PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

Summary of Material Modifications

November 30, 2021

SUMMARY OF MATERIAL MODIFICATIONS

TO: All Active Covered Plan Participants

FROM: The Writers' Guild-Industry Health Fund

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This document is a Summary of Material Modifications (SMM), intended to notify you of changes to your benefits under the Writers' Guild-Industry Health Fund.

These changes include:

- Benefit coverage for infertility treatment, up to a lifetime maximum infertility benefit of $30,000, per eligible individual.
- Infertility treatment must be received from an in-network Carrot provider to be eligible for coverage.

PLAN BENEFIT CHANGES

The Writers' Guild-Industry Health Fund ("the Fund") is implementing changes to the Plan benefits indicated herein, beginning January 1, 2022.

INFERTILITY BENEFIT

Currently, the Fund does not provide benefits for medically necessary infertility treatment. Effective January 1, 2022, the Plan's benefit coverage is expanded to provide coverage for medically necessary infertility treatment with a medical diagnosis of infertility through Carrot.

What does this mean for you?

- The Fund currently provides coverage for an initial office visit and any testing to determine the cