORE THAN ONE PLAN — ACTIVE PARTICIPANTS

If your eligible dependent children are enrolled in the Fund's medical plan **and** another group plan (such as your spouse's (opposite or same-sex) plan at work), the Fund uses the birthday rule to determine which plan pays benefits first. Under this rule, the plan of the parent **whose birthday occurs earliest** (month and day) in the year is the primary plan for dependent children. If both parents have the same birthday, the primary plan is the one that has covered a parent longer.

Note: If we do not have COB information on the first claim received on a dependent child, where the spouse's birthday occurs earliest, claims may be delayed until the required COB information is received.

When the Fund's medical plan is secondary, the Fund's payment will be limited so that the total payment from the primary plan and the Fund's plan is not more than what the Fund's plan would have paid if it had been the primary plan. However, the Fund reviews and pays coordinated benefit claims based on the highest allowable charges, up to the greater allowable expense of either plan.

If two or more plans cover a person as a dependent child (under 26 years old) of divorced or legally separated parents (whether or not they were ever married), benefits for the child are determined in this order:

- ▶ The plan of the custodial parent pays first;
- ▶ The plan of the custodial parent's spouse pays second; and
- ▶ The plan of the non-custodial parent pays third.

If the divorce settlement specifies otherwise, a copy of the court order is required, and the Fund will follow the court order. The primary-secondary rules

Note: The COB rules starting on page 51 applies to the pharmacy program and the dental plans. See page 55 for the specific COB rules that applies to your prescription drug coverage, page 79 for the DPO Plan and page 87 for the DHMO Plan

OTHER COB RULES

- ▶ A plan that covers you as an active participant is primary to a plan covering you as a participant receiving benefits under a severance plan or as a retiree.
- ▶ A plan that covers your dependent while you are an **active participant** is primary to a plan covering your dependent while you are a participant receiving benefits under a severance plan or a retiree.
- ▶ If none of the above rules determines the order of coverage, the plan that covered the participant longer is primary.
- ▶ If none of the above applies, the plan will coordinate payment with the other plan.

If the Fund pays benefits as the primary plan, it pays without consideration of what the secondary plan pays or does not pay.

If the Fund pays benefits as the secondary plan, it determines:

- ▶ What it would have paid if there had been no other group coverage; and
- ▶ What the primary plan has paid or will pay.

The Fund then pays the difference between the total charge for eligible expenses and the amount paid by the primary plan, within the maximums and limitations of the Fund's plan.

INFORMATION REQUIRED

You should notify the Administrative Office when you or your dependent is covered by another plan.

Claim Example: Let's say you need a minor operation that will cost \$1,200, which is within R&C limits. Let's also assume your individual calendar-year deductible is \$300 and your non-network coinsurance rate is 70% of R&C. Here's how the COB process would pan out based on the primary-secondary rule:

You must notify the Administrative Office as soon as you add or lose other group health coverage.

IF THE FUND IS PRIMARY . . .		IF THE FUND IS SECONDARY . . .	
Eligible expenses	\$1,200	Eligible expenses	\$1,200
Deductible	\$ 300	Primary plan paid	–\$ 700
	\$ 900	Fund pays	\$ 500
Non-network coinsurance	x 70%		
Fund pays	\$ 630		

COB Checklist

Before enrolling in or dropping coverage under any plan, consider the following:

- ▶ Which plan is considered my primary plan under each plan's coordination of benefits rules?
- ▶ What rules does each plan follow if another plan should be considered primary?
- ▶ Are there benefits if health coverage is provided under multiple plans for me or my dependents?

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 Administrative Office to update your records. See our website at www.wgaplans.org to access the COB form. You will need to click on the "Forms" tab displayed under the Health Fund menu, and then on the "Coordination of Benefits" link.

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

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 Producer - Writers Guild of America 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 were not involved. Surviving Spouses (opposite or same-sex) or Same-Sex Domestic Partners of such Certified Retirees, upon becoming eligible for Medicare, will then have their medical benefits coordinated with Medicare in the same way.

IMPORTANT!

Participants entitled to benefits under Medicare, whether or not they enroll will be deemed to have enrolled for purposes of determining which plan is primary and what benefits are payable by the Fund.

Claim Example: If you're enrolled in the PPO Plan, you've met your individual calendar-year deductible and you have eligible expenses of \$2,300. Let's also assume that, under the Fund, network coinsurance is 85% and non-network coinsurance is 70% of R&C.

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 Producer - Writers Guild of America 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 53, under the section titled: "Other COB Rules"). Surviving Spouses (opposite or same-sex) or Same-Sex Domestic Partners of such Certified Retirees, upon their becoming eligible for Medicare, will then have their medical benefits coordinated with Medicare in the same way.

IMPORTANT!

If your provider accepts Medicare assignment, the plan will consider up to the Medicare-allowed amount.

PPO PLAN		
	Network Provider	Non-network Provider
Eligible expenses	\$ 2,300	\$ 2,300
Assume Medicare pays first	– \$ 1,610	– \$ 1,610
Balance before the Fund pays	\$ 690	\$ 690
Maximum the Fund would pay if it were primary plan	$\$2,300 \times 85\% =$ \$ 1,955	$\$2,300 \times 70\% =$ \$ 1,610
Medicare payment	– \$ 1,610	\$ 1,610
Amount the Fund pays	\$ 345	\$ 00
Balance after the Fund pays	\$ 345	\$ 690
Amount you pay	\$ 345	\$ 690

HOW YOUR PRESCRIPTION DRUG BENEFITS WORK UNDER THE PPO PLAN AND LOW OPTION PLAN

Outpatient prescription drug benefits are not available if you enroll in the Low Option Plan.

PRESCRIPTION DRUG BENEFITS

The prescription drug program is administered by Express Scripts, an independent Claims Administrator. You and your dependents are covered for the cost of prescription medication for all outpatient needs through our outside Claims Administrator. You can purchase your medication from retail pharmacies and through the mail-order service.

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 in the plan and pay the required dependent coverage premium.

COORDINATION OF BENEFITS (COB)

The COB provision will be applied to the Prescription Drug Program. COB will apply when you obtain 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 will then have an opportunity to submit that portion to the Fund for reimbursement consideration. This will not apply to Certified Retirees, whose primary medical coverage is Medicare — we will continue as the primary plan for their prescription drugs.

If your coverage through the Fund is secondary, the COB claim form is available on our website at www.wgaplans.org, click "Forms/Health Fund". You will need to submit an Express Scripts COB claim form along with the following information:

- ▶ The primary plan's explanation of benefits (EOB) statement; and
- ▶ A copy of the pharmacy receipt or invoice that supports the prescription submitted to the primary plan.

Express Scripts will coordinate with your primary plan and reimburse you the lesser of:

- ▶ The amount your primary plan did not cover for you; or
- ▶ What the Fund would have paid on your behalf if it was the primary plan.

Claim Example: Participant uses their primary plan's RX card at the pharmacy and was responsible for the primary plan's \$20 copay. This is how the claim was coordinated with the primary plan and benefits paid:

FUND'S PRIMARY CALCULATION		AMOUNT SUBMITTED FOR SECONDARY PAYMENT	
Fund's approved amount	\$ 50.00	Primary Plan's copay amount	\$ 20.00
Less copay	\$(10.00)		
Fund's normal benefits	\$ 40.00	Amount submitted for reimbursement	\$ 20.00
Reimbursement amount will be the lesser of the two Amount Reimbursed To The Participant: \$ 20.00 Participant's Out-of-Pocket: \$ 0.00			

IMPORTANT!

Using the mail-order program is your most effective option when purchasing long-term maintenance medications. Ask your physician to write a prescription for a 90-day supply of each of the maintenance medications you need (including refills) and mail it with your order form and applicable copay(s) to Express Scripts.

IMPORTANT!

Both the Fund and you will pay the least when you purchase generic drugs through the mail-order service and the most 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 physician prescribes “Dispense as Written” (DAW) — you will 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. At the time your physician writes the prescription, you may also want to ask him/her whether a generic equivalent can be substituted.

HOW THE PRESCRIPTION DRUG PROGRAM WORKS

There are three categories of prescription drugs under your prescription drug benefit:

- **Generic** — The equivalent to a brand-name original drug and containing identical active ingredients at the same dosage (you will pay the least out of pocket);
- **Preferred brand** — A brand-name drug that appears on the Preferred Drug List (PDL) which identifies preferred choices in selected drug categories (you will pay more out of pocket for preferred brand-name drugs than you would for generic drugs); and
- **Non-preferred brand** — A brand-name drug that doesn't appear on the PDL (you will pay the most out of pocket).

You will pay a lower copay for generic and preferred-brand drugs than you will for non-preferred drugs. To obtain a copy of the PDL, contact Express Scripts or visit their website. (For their contact information see the *Summary of Benefits*, on page 16.)

You can fill your prescriptions in these three ways:

- For short-term medication, you can fill a prescription for up to a two-month supply (initial plus one refill) at:
 - A participating retail pharmacy; or
 - A non-participating pharmacy.
- For long-term (maintenance) medication, you **must** use the mail-order service when you fill a prescription. Otherwise, you will be required to pay the full cost of the medication.

Because both you and the Fund pay the least when you purchase prescription drugs through the convenient mail-order service, using this service whenever possible is the most cost-effective way to fill your prescriptions.

GETTING THE MOST FROM YOUR BENEFITS

RETAIL PURCHASES

If you have a short-term illness or injury and need to fill a prescription for up to a 30-day supply and one refill, you can purchase your medication at a retail pharmacy. You may go to any retail pharmacy you wish, but if you use a participating retail pharmacy, you pay only a copay at the time of purchase. Participating pharmacies have negotiated a lower rate for prescription drugs, so you pay less. If you go to a **non-participating 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 (proof of purchase) for reimbursement.

When you go to a participating 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.
- A participating pharmacy will automatically fill the prescription with a generic equivalent, unless your physician indicates “Dispense as Written” (DAW). If he/she makes that specification, your pharmacist is required to provide the exact brand and dosage indicated. Under these circumstances, dispensing a generic equivalent is **not** an option. You are responsible for paying the generic copay plus the difference in cost between the generic drug 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*”, page 58.)

For a copy of the participating retail pharmacies within your home state or when traveling, contact Express Scripts or visit their website. (See the *Summary of Benefits*, page 16 for contact information.)

When you go to a non-participating pharmacy:

- ▶ Present the pharmacist with your prescription for up to a 30-day supply (and one refill) of medication.
- ▶ Pay the pharmacy the full amount of your prescription.
- ▶ Obtain a copy of the pharmacy claim form from our website at www.wgaplans.org, forms section. Submit your receipt along with this claim form to Express Scripts. You will receive a reimbursement of the highest dollar amount according to the plan formula. (See “*Filing a Claim*” on page 60.)

MAIL-ORDER PRESCRIPTIONS

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 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:

- ▶ Ask your physician 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 physician. This list is available upon request from the Administrative Office or from Express Scripts. The pharmacist will automatically fill the prescription with a generic equivalent, unless your physician specifies “DAW.”
- ▶ If you need to begin a new maintenance medication immediately, have your physician write two prescriptions:
 - One for up to a 30-day supply, to be filled immediately at a retail pharmacy; and
 - Another for up to a 90-day supply (plus up to three refills, if applicable), to be filled through the mail-order service.
- ▶ If your physician 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.
- ▶ If you are currently on a maintenance medication that you want to start obtaining through the mail-order service, ask your physician to write a new prescription for a 90-day supply with three refills, if applicable.

IMPORTANT!

You are eligible to receive a discount off the purchase price of any prescription drug not covered under the Fund’s Prescription Plan. This pricing discount is available at any retail pharmacy that participates in the Express Scripts (E.S.I.) pharmacy network and through E.S.I.’s Mail Order Pharmacy.

At retail - just present your Health Fund ID card to your participating retail pharmacy, they will run your card through the E.S.I. system and obtain your discounted cost. You will pay 100% of the discounted cost for the non-covered drug.

To use E.S.I.’s Mail Order Pharmacy – simply mail your prescription in with your completed “Mail Order Form” to E.S.I. for processing. You can determine your cost for the medication in advance by logging onto E.S.I.’s website.

www.express-scripts.com

SAVINGS SYNOPSIS

When you purchase prescription drugs through the mail-order service, you pay one low copay for up to a 90-day supply, and you pay the lowest copay of all when your physician prescribes generic medications. Keep in mind that you will pay the same copay for a 90-day supply through the mail-order service 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 order form. The form is available by calling the Administrative Office or by visiting the Express Scripts website. Remember to include your prescription drug ID card number on the form.

Mail the following in the pre-addressed envelope:

- ▶ Patient Profile Card;
- ▶ Order form;
- ▶ Original prescription(s) written by your physician; and
- ▶ Your copay(s). Refer to the *Summary of Benefits*, page 12 for the correct amount.

You should receive your medication within 10 to 14 days from the date you mail your order. Due to this short delay, it is important to plan ahead for your long-term medication needs.

REFILLS

Your prescription label lists the date when you can request a refill and indicates 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 the mail-order service is to log on to Express Script's website at www.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 a participating pharmacy, a non-participating 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 copay for each prescription, and there is no out-of-pocket maximum.

WHAT'S COVERED

The prescription drug program covers the following medications, whether purchased at a retail pharmacy or through the mail-order service:

- Prescription medications and injectable insulin;
- Diabetic supplies when purchased with insulin, including:
 - Needles/syringes/cartridges;
 - Glucose meter;
 - Alcohol swabs;
 - Lancets; and
 - Test strips.

Note: when ordered by a physician and purchased separately, these diabetic supplies may also be covered under the medical plan.

- Compounded medication (that is, one prescription combining several ingredients of which at least one ingredient is an eligible prescription drug);
- Prescription contraceptives when prescribed by a physician (such as pills, patch, injectables, etc.);
- Tretinoin for covered persons under 26 years of age;
- Vitamins that require a prescription; and
- Any other drug which, under state law, may be dispensed only upon written prescription of a physician unless excluded as indicated under “*What’s Not Covered*,” below.

WHAT'S NOT COVERED

The following is a list of charges that are not covered by the prescription drug program:

1. Any charge for the administration of a prescription drug or injectable insulin;
2. Any medication, prescription or otherwise, that is consumed or administered at the place where it is dispensed, such as
 - Botulinum Toxin A (Botox) (unless approved for certain conditions, contact the Fund office to obtain a Medical Review); or
 - Botulinum Toxin B (Myobloc) (unless approved for certain conditions, contact the Fund office to obtain a Medical Review);
3. Charges you or your dependents aren't required to pay;
4. Contraceptives not prescribed by a physician;
5. Cosmetic hair growth removal products;
6. Depigmenting agents;
7. Drugs labeled: “Caution — limited by Federal Law to investigational use” or experimental drugs, even though the drug was prescribed by their physician;
8. Hair-growth stimulators;
9. Immunization agents (except for Synagis), biological sera, blood or blood plasma;
10. Items that may be purchased without a written prescription (“over-the-counter”) Exception is the over-the-counter drugs covered under the *Preventive Care Services*, see pages 69-72.

11. Loratadine products;
12. Medication that is 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 operates a facility for dispensing pharmaceuticals on its premises;
13. Naturopathic medicine/Naturopathy services;
14. Non-sedating antihistamines, such as Allegra, except in select cases when your physician 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.;
15. Obesity treatment medications;
16. Over-the-counter medications, such as Tylenol, Colace, etc.;
17. Prescription drugs taken for cosmetic reasons;
18. Prescription drugs that aren't medically necessary;
19. Prescription drugs that may be obtained without charge under local, State or Federal programs, including Workers' Compensation;
20. Prescriptions for more than a 30-day supply for retail purchase or a 90-day supply for mail-order (contact the Eligibility Department if you are going to be out of the state or the country for longer than 90 days);
21. Proton pump inhibitors (PPIs), such as Nexium;
22. Refilling of a prescription over the amount specified by the physician or dentist, or any refill purchased more than one year from the date of the prescription;
23. Testosterone replacement and erectile dysfunction drugs, except in certain cases if your physician provides a letter explaining why the drug is medically necessary. Contact the Fund office to obtain a Medical Review.;
24. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances; and
25. Tretinoin, all dosage forms (e.g., Retin-A) for individuals 26 years of age or older. The use of Retin-A as a treatment for photo-aging (wrinkles) is not covered.

FILING A CLAIM

You need to file a claim whenever you purchase a prescription at a non-participating pharmacy. Claim forms can be obtained from our website at www.wgaplans.org, click "Forms/Health Fund". You can 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 under Preventive Care Services benefits are covered through the Plan's Pharmacy Benefit Program.

HOW YOUR VISION BENEFITS WORK UNDER THE PPO PLAN AND LOW OPTION PLAN

Outpatient Vision benefits are not available if you enroll in the Low Option Plan.

Your vision plan acts as a plan within your medical plan, with its own specific benefits. Most routine eye care services are covered under the vision plan. Some services, however, such as treatment for an eye injury or illness, may be covered under the medical plan's benefits and limitations.

WHO'S COVERED

You and your covered dependents are covered for vision benefits 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 in the medical plan and pay the required dependent coverage premium.

HOW YOUR VISION BENEFITS WORK

The Fund pays benefits **regardless of where you receive vision care services**. Although the vision plan doesn't have a specific network for eye care services, the Medical Plan's PPO network does include ophthalmologists. (See contact information and in the *Summary of Benefits* section, page 16.)

WHAT YOU PAY

Regardless of where you go for eye care, the following applies:

- You must meet either the individual or family deductible before benefits begin. Your medical calendar-year deductible applies to both medical and vision care, so you do not have to satisfy a separate deductible.
- After you satisfy the deductible, the plan's coinsurance level is applied, up to the plan's \$200 calendar-year maximum benefit.
- If your provider doesn't accept assignment of benefits, you must pay your provider for vision care expenses up-front, and then submit a claim for reimbursement.

WHAT'S COVERED

The vision plan includes coverage, up to a calendar-year maximum benefit, for:

- Frames, prescription lenses and contact lenses; and
- Refractions, tonometry and exams to assess your vision and for prescribing corrective lenses.

WHAT'S NOT COVERED

The vision plan does not cover:

1. Non-prescription sunglasses, clip-on sunglasses, or color contact lenses;
2. Laser eye surgery;
3. Shipping and handling charges; and
4. Any cost for services above the calendar-year maximum benefit.

HOW TO FILE A CLAIM

For information about filing claims, see "*Filing Claims*", page 49.

** Dependents under the age of 18 years old are not subject to the \$200 calendar-year maximum benefit for vision benefits that are determined to be essential health benefits.*

LOOKING AT ELIGIBLE AND INELIGIBLE MEDICAL EXPENSES

IMPORTANT!

All **alternative therapy**, claims are subject to review for medical necessity at time of payment. See the section to the right for the services that require a referral from a M.D.

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 their license:

- Certified Acupuncturist;
- Doctor of Chiropractic;
- Doctor of Medicine;
- Doctor of Oriental Medicine (only acupuncture treatments are covered);
- Doctor of Osteopathy;
- Registered Occupational Therapist; and
- Registered Physical Therapist.

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 Administrative Office.

Once you satisfy the deductible, the Fund will pay a percentage of charges for medically necessary expenses required to treat an illness or injury. (See page 129 for the definition of “*medically necessary*.”) The percentage will depend on whether you see a network or non-network provider, or whether you live outside the network area. (For details, see the *Summary of Benefits* starting on page 6.)

The following eligible expenses appear in alphabetical order. This list includes most, but not all, eligible expenses. Expenses are eligible only if medically necessary and not more than the network allowances or the reasonable and customary (R&C) limits.

ALTERNATIVE MEDICAL BENEFIT

Benefits for therapy provided by a “covered provider” are covered for the following services and therapies:

- ▶ Acupuncture for chronic pain control;
- ▶ Biofeedback therapy; *
- ▶ Chiropractic care;
- ▶ Lymphedema therapy; *
- ▶ Occupational therapy; *
- ▶ Osteopathic manipulative therapy; and
- ▶ Physical therapy *
- ▶ Electro Convulsive therapy *
- ▶ Orthoptic treatment (i.e., eye training or visual programs).

* A referral is required from an M.D.

The Fund allows up to \$60 per day, payable at the in or out-of-network coinsurance level.

AMBULATORY SURGICAL CENTER

An Ambulatory Surgical Center must have permanent facilities and be equipped and operated 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.

BIRTHING CENTERS

A birthing center is a facility established to manage low risk, normal, uncomplicated pregnancy with delivery within 24 hours of admission to the center. 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;
- ▶ Services of a midwife under the supervision of a medical doctor.

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

Various forms of contraception are covered by the Health Fund. Some forms are covered under medical benefits and some under prescription drug benefits (see *Prescription Drug Benefits* section beginning on page 55 for more information), as follows:

- ▶ Depo-Provera, IUDs and Norplant are covered under the prescription drug benefits. These devices are covered under the prescription drug benefits if purchased at a retail pharmacy or mail-order services. Otherwise they are covered under medical benefits;
- ▶ Vasectomies and tubal ligations are covered under medical benefits; and
- ▶ Diaphragms and birth control pills are covered under prescription drug benefits.

Note: Effective January 1, 2013, the Fund will cover approved women's contraceptive methods under the Preventive Care Benefits at 100% with no deductible or copayment if rendered by an in-network provider in accordance with the applicable requirements under PPACA (PPO and Low Option Plans). (See page 72 of the SPD for details as to what contraceptive methods are covered under this rule.)

EMERGENCY ROOM SERVICES

The Fund will charge you the same copayment or coinsurance for hospital emergency room services whether you obtain those services from a participating in-network hospital or from a non-participating out-of-network hospital. Accordingly, emergency care provided in an emergency room by an out-of-network provider will be considered at the network coinsurance level or 85% for the PPO Plan and 70% for the Low Option Plan, subject to the Fund's \$50 copayment* and annual deductible. However, if you obtain those services from a non-participating out-of-network hospital, that hospital may bill you separately if the hospital's charges exceed the Fund's allowances for the services. Coverage for the emergency room services at the network coinsurance rate must meet the definition of emergency care as noted on page 48.

* Copay is waived if admitted; hospital admission copay applies.

ELECTIVE SURGERY — NETWORK SECOND OPINION

Services from a physician and diagnostic X-ray and laboratory services in connection with one second opinion per surgery are covered when the physician recommends non-emergency elective surgery and when the services are coordinated through the Plan's network. If the second opinion confirms the first, the Fund will pay a percentage of the primary surgeon's R&C charges over and above what it would otherwise pay.

ENHANCED EXTERNAL COUNTERPULSATION (EECP) THERAPY

EECP therapy is covered. (See the *Summary of Benefits* section, page 10, for details.)

HOME HEALTH CARE (PREAUTHORIZATION REQUIRED)*

Home health care services are provided to individuals who are considered to be home-bound. These services are covered when they are ordered by your physician and reviewed by the Fund's Utilization Administrator. Intermittent services include physical, occupational or speech therapy or nursing care provided by a licensed provider (R.N., L.P.N, or L.V.N.).

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

- ▶ Used in place of hospital or skilled nursing facility confinement or otherwise meet the Fund's Utilization Administrator requirements; and
- ▶ Periodically reviewed for medical necessity through preauthorization. **Custodial care (such as bathing, dressing or cooking) is not a covered benefit.**

HOME INFUSION THERAPY (PREAUTHORIZATION REQUIRED)*

Home infusion care (i.e., the administration of medication in the home setting as an alternative to hospitalization) is covered when your physician and the Fund's Utilization Administrator have determined it is medically appropriate for your condition and a licensed health care professional provides the service.

Examples of home infusion therapy include:

- ▶ Central line care and maintenance;
- ▶ Chemotherapy;
- ▶ Drug therapy (such as antibiotics or antivirals);
- ▶ Hydration therapy (with fluids, electrolytes and other additives);
- ▶ Pain management; and
- ▶ Total Parenteral Nutrition (TPN).

HOSPICE (PREAUTHORIZATION REQUIRED)*

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.

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;
- ▶ Any other services required for the patient's comfort; and
- ▶ Rental of all equipment needed for care in the home such as a hospital bed or bedside commode.

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 through Case Management.

* Please have your provider contact the Fund's Utilization Administrator to facilitate your care through Case Management Intervention. On the backside of your Medical ID card, you will find the phone number for PreAuthorization or Pre-Service Review.

HOSPITAL, SURGICAL, MEDICAL

All plans cover the following at the applicable network or non-network level:

- ▶ Artificial limbs and eyes;
- ▶ Cardiac rehabilitation for medically necessary treatments, including angioplasty and valvoplasty procedures;
- ▶ Charges for fitting or purchasing hearing aids or devices, subject to limitations (see the *Summary of Benefits*, page 10, for details);
- ▶ 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;
- ▶ Collection, processing and storage of self-donated blood when collected for a planned and covered surgical procedure;
- ▶ Electrocardiograms;
- ▶ Emergency air or sea ambulance, when approved by the Fund's Medical Consultant, subject to limitations (See the *Summary of Benefits*, page 9, for details);
- ▶ Emergency ground ambulance transfer to the nearest hospital;
- ▶ Emergency medical care;
- ▶ Hydrotherapy;
- ▶ In-hospital/ambulatory center prescription medication and oxygen (excluding take-home medication);
- ▶ Inpatient rehabilitative therapy provided at a comprehensive medical rehabilitation hospital (acute rehabilitation facility), provided that case management reviews the placement, and:
 - 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) provided at least three times per day, five days per week; and
 - The patient's medical condition and treatment require physician supervision at least three times per week;
- ▶ Intensive care unit or similar care unit;
- ▶ Laboratory, X-ray and diagnostic tests;
- ▶ Maternity and newborn infant coverage. 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 normal vaginal delivery, and for a minimum of 96 hours after a Caesarean section;
- ▶ Ordinary casts, splints, dressings and crutches;
- ▶ Outpatient hospital/ambulatory center care and treatment;
- ▶ Oxygen and rental of equipment for giving oxygen for medically appropriate patients based on the following guidelines as determined by Medicare:
 - Chronic lung disease, such as chronic obstructive pulmonary disease, interstitial fibrosis, bronchiectasis, cystic fibrosis or cancer; and
 - Hypoxemia at rest, with exercise or during sleep;

- ▶ Physical therapy as described under “*Alternative Medical Benefit*” on page 62;
- ▶ Physician care within or outside the hospital;
- ▶ 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.
- ▶ Screening colonoscopies;
- ▶ Services of surgeons, assistant surgeons, anesthesiologists and other specialists;
- ▶ Services related to a hospital/ambulatory center;
- ▶ Surgical and anesthetic supplies;
- ▶ 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;
- ▶ Use of operating and cystoscopic rooms; and
- ▶ X-ray, radium and radioisotope therapy.

INVERSION DEVICE

The rental or purchase of an inversion device is covered if a physician prescribes the device as a treatment for chronic back problems. Documentation of at least six months of prior medical treatment is required.

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 recognized by the American Hospital Formulary Service Drug Information, the U.S. Pharmacopoeia Dispensing Information, Vol. 1, 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; and
- ▶ The drug is medically necessary to treat the specific medical condition, including life-threatening conditions or chronic and seriously debilitating conditions.

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 definition of *medically necessary* on page 129.

ORGAN AND TISSUE TRANSPLANTS (PREAUTHORIZATION REQUIRED)*

Organ and tissue transplants must be preauthorized to be eligible for coverage. If preauthorization is not received, coverage will be denied.

The following organ and tissue transplants are eligible for coverage:

- ▶ Bone transplants;
- ▶ Heart-lung transplants;
- ▶ Intestine transplants;
- ▶ Kidney-pancreas transplants;
- ▶ Liver transplants;
- ▶ Pancreas transplants;
- ▶ Bone marrow transplants, either autologous or allogeneic.
- ▶ Corneal transplants;
- ▶ Heart transplants;
- ▶ Kidney-renal transplants;
- ▶ Knee chondrocyte transplants;
- ▶ Lung transplants;
- ▶ Stem cell transplants; and

Each transplant case will be reviewed by the Fund's Utilization Administrator. Case Management will review the data and recommendations before treatment begins to determine whether the proposed treatment is investigational and/or medically necessary.

If preauthorization of an organ or tissue transplant is denied by the Fund or the Fund's Utilization Administrator and the organ or tissue transplant is one that could be eligible for coverage in appropriate cases, the denial may be appealed in accordance with the Fund's appeals procedures described on page 105. 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 approved and donor expenses are involved and the donor has no coverage under his or 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 evidencing that donor expenses are not covered under the donor's plan is required.

Coverage of expenses for the donor will be limited to the surgical removal of the organ or tissue, related in-patient 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, and the expenses are incurred at, a network provider. 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. You (the recipient of the donated organ or tissue) are responsible for the amount of any donor expenses not covered by the Fund. For example, if you are in 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 through Case Management Intervention. On the backside of your medical ID card, you will find the phone number for Preauthorization or Pre-Service Review.

PREAUTHORIZATION – INPATIENT AND OUTPATIENT FACILITY EXPENSES

To receive the highest level of benefits for inpatient and outpatient facility expenses, you need to see a network provider, who will work with Blue Cross/Blue Card to preauthorize your care. It is your responsibility, however, to first call Blue Cross/Blue Card to verify that the 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 Blue Cross/Blue Card.

Preauthorization is required for:

- ▶ All in-network and out of network inpatient admissions; and
- ▶ All in-network and out of network outpatient facilities. (Facility includes Residential, Partial hospitalization and Intensive Outpatient Programs)

If you do not preauthorize your care, your claim will be subject to a post-admission medical necessity review, which may delay the processing of your claim.

Preauthorization for inpatient or outpatient facilities should be obtained 7 to 10 days in advance by calling Blue Cross/Blue Card.* This includes any facility-based treatment, such as inpatient hospitalization, rehabilitation and residential treatment, or partial hospitalization and intensive outpatient programs for all conditions.

If you are admitted to the hospital or other facility because you have an emergency, you must preauthorize within 48 hours (or two business days) of your admission by calling Blue Cross/Blue Card. Your case will be assigned to a team of Clinical Care Managers.

** Please have your provider contact the Fund's Utilization Administrator to facilitate your care through Case Management Intervention. On the backside of your medical ID card, you will find the phone number for Preauthorization or Pre-Service Review.*

PHYSICIAN CARE

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

- ▶ 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 paramedical 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.

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 procedure considered incidental or non-covered.

PREVENTIVE CARE SERVICES

The Health Plan will cover certain preventive care services at 100% with no deductible or co-payment if they are rendered by an in-network provider.

The preventive services to which this new rule applies is generally defined to include the following, and may be amended from time to time:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventative Services Task Force (“Task Force”) with respect to the individual involved. (For a complete list of “A” and “B” recommendations of the Task Force see <http://www.healthcare.gov/center/regulations/prevention/taskforce.html>).
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force).

Pages 70–72 contain a list of preventive care services that are currently covered at this level under the Plan, but this will change automatically as the above guidelines/recommendations change. Additional detail regarding these preventive care services may be found online at www.healthcare.gov/center/regulations/prevention/taskforce.html.

Many of the tests and screenings listed on these charts are already covered under the Plan’s wellness benefits. There are certain wellness services that are not deemed to be preventive care services and, therefore, will continue to be covered under the Plan’s Wellness Benefit Program. Accordingly, the Fund will apply the preventive care benefits first and any remaining wellness benefits (that do not constitute preventive care services) will be applied toward the Plan’s \$500/person or \$1500/family annual wellness benefits.

Note: Cost Sharing When Preventive Care Services Are Provided as Part of an Office Visit:*

Generally speaking, the imposition of a cost-sharing requirement 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: (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.*

Also, 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 in-network. Some of the tests ordered by your doctor might not be for preventive services and may be subject to any applicable deductibles, co-pays, or co-insurance. For example, if you go to a network provider for a sore throat and while there it is recommended that you have your cholesterol checked, the office visit is subject to the deductible/co-pay/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.

**The office visit rules stated above will apply to facility charges and it may not include all associated services, such as the anesthesia services or facility charges.*

Note: the following applies to the charts on pages 70, 71 & 72.

- PPO and Low Option Plan, in-network provider 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.
- Wellness Benefits are not available under the Low Option Plan.
- Refer to recommendation listed in the July 2011 IOM report entitled “Clinical Preventive Services for Women”: Closing the Gaps concerning individual preventive services that may be obtained during a well-women preventive service visit.

LIST OF COVERED PREVENTIVE CARE SERVICES: NETWORK ONLY

HEALTH SCREENINGS FOR ADULTS

- Blood pressure screening for adults
- Cholesterol screening for men age 35 and older, women age 45 and older, and younger adults at higher risk
- Diabetes screening for type 2 diabetes for adults with high blood pressure
- HIV and sexually transmitted infections (STI) screenings for adults at higher risk

<p>Cancer Screenings</p>	<ul style="list-style-type: none"> • Breast cancer mammography every 1 to 2 years for women over age 40 • Breast cancer chemoprevention counseling for women at high risk for breast cancer • Cervical cancer pap test for women • Colorectal cancer screening including fecal occult blood testing, sigmoidoscopy or colonoscopy from age 50 to 75 • Prostate cancer (PSA) screening for men 	
<p>Health Counseling</p>	<ul style="list-style-type: none"> • Healthy diet • Weight loss • Tobacco use • Alcohol misuse 	<ul style="list-style-type: none"> • Depression • Prevention of STIs • Use of aspirin to prevent cardiovascular disease
<p>Adult Immunizations</p>	<ul style="list-style-type: none"> • Depression screening • Alcohol and drug use assessment • Cervical dysplasia screening for sexually active young women • Counseling to prevent sexually transmitted infections (STIs) for sexually active adolescents • HIV screening for adolescents at higher risk 	
<p>Screenings for Men</p>	<ul style="list-style-type: none"> • Abdominal aortic aneurysm one-time screening for men age 65 to 75 who have smoked 	
<p>Screenings for Women</p>	<ul style="list-style-type: none"> • Osteoporosis screening for women age 60 and older, depending on risk factors • BRCA counseling about genetic testing for women at higher risk 	
<p>Specifically for Pregnant Women</p>	<ul style="list-style-type: none"> • Folic acid supplements for women who may become pregnant • Alcohol and drug use assessment • Tobacco cessation counseling for all pregnant women who smoke • Syphilis screening for all pregnant women 	<ul style="list-style-type: none"> • Hepatitis B screening during the first prenatal visit • RH incompatibility blood type at first prenatal visit and 24-28 weeks • Bacteriuria urinary tract infection screening at 12 to 16 weeks • Breastfeeding education to promote breastfeeding

LIST OF COVERED PREVENTIVE CARE SERVICES: NETWORK ONLY

CHILDREN AND ADOLESCENTS

<p>Newborns</p>	<p>Screening all newborns for</p> <ul style="list-style-type: none"> • Hepatitis A & B • Hypothyroidism 	<ul style="list-style-type: none"> • Phenylketonuria (PKU) • Sickle cell disease • Gonorrhea preventive medication for eyes of all newborns
<p>Childhood / Adolescent Immunizations</p>	<ul style="list-style-type: none"> • Diphtheria, Tetanus, Pertussis • Haemophilus influenzae type B • Hepatitis A & B • Human Papillomavirus (HPV) • Influenza (Flu) 	<ul style="list-style-type: none"> • Meningococcal • Pneumococcal • Inactivated Poliovirus • Rotavirus • Varicella (chickenpox)
<p>Childhood Screenings</p>	<ul style="list-style-type: none"> • Medical history of all children throughout development • Height, weight and Body Mass Index (BMI) measurements • Developmental screening for children throughout childhood • Autism screening for children at 18 and 24 months • Behavioral assessment for children of all ages • Vision screening • Oral health risk assessment for young children 	<ul style="list-style-type: none"> • Hematocrit or Hemoglobin screening • Obesity screening and weight-management counseling for children age 6 or older • Iron supplements for children 6 to 12 months who are higher risk for anemia • Floride supplements for children without floride in their water • Lead screening for children at risk of exposure • Dyslipidemia screening for children at higher risk of lipid disorder • Tuberculin testing for children at higher risk of tuberculosis
<p>Additional Screenings for Adolescents</p>	<ul style="list-style-type: none"> • Depression screening • Alcohol and drug use assessment • Cervical dysplasia screening for sexually active young women • Counseling to prevent sexually transmitted infections (STIs) for sexually active adolescents • HIV screening for adolescents at higher risk 	

TYPE OF PREVENTIVE SERVICE	HHS GUIDELINE FOR HEALTH INSURANCE COVERAGE	FREQUENCY
Well-Women Visits	Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services covered by the Fund with no cost-sharing.	Annual, as well as additional visits needed to obtain recommended preventive services as determined by the health care provider, depending on a woman's health status, health needs, and other risk factors.* (see note)
Screening for gestational diabetes	Screening for gestational diabetes	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
Human papillomavirus testing	High-risk human papillomavirus DNA testing in women with normal cytology results.	Beginning at age 30 and no more frequently than every 3 years, regardless of Pap smear results.
Counseling for sexually transmitted infections	Counseling on sexually transmitted infections for all sexually active women.	Annual
Counseling and screening for human immune deficiency virus	Counseling and screening for human immune-deficiency virus infection for all sexually active women.	Annual
Contraceptive methods and counseling	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.	As prescribed
Breastfeeding support, supplies, and counseling	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.	In conjunction with each birth
Screening and counseling for interpersonal and domestic violence	Screening and counseling for interpersonal and domestic violence.	Annual

Note: In accordance with the applicable requirements under PPACA, effective January 1, 2014, the Fund will not have any preexisting condition exclusions.

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 Administrative Office.

SKILLED NURSING FACILITIES — (PREAUTHORIZATION REQUIRED)*

Case Management may authorize coverage for a skilled nursing facility if it will benefit the patient and satisfy the Fund's medically necessary guidelines. The skilled nursing facility must also satisfy each of the following requirements:

- ▶ 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's 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 provider contact the Fund's Utilization Administrator to facilitate your care through Case Management Intervention. On the backside of your medical ID card, you will find the phone number for Preauthorization or Pre-Service Review.

SPEECH THERAPY

Speech therapy services, up to 100 visits annually, are eligible for coverage when prescribed by a physician to treat any 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, an 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 is **not** an available benefit when it's part of an educational program for a child with learning delay unless the child has been diagnosed with of autism, pervasive developmental disorder, severe attention deficit hyperactivity disorder or another condition listed as eligible for speech therapy benefits in this section.

Only licensed speech therapists/pathologists are eligible providers of speech therapy.

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 Administrative 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 less 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)

X-rays and physiotherapy visits per person at the applicable in-network or out-of-network benefit levels are covered. Charges for a TMJ appliance or splint, including follow-up visits for adjustments, will also be paid at applicable in-network or out-of-network benefit levels.

WELLNESS BENEFIT

The PPO Plan provides each family with a calendar-year Wellness Benefit, up to a maximum calendar year limitation. (See the *Summary of Benefits*, page 12 for the maximum amount):

- ▶ Routine physical examinations;
- ▶ Well child care for children age seven and older;
- ▶ Flu shots, vaccinations and immunizations. Charges in connection with a wellness visit for children under age seven are considered an eligible expense under the plan's benefits rather than under the wellness benefit;
- ▶ Smoking cessation programs;
- ▶ Weight-loss programs if the program includes treatment for a specific disease diagnosed by a physician. Programs that require attendance, such as Weight Watchers, will be reimbursed only after services are rendered. Proof of attendance is required when you submit your claim;
- ▶ Nutritional counseling if to treat a specific disease diagnosed by a physician;
- ▶ Genetic testing;
- ▶ Lifestyle classes and Fitness Enhancement (offered at the Motion Picture & Television Fund Health Centers (MPTF) located in Southern California);
- ▶ Routine mammograms; and
- ▶ Routine pap smears.

**The Fund will cover certain preventive services at 100% with no deductible or co-payment if they are rendered by an in-network provider. Please see page 69 for more details about these services.*

As with all Fund benefits, only services performed by a licensed practitioner 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 go to a provider, contact the Administrative Office.

Note: *If the wellness benefit is exhausted, the expenses will be considered under medical benefits, subject to the Plan's annual deductible and out-of-pocket maximum. This rule doesn't apply to the Low Option Plan. (See the *Summary of Benefits* section, page 6, for more information).*

WIGS

Wigs are covered, if necessary due to injury, disease or treatment of an injury or disease, but **not for cosmetic reasons**.

EXPENSES NOT COVERED

Notwithstanding the above, none of the medical plans cover any of the following expenses:

1. Acupressure or massage therapy.
2. Acupuncture (except for treatment of chronic pain).
3. Air conditioners, humidifiers, allergy-free pillows, mattress covers and similar environmental control equipment.
4. Autologous blood storage charges, unless in association with a scheduled surgery that is normally covered by the Fund.
5. Bariatric surgery, unless it meets the Plan's requirement for bariatric surgery (available in writing from the Fund office).
6. Charges associated with the translation of foreign claims.
7. Charges billed for procedure codes determined by the Plan to be incidental or mutually exclusive to or unbundled from a more global procedure code, except as determined by network pricing.

8. Charges for completing claim forms, reports, etc.
9. Charges for copying medical file records, except when requested by the Fund for medically necessary review.
10. Charges for eye refraction, eye exams, contact lenses and eyeglasses, except as provided under the vision plan. (See “*What’s Covered*” on page 61 for details). Any surgical procedure, such as LASIK, to correct a refractive error.
11. Charges for mailing and shipping of medical supplies.
12. Charges for umbilical cord blood collection, to randomly freeze and/or store umbilical cord blood for possible future use.
13. Charges in connection with private duty or full-time nursing care while hospitalized.
14. Charges in connection with the pregnancy of dependent children, except as described under the “Preventive Care Benefits” on page 70. However, complications of pregnancy are covered.
15. Charges the patient is not required to pay.
16. Christian Science treatment.
17. Cold or heat therapy equipment for home use.
18. Collagen or fat injections.
19. Collection, processing and storage of self-donated blood, unless it is specifically collected for a planned and covered surgical procedure.
20. Concierge medical supplies or other personalized medicine services billed by an unlicensed provider and as an all-inclusive package.
21. Cosmetic surgery or related complications, except life-threatening complications, and prescription drugs prescribed for cosmetic purposes.
22. Cultured Chondrocyte Transplantation to joints other than the knee.
23. Custodial Care in convalescent homes, nursing or rest homes, or institutions of a similar nature.
24. Custodial Care or Rest Cures, as defined on page 126, whether received at home, in a Skilled Nursing Facility or in a hospital.
25. Custodial Shift Care is not covered.
26. 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.
27. Dental expenses, including bone or metal bases for dental implants, except:
 - a. Treatment rendered within 90 days of accidental injuries to sound natural teeth (due to external blow), including the replacement of such teeth. (There is no guarantee that treatment will be covered. The expense must be reviewed and be deemed medically necessary); or
 - b. Setting of jaw fractured or dislocated in an accident.

(Dental expenses may be covered under the Dental Plan. (See *Dental Benefits* on page 78, for details.)
28. Diet pills or homeopathic remedies.
29. Education training, equipment or supplies, except those mandated by law.
30. Educational therapy, academic evaluations, play therapy, or treatment of learning disabilities.
31. Erectile dysfunction prescription drugs.
32. Expenses incurred that are not due to illness or injury.

33. Expenses that are in excess of R&C charges as defined on page 130.
34. Expenses that are not approved by a physician.
35. Expenses that are not considered necessary treatment as defined on page 129.
36. Expenses written off by the provider or not charged to the patient.
37. Experimental or investigational treatments (See the Glossary on page 128 for the definition of “*Investigational Experimental Treatment*”).
38. 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.
39. Fees charged by masseurs, masseuses, dance therapists, or for Pilates or yoga, even when prescribed by a physician.
40. 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.
41. Fees for membership at a health club, gymnasium, YMCA or similar facility.
42. Food supplements, except those that require a prescription or that are essential to the treatment of special metabolic conditions and approved as medically necessary.
43. Home IV infusion therapy, unless authorized through case management intervention as described on page 69.
44. Home uterine monitoring, except when approved as medically necessary.
45. Hospital confinement or service which is not approved by a physician.
46. Hospitalization primarily for diagnostic studies.
47. Hydrocolators, whirlpool baths, sunlamps, heating pads and exercise devices, except as provided under “*Inversion Device*” on page 66, and similar general-use items.
48. Hydrotherapy if used for exercise purposes.
49. Hypnosis.
50. Illness or injury caused by declared or undeclared war or act of war.
51. Illness or injury sustained during the commission of a felony.
52. Incontinence supplies, except when approved as medically necessary.
53. Infertility treatments, including but not limited to ovulation stimulation, insemination, in vitro fertilization with embryo transfer, gamete intrafallopian transfer and zygote intrafallopian transfer.
54. Intentionally self-inflicted injury, suicide or attempted suicide, except when the product of a mental disorder.
55. Internet or email consultations or testing.
56. Loss caused by illness or injury:
 - a. That arises out of, or occurs in the course of, any occupation or employment for wage or profit; or
 - b. For which the covered person is entitled to any benefits under a Workers’ Compensation or occupational disease law.
57. Medication or devices used for contraception, except when covered under the rules regarding those contraceptives that are described under “*Prescription Drug Benefits*” on page 55 or under the “*Preventive Care Benefits*” on page 69.
58. 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.

59. Medical expenses incurred by an organ donor for an eligible participant or dependent to the extent that such expenses are eligible for coverage under the donor's own group health insurance.
60. 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) and should be used for pain management.
61. Outpatient prescription drugs and medicines not billed as part of a facility charge, except those prescribed through Case Management Intervention as part of home health care. (Outpatient prescription drug benefits are described under "*Prescription Drug Benefits*" starting on page 55.)
62. Outpatient vitamins except for B12 injections when medically necessary for pernicious anemia or other B12 deficiency, food supplements and over-the-counter drugs.
63. Over-the-counter supplies for home care, such as bandages, cotton swabs, cotton balls, alcohol pads, gauze pads or similar products.
64. 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.
65. Patient or provider travel costs or expenses.
66. 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.
67. Prepared child birth classes (including Lamaze), parenting classes and doulas.
68. Reversal of vasectomies or tubal ligation.
69. Replacement batteries for Durable Medical Equipment.
70. Routine foot care including heel lifts, and shoe inserts except when special shoes/inserts are necessary to prevent complications of diabetes. Orthopedic shoes are subject to medically necessary review.
71. Routine physical examinations, preventive treatment or well child care, including tests, for children age seven or older, except as described under "*Wellness Benefit*" on page 74 or under the "*Preventive Care Benefits*" on page 69.
72. Sales or other taxes on services, products and equipment.
73. Services and supplies for which the patient is not legally required to pay.
74. Services incidental to outpatient tests, procedures, or examination, including venipuncture, specimen handling and conveyance, unless allowed by network pricing or clinical editing system.
75. Services received from a health care provider who is a member of your immediate family, or living with the person requiring treatment.
76. Supports or devices used primarily for safety or performance in sports-related activities.
77. Transportation, except local ambulance services for emergency services.
77. Unlicensed assistive personnel and/or providers whose services are custodial in nature, including but not limited to home health aides.

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 Administrative Office. (For contact information, see the *Summary of Benefits*, page 16.)

DENTAL *Benefits*

The Fund offers you two dental plans to choose from, depending on where you live.

PLAN	AVAILABILITY
Delta Preferred Option (DPO)	Nationwide.
DeltaCare USA (DHMO)	California locations with DeltaCare USA participating providers.

The Fund makes dental services available to you because regular checkups are important to help you keep your teeth and gums healthy. You and your covered dependents will automatically be enrolled in the Delta Preferred Option (DPO) if you are enrolled in the PPO Plan. If you live in California, you may choose to enroll in the DeltaCare USA Dental HMO (DHMO), a managed dental plan, instead. You also have the option of enrolling your eligible dependents in the DHMO.

HOW THE DELTA PREFERRED OPTION (DPO) WORKS

With the DPO, 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 Plan covers the following categories of services:

- ▶ Diagnostic and preventive care;
- ▶ Basic care (preventive and diagnostic services, including x-rays);
- ▶ Basic Benefits (usually includes restorations (fillings), oral surgery (extractions), endodontics (root canals), periodontal treatment (root planing) and sealants);
- ▶ Major Benefits (usually includes crowns, dentures, implants and oral surgery, jackets and cast restorations);
- ▶ Emergency Care;
- ▶ Prosthodontic care; and
- ▶ Orthodontic care for children up to age 19.

The amount the Dental Plan pays for each dental service depends on the 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 DPO 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 DPO network; or
- ▶ A dentist who doesn't participate in the Delta Dental network (a “non-Delta dentist”).

If you want to lower your out-of-pocket dental costs, you may want to choose a Delta dentist. Ultimately, the choice is yours.

PAYING FOR YOUR CARE

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 Plan begins to pay benefits, you must meet either an individual or a family calendar-year Dental Plan deductible for most services. In addition, there is 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 Plan 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 51. 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 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 Plan, 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 an HMO and your secondary coverage is PPO, the dentist can bill out your copayments from your dental HMO to the PPO plan. However, if your primary coverage is a PPO plan and your secondary coverage is a HMO plan, there will be no coordination of benefits.

REASONABLE AND CUSTOMARY (R&C) LIMITS

R&C limits are maximums for charges considered reasonable and customary based on what 80% of providers in your geographic area charge for similar services or supplies. (A "geographic area" is an area grouped by several ZIP Codes).

R&C limits apply **only** when you see a non-Delta dentist. The plan doesn't cover charges above R&C limits — they are your responsibility. To find out whether your non-network dentist's charges fall within R&C limits 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 81 for more information.)

ANNUAL BENEFIT MAXIMUM

The annual benefit maximum represents the total amount the Dental Plan 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.

GETTING THE MOST FROM YOUR PLAN

CHOOSING A DENTIST

You receive the maximum benefits available when you use a DPO dentist. DPO dentists are Delta dentists who have agreed to charge DPO 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 DPO dentist	<ul style="list-style-type: none">• Your out-of-pocket costs will probably be less because DPO dentists agree to charge DPO patients reduced fees• You will pay a deductible,* copay and/or any amount over the annual benefit maximum when you receive care• You do not need to file a claim form
A non-DPO dentist	<ul style="list-style-type: none">• You will be charged no more than the fees approved by Delta Dental, but these fees could be higher than those charged by a DPO dentist• You will pay a deductible*, copay and/or any amount over the annual benefit maximum when you receive care• You do not need to file a claim form
A non-Delta dentist:	
	<ul style="list-style-type: none">• The dentist's fee may be higher than the rates negotiated for DPO providers or other Delta providers• You will pay a deductible*, copay and/or any amount over the annual benefit maximum when you receive care• You will also be responsible for any charges over the R&C limit• You may have to pay the entire cost in advance• You may have to complete and submit your own claim form and wait for reimbursement from the Dental Plan

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.

IMPORTANT!

Within the Delta Dental network is a select group of dentists called DPO dentists. Both DPO dentists and non-DPO dentists are part of the larger Delta Dental network but DPO dentists agree to offer lower negotiated rates. (See "Choosing a Dentist" chart on this page for more information.)

IMPORTANT!

The DHMO is available only to participants that reside in California. Before choosing this plan, be sure to carefully review the plan's provider directory to ensure there's a provider in your area.

* Deductible waived for diagnostic and preventive care.

DENTAL BENEFITS

You will automatically receive a network provider list at no charge. To learn more about the dentists who participate in the nationwide DPO network, as well as other Delta Dental providers, you can also:

- ▶ Call Delta Dental for a list of participating dentists in your area; or
- ▶ Log on to Delta Dental's website at www.deltadentalca.org/dentalcareusa to search for a provider online.

Keep in mind that network dentists occasionally change, so you will want to make sure the dentist you choose is still in the DPO 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.

Claim example: 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 DPO 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 DPO 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 DPO dentist and a non-Delta dentist:

With a Delta DPO Dentist	
Charge for crown	\$ 175.00
Janet's deductible	– \$ <u>75.00</u>
	\$ 100.00
Plan pays 80% of the remaining \$100	– \$ <u>80.00</u>
Janet pays 20%	\$ 20.00
Janet's cost with a DPO dentist (deductible + her coinsurance)	\$ 95.00
With a Non-Delta Dentist	
Charge for crown	\$ 280.00
Delta-approved fee for a crown (R&C)	\$ 175.00
Janet's deductible	– \$ <u>75.00</u>
	\$ 100.00
Plan pays 70% of the remaining \$100	– \$ <u>70.00</u>
Janet pays 30%	\$ 30.00
Plus the difference between non-Delta dentist submitted fee and Delta-approved fee	\$ <u>105.00</u>
Janet's cost with a non-Delta dentist (deductible + amount over R&C + her coinsurance)	\$ <u>210.00</u>
Janet's Savings With a Delta DPO Dentist	
Janet's cost with a non-Delta dentist	\$ 210.00
Janet's cost with a DPO dentist	– \$ <u>95.00</u>
Janet's savings with a DPO dentist	\$ <u>115.00</u>

Note: Costs cited in this example are for illustrative purposes only. Your own costs may be differ.

PREDETERMINATION OF BENEFITS

The Plan has a feature called Predetermination of Benefits. It lets you know in advance how much the Dental Plan will pay before your dentist actually begins the dental work he/she is recommending. Predetermination of benefits allows you to have your questions answered before you incur an expense and 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 is 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;
- ▶ Whether you have met the plan-year benefit maximum;
- ▶ The amount of the deductible; 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 Dental 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, you choose a gold crown when one made of semi-precious metals would restore the tooth just as well. Because you have chosen a more expensive treatment, you would be responsible for the cost above and beyond what the Plan would pay for a crown made of semi-precious metals.

LOOKING AT ELIGIBLE AND INELIGIBLE EXPENSES

ELIGIBLE EXPENSES

The Dental Plan 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*, page 16 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 R&C charges for non-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 the 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 coverage:

1. Bitewing X-rays are provided on request by the dentist, but no more than once in a six-month period.
2. Implants are covered once every five years.
3. 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.
4. The Dental Plan will pay the applicable percentage of the dentist's fee for a standard partial or complete denture, up to a maximum fee allowance. This fee allowance is the fee that would satisfy the majority of Delta Dental dentists. A standard partial or complete denture is one made from accepted materials and by conventional methods. The Maximum Fee Allowance is revised periodically, as dental fees change. If your dentist's accepted fee on file with Delta Dental for a partial or complete denture is higher than this maximum allowance, you will be required to pay that portion of his/her fee that exceeds Delta Dental's allowance in addition to your portion of the allowance.

IMPORTANT!

You cannot convert dental coverage to an individual policy.

IMPORTANT!

The **Summary of Benefits** includes contact information, phone numbers and websites for the DHMO. See page 16.

5. 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.
6. Full mouth X-rays and panoramic X-rays are covered only once in a three-year period.
7. 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.
8. 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.
9. Only the first two oral examinations in a 12-month period are covered.
10. Orthodontic payment is limited to treatment of covered children up to age 19.
11. 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.
12. Replacement implants are covered only following a five-year period after installation of an original implant provided under any Delta Dental plan.
13. 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.
14. Three cleanings or procedures that include a cleaning or combination thereof are covered every calendar year (January through December).
15. 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.
16. Full-mouth debridement (gross scale) is limited to one treatment in a lifetime.
17. Periodontal treatments (root planning/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:

1. 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;*
2. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility;
3. Charges for replacement or repair of an orthodontic appliance paid in part or in full by the Plan;
4. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues;
5. Experimental procedures;
6. Grafting of tissues from outside the mouth to tissues inside the mouth ("extraoral grafts");
7. Complete occlusal adjustment;
8. Prescribed drugs or applied therapeutic drugs, premedication or analgesia;
9. Replacement of existing restoration for any purpose other than restoring active tooth decay or fracture of the restoration;

10. 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;
11. Services for injuries covered by Workers' Compensation or employers' liability laws;
12. 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*
13. 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.

*Anesthesia is covered for the following endodontic and periodontal procedures:

Endodontic Procedures

<u>Code</u>	<u>Procedure</u>
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)

Periodontic Procedures

<u>Code</u>	<u>Procedure</u>
D4240	Gingival flap procedure, including root planning – 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

FILING A CLAIM

One of the advantages of using a Delta Dental 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 a non-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 Administrative Office or log on to Delta Dental's website at www.deltadentalca.org/dentalcareusa to download a Delta claim form online.
- ▶ Complete sections 1 through 15 of the claim form.
- ▶ 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 Plan of California
P.O. Box 997330
Sacramento, CA 95899-7330

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 page 105.)

HOW THE DELTACARE USA DENTAL HMO WORKS

DeltaCare USA (DHMO) differs from the DPO 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 the DHMO network of 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 choose a primary care dentist (PCD) from the DHMO network for yourself and each family member you cover. You must see your PCD each time you need dental care. Once enrolled, you will receive a DeltaCare USA membership packet that includes an identification card and an Evidence of Coverage (EOC) booklet that fully describes the benefits under the program. Also included in this packet are the name, address and phone number of the PCD you selected.

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 on our website.

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 51. 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 expenses* 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."

OPTIONAL FEES

You will incur an additional charge if you request your contract 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 DENTAL HMO 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 DPO, the DHMO requires that your treatment be coordinated by your PCD for you to receive benefits.

Here is how it works:

WHEN YOU SEE THE FOLLOWING PROVIDER	WHAT TO EXPECT
Primary Care Dentist (PCD) or a specialist referred by your PCD	<ul style="list-style-type: none"> • 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. • You do not need to file a claim form.
Non-Primary Care Dentist	<ul style="list-style-type: none"> • Your care will not be covered, except under certain emergency circumstances (please see the section below entitled "Emergency Care" for more information).

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 network is available where your dependent lives.

To learn more about the dentists who participate in the DHMO network, you can:

- ▶ Call Delta Dental's Customer Service Department for a list of participating dentists in your area; or
- ▶ Log on to the DHMO website to search for a provider online.

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 must notify Delta Dental's Customer Service Department by phone or in writing. You can also change your PCD online by visiting the DHMO website. If you make the change by the 21st of the 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.

NON-NETWORK DENTISTS

Except in an emergency situation, the DHMO does not pay any benefits if you go to a non-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 a non-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 \$100.00 per emergency, per enrollee, for services performed by a non-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's Customer Service Department.

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. The DeltaCare EOC Booklet can also be found on our website.

ELIGIBLE EXPENSES

The following is a list of 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: 1 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) — 1 per 6-month period.

RESTORATIVE BENEFITS

These benefits include:

- Amalgam – four or more surfaces, permanent;
- Amalgam – four or more surfaces, primary;
- Resin-based Composite crown, anterior – primary;

- ▶ Resin-based composite – four or more surfaces or involving incisal angle (anterior);
- ▶ Resin based composite – four or more surfaces - posterior;
- ▶ Inlay – metallic/porcelain/ceramic/resin-based composite – three or more surfaces; and
- ▶ Onlay – metallic/porcelain/ceramic/resin-based composite – four or more surfaces.

ORAL AND MAXILLOFACIAL SURGERY BENEFITS

Oral surgery benefits include preoperative and postoperative evaluations and treatment under local anesthetic, as well as:

- ▶ Removal of impacted tooth – soft tissue/partially bony/completely bony;
- ▶ Root removal – exposed roots;
- ▶ Single tooth extraction/each additional;
- ▶ Surgical removal of erupted tooth;
- ▶ Surgical removal of residual tooth roots;
- ▶ Biopsy of oral tissue – soft (does not include pathology laboratory procedures);
- ▶ Removal of lateral exostosis (maxilla or mandible); and
- ▶ Frenulectomy (also known as frenectomy or frenotomy).

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 4 quadrants during any 12 consecutive months).

PROSTHETIC BENEFITS (CROWNS, BRIDGES AND DENTURES)

These benefits include:

- ▶ Crown – porcelain/ceramic;
- ▶ 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:

- ▶ 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);
- ▶ Apicoectomy/periapical surgery - anterior;

- ▶ Apicoectomy/periapical surgery - bicupid (first root);
- ▶ Apicoectomy/periapical surgery - molar (first root); and
- ▶ Therapeutic pulpotomy (excluding final restoration).

GENERAL SERVICES

These benefits include:

- ▶ Local anesthesia; and
- ▶ Palliative (emergency) treatment of dental pain.

ORTHODONTIC BENEFIT

Orthodontic benefits are provided for:

- ▶ Adults (you, your covered spouse or your Same-Sex Domestic Partner); 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.

Note: 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 six-month period;
- ▶ The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:
 - a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and
 - b. 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.
- ▶ 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);
- ▶ 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 USA 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.
- ▶ 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 your plan, please refer to your DeltaCare EOC booklet, issued by DeltaCare USA (the EOC can also be found on our website).

The DHMO does not cover the following services:

1. 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;
2. Any procedure that is not specifically listed under Schedule A, Description of Benefits and Copayments;
3. Any procedure that in the professional opinion of the Contract Dentist:
 - a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
 - b. is inconsistent with Generally Accepted Standards of Dentistry;
4. 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;
5. Restoration placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth;
6. Crown lengthening procedures;
7. Cysts and malignancies;
8. Dental conditions arising out of and due to your employment, or for which Workers' Compensation is payable;
9. Dental expenses incurred in connection with any dental procedures started after eligibility for coverage has terminated;
10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility;
11. 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*" on page 5 of the EOC Booklet;
12. Dispensing of drugs not normally supplied in a dental facility;
13. General anesthesia and the services of a special anesthesiologist;
14. Implant placement or removal, appliances placed on or services associated with implants, including, but not limited to, prophylaxis and periodontal treatment;

15. Loss or theft of fixed and removable prosthetics (e.g., crowns, bridges, full or partial dentures);
16. 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;
17. 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;
18. Consultations for non-covered benefits;
19. Treatment of fractures and dislocations; and
20. Treatment required by reason of war.

The following orthodontic services are also not covered:

21. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;
22. Pre-treatment, mid-treatment and post-treatment records, including cephalometric X-rays, tracings, photographs and study models;
23. Re-treatment of orthodontic cases;
24. Treatment in progress when eligibility for coverage begins;
25. Transfer after banding has been initiated;
26. Changes in treatment necessitated by accident of any kind;
27. Initial or continuing orthodontic treatment when such treatment would be inconsistent with Generally Accepted Professional Standards;
28. Surgical procedures incidental to orthodontic treatment;
29. Myofunctional therapy;
30. Surgical procedures related to cleft palate micrognathia or macrognathia;
31. Treatment related to temporomandibular joint disturbances;
32. Supplemental appliances not routinely used in typical comprehensive orthodontics;
33. Restorative work caused by orthodontic treatment;
34. 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;
35. Extractions solely for the purpose of orthodontics;
36. Treatment in progress at inception of eligibility, unless qualified for the orthodontic treatment in progress provision; and
37. Composite bands, lingual adaption of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

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.

WHAT ELSE YOU SHOULD KNOW

about your Health Care Plans

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 Administrative Office.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under Federal Law, group health plans and health insurance issuers 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 normal 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) after the birth. In any case, the Fund may not require a provider to obtain authorization from the Fund for prescribing a hospital stay of not more than 48 hours (or 96 hours).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A Qualified Medical Child Support Order is a decree issued by a court requiring healthcare coverage for a child. The Fund will honor medical child support orders if they're Qualified Medical Child Support Orders (QMCSOs).

If a QMCSO issued in a divorce or legal separation proceeding requires you to provide medical 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 Administrative 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 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 Administrative Office.

GRANDFATHER STATUS UNDER THE PPACA

The Trustees believe the Fund is no longer a “Grandfathered Health Plan” under the Affordable Care Act as of January 1, 2012. Accordingly, the Trustees have decided to implement the necessary changes (as reflected herein) under the Affordable Care Act that apply to non-grandfathered group health plans. These changes were effective as of January 1, 2012.

FAMILY AND MEDICAL LEAVES OF ABSENCE

Through the Family and Medical Leave Act (FMLA), you are allowed take up to 12 week’s unpaid leave during any 12-month period due to:

- ▶ The birth, adoption, or placement with you for adoption of a child;
- ▶ To provide care for a spouse, child, or parent who is seriously ill; or
- ▶ Your own serious illness

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.

If you do not return to work after your FMLA leave ends, you may qualify for COBRA Continuation Coverage, as described on pages 35-38.

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 week’s 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 week’s 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 or 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 Administrative 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 (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 31 days or less, you (and your eligible dependents covered under the Fund when your leave began) will continue to receive the health care coverage that you would otherwise have received under the Fund. If you are on active duty for more than 31 days, 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 rate 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 51-54 and visit www.tricare.mil for additional information.

If you are called to active duty, you must notify the Administrative 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 Administrative 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 dependents, 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; or
- ▶ 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 (8) 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.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

To comply with the Mental Health Parity and Addiction Equity Act of 2008, the Fund coverage for mental health and chemical dependency benefits will be provided at the same benefit levels as the medical coverage. Effective January 1, 2012, mental health and chemical dependency benefits will have the same deductibles, copays, coinsurance and out-of-pocket maximums as medical benefits. In addition, please note the following:

Calculation of deductibles and out-of-pocket expenses will combine mental health and chemical dependency treatment costs with other medical costs; co-insurance rules will apply to all such services.

- ▶ Coverage for mental health and chemical dependency treatments will still be subject to medical necessity considerations and reasonable and customary industry practice.
- ▶ Blue Cross/BlueCard provider network is the current approved network for both medical and mental health care.
- ▶ Claims processing for mental health benefits is administered by the Administrative Office.

GENETIC INFORMATION NON-DISCRIMINATION ACT (“GINA”)

Effective June 1, 2009, 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, and may not collect genetic information about an individual before the individual is enrolled or covered. 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 (including without limitation Covered 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 their 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 any of them have any control over any diagnosis, treatment, care or lack thereof, or any healthcare services provided or delivered to you by any healthcare provider. Neither the Fund, the Trustees, or 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

PROTECTION *Benefits*

The Fund automatically provides you with basic life insurance coverage, including a separate accidental death and dismemberment (AD&D) benefit if you experience certain injuries or loss as the result of an accident. You are not required to pay for this coverage.

In the next few pages, we will take a closer look at your life and AD&D insurance coverages to help you understand the protection benefits available to you through the Fund.

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 the Life Insurance Plan if you are enrolled in the [PPO Plan](#). The Fund pays the entire cost of coverage under the Life Insurance Plan **for eligible participants only (Earned, Extended Coverage, Excess Earnings Extension and Certified Retiree Coverage)**. This insurance coverage is not available if you elect COBRA coverage, or to your dependents as the covered life.

Life Insurance benefits are not available if you are enrolled in the Low Option Plan.

PAYING BENEFITS

If you die while you covered under the Life Insurance Plan, benefits will be paid as a lump sum to the beneficiary you have on file with the Administrative Office.

You may choose anyone you wish to be your designated beneficiary by completing the appropriate beneficiary designated form and returning it to the Administrative Office, and you may change your designation at any time. If you have not named a beneficiary, or if your beneficiary doesn't survive you, the Life Insurance Plan 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, 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 YOU BECOME DISABLED

If you become totally disabled while covered under the Life Insurance Plan and under age 60, your 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. (For a definition of “total disability” see page 131 of the Glossary.)

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 on a yearly basis.

REQUESTING BENEFITS

Upon notification of your death or receipt of your death certificate, the Fund will process the necessary paperwork. Benefits are 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 page 105.)

CONVERTING YOUR COVERAGE

You may be able to convert your life insurance coverage through Hartford Life to an individual policy when your active coverage ends. Evidence of good health is not required, but you will be responsible for the full coverage premium.

You may convert any amount of insurance up to the amount you had while covered by the Fund. If you want to convert your life insurance coverage, contact the Administrative Office within 31 days after your coverage ends to obtain the applicable conversion forms.

HOW THE ACCIDENTAL DEATH AND DISMEMBERMENT PLAN (AD&D) PLAN WORKS

In addition to the life insurance benefit, the Fund provides you with an AD&D benefit of \$5,000. You will automatically be enrolled in the AD&D Plan if you are enrolled in the PPO Plan. The Fund pays the entire cost of coverage under the AD&D Plan **for eligible participants only, excluding those who are on COBRA**. Your dependents are not eligible for coverage under the AD&D Plan.

UNDERSTANDING THE BENEFIT

If you are covered under the AD&D Plan, you will receive an AD&D benefit if you suffer an accidental injury and a loss resulting directly from the injury or from an injury that occurs within 365 days of the accident.

The maximum AD&D 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 AD&D loss while operating or riding as a passenger in an automobile. If you were wearing a seat belt at the time of the accident, 10% of your AD&D benefit will be paid in addition to the AD&D benefit.

The police report must attest to the fact that you were wearing a seat belt at the time of the accident, or the benefit will not be paid.

AIR BAG BENEFIT

If you are eligible for a seat belt benefit, then an additional 5% of your AD&D 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 AD&D Plan pays a benefit for an accident or injuries that lead to the losses described on page 99. 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;
- ▶ Taking drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens, unless prescribed or administered by a licensed physician; or
- ▶ Intoxication of the injured person.

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 Administrative Office in accordance with the procedures for the payment of your life insurance benefit. (See “*Requesting Benefits*” on page 99 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 Administrative 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 page 105.)

CONVERTING YOUR COVERAGE

You may not convert your AD&D coverage to an individual policy.

ADMINISTRATIVE

Information

GENERAL PLAN INFORMATION

Plan Information	Writers' Guild-Industry Health Fund
Employer Identification Number	23-7108536
Plan Number	501
Plan Administrator	Board of Trustees Writers' Guild-Industry Health Fund 1015 North Hollywood Way Burbank, CA 91505 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, mental health and chemical dependency, life, and AD&D insurance benefits.
Plan Administration	The medical plans (including outpatient prescription drugs, mental health, and chemical dependency) 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: ADMINISTRATIVE SERVICES ONLY	NETWORK ARRANGEMENTS
<ul style="list-style-type: none"> • Hartford Life — Life and AD&D • DeltaCare USA — DHMO 	<ul style="list-style-type: none"> • Express Scripts — Outpatient Prescription Drugs • Delta Dental — DPO 	<ul style="list-style-type: none"> • The Industry Health Network (TIHN) — Southern California only • Anthem BlueCross — PPO Network for PPO Plan and Low Option Plan in California • Blue Card — PPO network for PPO and Low Option Plans outside California

**Agent for the Service
of Legal Process**

Gregory L. Sulier
Chief Executive Officer
Writers' Guild-Industry Health Fund
1015 North Hollywood Way
Burbank, CA 91505
Telephone: (818) 846-1015
Outside area: 1-800-227-7863

Service of legal process by a court, upon a Trustee of the Fund in his or 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 December 31 each year.

Principal Trustees

To contact a Plan Trustee, send correspondence care of the Plan Administrator to the following address:

Writers' Guild-Industry Health Fund
1015 North Hollywood Way
Burbank, CA 91505

EMPLOYER TRUSTEES

JEAN BONINI

Executive Vice President, Labor Relations
Sony Pictures Entertainment
10202 W. Washington Blvd.,
SPP Suite 5600, Culver City, CA 90232

J. KEITH GORHAM

Senior Vice President, Industrial Relations
NBC Universal
100 Universal City Plaza, 1280-3
Universal City, CA 91608

VIRGINIA HOYT

Vice President, Labor Counsel
NBC Universal
100 Universal City Plaza, 1280-3
Universal City, CA 91608

HARRY ISAACS

Executive Vice President, Labor Relations,
CBS
4024 Radford Ave. Carpenter Bldg 102
Studio City, CA 91604

STEPHEN KOPPEKIN

Executive Vice President, Industrial Relations
Paramount Pictures Corp.
555 Melrose Avenue, Zukor Bldg 1102
Los Angeles, CA 90038

HANK LACHMUND

Senior Vice President, Labor Relations
Warner Bros. Television Prod.
300 Television Plaza, Bldg. 137
Burbank, CA 91505

CAROL LOMBARDINI

President
AMPTP
15301 Ventura Blvd., Building E
Sherman Oaks, CA 91403-5885

MARC SANDMAN

Senior Vice President, Labor Relations
ABC, Inc.
500 S. Buena Vista St.
Burbank, CA 91521-4481

MARK STUBINGTON

Vice President, Labor Relations Counsel
Walt Disney Pictures & Television
500 Buena Vista St.
Burbank, CA 91521

EMPLOYER TRUSTEES - ALTERNATES

TIFFANY BURRELL

Director, Labor Relations
Warner Bros. Television Prod.
300 Television Plaza
Bldg., 137, Rm. 1005
Burbank, CA 91522

STEPHEN CARROLL

Vice President, Senior Labor Relations Counsel
Warner Bros. Television Prod.
4000 Warner Blvd.,
Bldg., 156 North, 1st Floor
Burbank, CA 91522

JILL GLOSSER

Senior Vice President
Employee Relations Legal Services
Paramount Picture Corp.
5555 Melrose Ave., Zukor Bldg 1202
Los Angeles, CA 90038

DAVID G. GROSS

Counsel
AMPTP
15301 Ventura Blvd., Building E
Sherman Oaks, CA 91403-5885

MELISSA LOPEZ

Vice President and General Counsel, Labor Relations
100 Universal City Plaza., 1280-3
Universal City, CA 91608

JOHN MENDONSA

Vice President & Counsel
ABC, Inc.
500 S. Buena Vista St.
Burbank, CA 91521-4488

LAURA RITCHIE

Director, Labor Relations,
Fox Group
2121 Avenue of the Stars, Room 75
Los Angeles, CA 90067

LEON SCHULZINGER

Senior Vice President, Labor Relations
CBS Studio Center, Carpenter Bldg. 102
4024 Radford Ave.
Studio City, CA. 91604

GUILD TRUSTEES

NEAL BAER

c/o WGA, West
7000 W. Third St.
Los Angeles, CA 90048

JOHN BOWMAN

c/o WGA, West
7000 W. Third St.
Los Angeles, CA 90048

LOWELL PETERSON

Executive Director
c/o WGA, West
WGA, East
250 Hudson Street, Suite 700
New York, NY 10013

ADAM RODMAN

c/o WGA, West
7000 W. Third St.
Los Angeles, CA 90048

BOB SCHNEIDER

c/o WGA, East
250 Hudson Street, Suite 700
New York, NY 10013

DAVID WEISS

c/o WGA, West
7000 W. Third St.
Los Angeles, CA 90048

ANN WIDDIFIELD

Assistant Executive Director
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

DAVID YOUNG

Executive Director
WGA, West
7000 W. Third St.
Los Angeles, CA 90048

GUILD TRUSTEES - ALTERNATES

LISA ANDERSON

Senior Directors of Contracts
WGA, West
7000 W. Third Street
Los Angeles, CA 90048

JOHN AUERBACH

c/o WGA, East
250 Hudson Street, Suite 700
New York, NY 10013

CAROL BARBEE

c/o WGA, West
7000 W. Third St.
Los Angeles, CA 90048

PATTI CARR

c/o WGA, West
7000 W. Third St.
Los Angeles, CA 90048

STAN CHERVIN

c/o WGA, West
7000 W. Third St.
Los Angeles, CA 90048

ASHLEY GABLE

c/o WGA, West
7000 W. Third St.
Los Angeles, CA 90048

TIMOTHY J. LEA

c/o WGA, West
7000 W. Third St.
Los Angeles, CA 90048

MELISSA SALMONS

c/o WGA, East
7000 W. Third St.
Los Angeles, CA 90048

CHARLES SLOCUM

Assistant Executive Director
WGA, West
250 Hudson Street, Suite 700
New York, NY 10013

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 (ERISA). ERISA provides that all plan participants are entitled to the following rights:

Receive information about your plan and benefits

- ▶ Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Fund, including 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;
- ▶ Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies; and
- ▶ 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

- ▶ Continue health care coverage for yourself, spouse or 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 SPD and the documents governing the Fund on the rules governing your COBRA Continuation Coverage rights; and
- ▶ Experience a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan (if applicable) if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ends, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate 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, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. 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 \$110 a day until you receive the materials, unless the materials were not sent due to reasons beyond the Plan Administrator's control. 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 following the date the Plan Administrator notifies the claimant of a final adverse determination, provided that the Fund's claims and appeals 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. 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 the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline at 866-444-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. Inquiries that are unrelated to a specific claim, such as inquiries regarding benefits available under the Fund, or 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 prior approval of a benefit that does not require prior approval under the Fund is considered an inquiry, and not a claim for purposes of these procedures and the appeal procedures that follow on pages 107-112.

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 number (WRXA12345678);
- ▶ 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 identification number;
- ▶ 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-9 (International Classification of Diseases, Ninth Edition) diagnosis code(s);
- ▶ Date(s) of service; and
- ▶ Other information or proof reasonably required by the Fund.

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 16.

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 Administrative Office, is referred to as a “Claims Administrator.” This chart illustrates the Claims Administrator for each plan:

Generally, if you receive services from a network provider, the provider will submit the claim to the applicable Claims Administrator directly. If you receive services from a non-network provider, you or your provider will submit the claim to the applicable Claims Administrator. For “*Claim Submission*” details, see pages 49-50.

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, Vision, Wellness, Mental Health and Chemical Dependency claims	Administrative Office /Blue Cross/Blue Card (see claim submission section)
Dental claims	Delta Dental (PPO) or DeltaCare USA (DHMO)
Outpatient Prescription Drug claims	Express Scripts
Life and AD&D claims	Administrative Office

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 health care claims.

POST-SERVICE HEALTH CARE CLAIMS

- ▶ A post-service claim is a claim for benefits after services or treatment have been provided.
- ▶ 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.

DENIAL NOTICES

Any notice of an adverse benefit decision will include one or more of the following:

- ▶ 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 or guideline was applied in making the determination, a statement that the rule will be provided free of charge upon request;
- ▶ If the determination is based on a medical necessity or experimental exclusion, 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.

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 Administrative Office will be conducted by the Fund’s Benefits Committee. (However, the Benefits Committee may delegate this power with respect to certain pre-service claim appeals or first level claim appeal review.)

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. 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.

DECISIONS ON APPEAL

The Claims Administrator’s review will take into account all comments, documents, records and other information submitted, regardless of whether the information was previously considered on initial review. The Claims Administrator 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 Claims Administrator will have discretion to determine which claimants are similarly situated in similar circumstances.

Reviews of denials by the Administrative Office will be heard by the Benefits Committee at its 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 appeals of claims denied by a party other than the Administrative Office, 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 Fund 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 Fund with sufficient information for it to determine whether and to what extent benefits are covered under the Fund under such circumstances. If the Fund 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.

Following an adverse determination on appeal by a party other than the Benefits Committee (i.e., a third party claims administrator), 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.

If the decision to deny the claim was based in whole or in part on a medical judgment, the Claims Administrator 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. Identification of any such health care professional will be provided to the claimant upon request and free of charge.

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, 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, 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; 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.

No lawsuit may be brought with respect to Fund benefits until the foregoing administrative procedures have been exhausted. **Additionally, no lawsuit may be brought more than two years following the date the Claims Administrator notifies the claimant of a final adverse determination.**

EXTERNAL REVIEW PROCEDURE

Effective for claims incurred on and after January 1, 2012, the Fund's claims and appeals procedures have been changed pursuant to PPACA. Most notably, the Fund implemented an external review appeal process. If, after exhausting the Fund's internal appeals procedure, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- ▶ Clinical reasons,
- ▶ The exclusions for Experimental or Investigational Services or Unproven Services, or
- ▶ As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a 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 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 (4) months of the notice of the Internal Appeal Denial.*

The Fund's internal appeal denial notice will inform you of your right to request an external review appeal, your external review rights and your right to file suit in federal court under the ERISA. See page 107 of the SPD for details regarding the *Internal Appeals Process*.

The external review will be performed by an independent Physician, 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 on the case; 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 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.

* If there is no corresponding date four (4) 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 October 30, because there is no February 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.

PRELIMINARY REVIEW BY THE PLAN

Within five (5) 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 (1) business day after the Claims Administrator completes its preliminary review, it 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 (5) 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 ten (10) business days to submit additional information to the IRO. If you submit additional information, within one (1) 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 (1) 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 de novo 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 “NEW” 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

- (ii) If you 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.

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.

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 HEALTH CARE 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 health care 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 health care claim is a pre-service claim but is not a claim for urgent health 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 health care claim is a pre-service claim for urgent health 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 an eligibility determination or 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. For example, if BlueCross/BlueCard approves a three-week period of inpatient stay coverage and then determines mid-treatment that three weeks is inappropriate, the decision to shorten the three-week period is subject to the concurrent care rules.

- ▶ On the other hand, claimants may request an extension of the course of treatment beyond the approved time period or number of treatments. For example, if BlueCross/BlueCard approves a three-week period of inpatient coverage and the claimant wants to extend the coverage beyond three weeks, this is also a concurrent care claim. 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 health care 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 health 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 health 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.

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.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT CLAIMS

If the claim is for benefits other than health care or disability benefits (such as life insurance and accidental death and dismemberment), the claims and appeals rules described in this section apply, except as follows: 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.

If an audit discovers that the employer has mistakenly reported earnings to the Plan and Fund, or if it is discovered that earnings were reported in an incorrect time period that results in the rescission of coverage but, the participant may ask the Audit & Delinquency Committee to review the Administrators 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 the eligibility for and 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 updates thereto 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 information that relates to your physical or mental health, the health care that you have received or benefit payments for your health care, including your name, address, date of birth and Social Security number.

We are legally required to maintain the privacy of your 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. 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. 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 www.wgaplans.com 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 Administrative Office at (818) 846-1015 or visit www.wgaplans.com 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 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 an individual 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, 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 pre-authorization, 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, domestic partner 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 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. 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 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. 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.

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. 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.

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 may not 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, domestic partner, 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 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, but not prior to April 14, 2003. 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 poses a significant risk of financial, reputational or other harm to you, 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 www.wgaplans.com 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
1015 North Hollywood Way
Burbank, California 91505
(818) 846-1015

HIPAA privacy practices and applicable forms are also available on the Fund's website at www.wgaplans.org.

PARTICIPANTS WHO ARE UNABLE TO BE LOCATED

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/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 you or your dependents' right or behalf 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." 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.

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. 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 co-mingled 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 ten (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 aforementioned requirements, 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 ten (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 (5) 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 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 or her injuries or losses.

OVERPAYMENTS

If a payment to a participant or dependent or assigned to a provider is determined to be paid in error or otherwise be an overpayment, the Fund may commence legal action to recover the overpayment and/or offset future claim payments to recover the amount overpaid.

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;
- ▶ 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 17-39), 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 Union. 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 Union 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 forms tax returns;
- ▶ 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 Administrative Office at (818) 846-1015.

ABOUT THIS HANDBOOK

This handbook serves as your guide to the medical, mental health and chemical dependency, dental, prescription drug, vision, life insurance, accidental death and dismemberment benefits available to eligible participants in the Fund's plans. 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 Administrative Office.

OTHER *Resources*

FREQUENTLY ASKED QUESTIONS

Q: How will I know when I have met the eligibility requirement?

A: Once you have met the covered earnings minimum, the Administrative Office will send you an enrollment package with a Notice of Eligibility. The notice outlines your eligibility period and benefit coverage. If you believe you have met the eligibility requirement but do not receive a Notice of Eligibility, you should call the Administrative Office.

Q: What is the reason for the three-month waiting period between the earnings period and the benefit period?

A: The three-month waiting period is needed for employers to submit a report of earnings and for the Fund to process these reports so the Fund can be sure it has a record of all of your earnings.

Q: Can I make up the difference in cash between what I have earned and what I need to have earned to qualify for benefits? For example, if I am short of meeting the covered earnings minimum by \$1,000, can I pay \$1,000 so I can qualify?

A: No. The covered earnings minimum is based solely on employment covered by the collective bargaining agreement. You cannot pay to make up for any shortage in order to satisfy the covered earnings minimum.

Q: Do I have to accept or use this coverage?

A: The coverage you have earned under the Fund is automatically available to you as part of your collective bargaining agreement. However, you are not required to use the coverage provided by the Fund.

Q: Does my health care coverage include my family?

A: No, it covers you only. If you want to cover your eligible dependents, you must complete a dependent enrollment form, attach copies of all required documentation and pay the required applicable quarterly premium(s). Dependent coverage premiums are not required for Certified Retirees age 65 and over who do not have active earned coverage.

Q: Does my newborn automatically have coverage?

A: Yes, your newborn is automatically covered for 31 days after birth. But to continue coverage after that time, you must Special Enroll your child by submitting a completed dependent card and proof of birth, and pay the required dependent coverage premium by the 31st day following the birth of your child.

Q: I plan on adopting. Can my adopted child receive coverage?

A: Yes, if you Special Enroll your newly adopted child as a covered dependent and pay the required dependent coverage premium within 30 days following the adoption or placement for adoption. You may also enroll your adopted child during an Open Enrollment period. When you enroll your adopted child, you will also be required to provide the Fund with a copy of the adoption, guardianship or placement documents.

Q: My spouse has coverage through work. Can my 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: I am currently engaged. Is my fiancé covered?

A: No, not until you are married. Once you receive a certified copy of your marriage certificate you may add your spouse or Same-Sex Spouse as your dependent. To cover your Same-Sex Domestic partner, you must provide a signed Affidavit of Domestic Partnership and any additional documentation requested by the Fund. In either case, you must pay the required dependent coverage premium.

Q: Can I cover my parents under the Fund?

A: No.

Q: At what age do my children stop having coverage?

A: Unless your children are mentally or physically disabled and receiving coverage prior to age 26, your dependent children will be eligible for coverage until the last day of the month of their 26th birthday.

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. When you receive your COBRA packet, you will have several options to review for health coverage on an individual basis or for the entire family.

Q: How does The Industry Health Network (TIHN) work for me?

A: All industry participants in the Southern California area have the same opportunity to use The Industry Health Network at any time. If you live in Southern California and enroll in the Regular Plan or the Low Option Plan, you can get medical care at one of the local area health centers established especially for members of the entertainment industry. You do not need to select a Personal Care Physician (PCP). All you have to do is call for an appointment. (See *“How The Industry Health Network Works”* on page 45 for details.)

Q: Is there a separate deductible for the prescription drug program?

A: No.

Q: Can I use my health coverage if I am out of the country?

A: Yes. If you receive care outside the country, contact the BlueCard World Service Center for access to medical assistance services and healthcare providers around the world. The phone number is listed under the title “BlueCard Worldwide on the backside of your Medical ID Card. (See page 50 for details.)

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 *“Understanding Coordination of Benefits (COB)”* on page 51 for details.)

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: Yes. If you fail to enroll, the Fund’s payment of benefits will be processed assuming you have Medicare Part A and B benefits.

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.

Q: My Certified Retiree Health Fund Coverage will begin soon; do I have to enroll in Medicare Part D?

A: No. The prescription drug coverage offered by the Health Plan, is expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Credible Coverage. You may keep your Health Plan coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug program.

GLOSSARY

The definitions in this section apply whether or not the defined words are bolded, capitalized, italicized, or similarly distinguished when used in this handbook.

ACCESS:

Denotes that the dependent child is eligible to enroll in, or purchase health coverage through an employer (regardless of the costs of that coverage or the benefits it provides).

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 in to 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.

AMBULATORY SURGERY CENTER:

A freestanding outpatient surgical facility. It 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 on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

ASSIGNMENT OF BENEFITS:

Refers to giving a provider permission to submit claims (evidence of loss) for medical services to the appropriate Claims Administrator for processing. Benefits may be assigned automatically to network providers based on their agreement with the plan's network. Benefits may also be assigned to a non-network provider if he/she allows it.

BIRTHING CENTER:

A medical facility, often associated with a hospital, that is designed to provide a comfortable, homelike setting during childbirth and that is generally less restrictive than a hospital in its regulations, 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 which provides participants 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 page 29 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 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 hospital confinement (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; an elective Caesarean section; an ectopic pregnancy that is terminated; or a spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy as defined above are covered under the 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 service. 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 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 plans and their network providers. Contracted rate applies to 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% of eligible expenses.

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 may also be done to approximate a normal appearance.

COVERED EARNINGS:

Income for writing services covered by a collective bargaining agreement that employers report to the Fund.

CUSTODIAL CARE:

Care designed to help a person in the 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 amount you must pay for covered services in a plan year before the plan begins to pay benefits.

DEDUCTIBLE CARRYOVER:

A special provision that applies to every covered family member. It allows you, under certain circumstances, to carry over from one year to the next eligible expenses that were applied to your deductible.

DENTIST:

A doctor of dentistry who is licensed to practice dentistry at the time and place involved where the particular dental procedure was rendered.

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 reasonable and customary charge for medically necessary services or supplies which is covered in full or in part by the plan.

EMPLOYER CONTRIBUTIONS:

Contributions employers pay to the Fund that are based on a percentage of a participant's covered earnings.

ERISA:

The Employee Retirement Income Security Act of 1974, as amended.

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.

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.

HEALTH CARE PROVIDERS:

- ▶ A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
- ▶ One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, and is providing a service for which benefits are specified in this handbook; and when benefits would be payable if the services were provided by a physician, as defined above:
 - Acupuncturist (A.C.)
 - Audiologist
 - Chiropractor (D.C.)
 - Clinical social worker (L.C.S.W.)
 - Dispensing optician
 - Marriage, family and child counselor (M.F.C.C.)
 - Nurse midwife*
 - Optometrist (O.D.)
 - Oriental medicine doctors (O.M.D.)*
 - Physical therapist (P.T. or R.P.T.)*
 - Podiatrist or chiropodist (D.P.M, D.S.P. or D.S.C.)
 - Psychiatric mental health nurse (R.N.)*
 - Psychologist
 - Respiratory care practitioner (R.C.P.)*
 - Speech pathologist*

* The providers indicated by an asterisk (*) are covered only by referral of a physician as defined above.

The physician may not be you, a member of your immediate family, your Same-Sex Domestic partner or a person residing in your home. “Immediate family” means your spouse, children, brothers, sisters or parents.

HOME HEALTH CARE:

A program for care and treatment of a sick or injured person in that person’s home by a home health care agency. The program 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.

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 RN visits, intermittent visits by a nursing assistant, all equipment needed for the comfort and care of the patient, pain management, 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 physician or licensed R.N.;
- ▶ 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. It 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 on Accreditation of Health Care Organizations.

A hospital also includes:

- ▶ A psychiatric health facility as defined in 250.2 of the California Health and Safety Code, when service is rendered there for psychiatric or mental conditions; and
- ▶ An outpatient center as defined on page 129.

IRS CODE:

The Internal Revenue Code of 1986, as amended.

ILLNESS:

A sickness or disease that causes loss covered by the plan. Pregnancy is considered a sickness with respect to a covered female participant, the Same-Sex Domestic partner of a female covered participant and the spouse of a male covered participant only. Pregnancy for dependent children is not covered, except for complications of pregnancy.

INJURY:

Bodily harm caused by an accident. The injury must also result, for the purposes of accidental death and dismemberment coverage, 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 postoperative 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.

MAINTENANCE MEDICATIONS:

Prescription drugs that are used on an ongoing basis (e.g., thyroid replacement, diabetes or cardiac medications).

MEDICAL EMERGENCY:

A sudden and, at that time, unexpected change in a person's physical or mental condition which, if not treated immediately, could result in a loss of life or limb, significant impairment of a bodily function or permanent dysfunction of a body part. Examples include heart attack, stroke, severe bleeding, serious burns and poisoning.

MEDICALLY NECESSARY:

Medical treatment that satisfies the definition of “necessary treatment.”

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT:

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health and chemical dependency use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

MENTALLY RETARDED:

Having a condition of arrested or incomplete development of mind, present from birth or early infancy, which is especially characterized by a deficiency of intelligence.

MINIMUM BASIC AGREEMENT (“MBA”):

The 2011 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.

NECESSARY TREATMENT:

Provision of services or supplies that the 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 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.

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.

OUT-OF-POCKET MAXIMUM:

The maximum amount you pay in coinsurance each plan year for eligible medical expenses.

OUTPATIENT CENTER:

A freestanding center or entity within a hospital which is approved and licensed by the state as a place where outpatient diagnostic services or surgical treatment of an illness or injury are performed.

PARTICIPANT:

An individual or that individual’s spouse (opposite or same-sex), dependent children or Same-Sex Domestic Partner who meet(s) the eligibility requirements established by the Fund.

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.

PHYSICALLY HANDICAPPED:

Having a bodily defect, disability or characteristic that restricts, limits or prevents an individual's participation in normal physical activities or interferes with standard achievements, and/or limits or prohibits an individual's capacity to work or be gainfully employed, and requires dependency on parents or other care providers for lifetime care and supervision.

PLAN:

The group of benefits provided by the Fund. The Plans are subject to change by the Trustees.

PPACA (or the "Affordable Care Act" or "Health Care Reform Act"):

The Patient Protection and Affordable Care Act (Pub. I.111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub I. 111-152).

PPO:

An acronym for Preferred Provider Organization.

PREAUTHORIZATION:

Preauthorization, sometimes referred to as "pre-certification," 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 a plan for a procedure before it is performed.

PREEXISTING CONDITION:

An injury or illness for which you or your eligible dependent has received treatment, incurred expenses, or received a diagnosis within 90 days before the enrollment date.

PREFERRED PROVIDER ORGANIZATION:

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 out-of-network provider.

PRIMARY CARE PHYSICIAN:

A physician within your plan's network who you have selected to coordinate all of your medical care. This includes providing routine medical services and referring you to a specialist, if necessary.

REASONABLE AND CUSTOMARY (R&C) CHARGE:

"Reasonable and Customary (R&C) limits" are the maximum dollar amount of a charge that a plan will consider (prior to application of a deductible, coinsurance or maximum) when determining benefits payable by the Fund. Currently, the Fund's determination of what is reasonable and customary is based on what 80% of providers in your geographic area charge (as determined by the Fund, in its sole discretion) for similar services or supplies. (A "geographic area" is an area grouped by several ZIP Codes.)

SAME-SEX DOMESTIC PARTNER:

An individual who has submitted to the Fund an Affidavit of Domestic Partnership on a form provided by the Fund, along with supporting documentation, and who meets the criteria set forth in such Affidavit. Generally, for a partner to qualify, both the participant and his/her Same-Sex partner must acknowledge being in a committed relationship which has been in existence for at least six months. For more information, contact the Administrative Office.

SAME-SEX SPOUSE:

An individual who is legally married to a participant of the Same Sex or gender, and such relationship is legally recognized as a marriage in the state or jurisdiction where the marriage was performed.

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.

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.

SPECIAL ENROLL, SPECIAL ENROLLMENT OR SPECIAL ENROLLMENT RIGHT:

The right you and/or your dependents have to enroll in the Fund outside the Open Enrollment period, upon the occurrence of certain qualifying events.

TOTAL DISABILITY:

“Total Disability,” as used in *Section 3: Medical Benefits*, means:

- For an Active Participant, the inability to perform the substantial and material duties of his/her occupation or employment. The inability must be as a result of injury or illness;
- For a Certified Retiree and for a dependent spouse/Same-Sex Domestic partner, the inability to engage in the substantial and material activities engaged in before the start of the disability. The inability must be a result of injury or illness; or
- For a child, confinement to the house or a hospital. The confinement must be as a result of injury or illness. For a child over age 26, who is incapable of self-sustaining employment because of mental retardation or physical handicap, and began before the child reached age 26.

“Total Disability,” as used in *Section 6: 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.

UNION:

“Union” shall mean the Writers Guild of America, East, Inc. or the Writers Guild of America, West, Inc.

URGENT CONDITION:

A condition that’s 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.

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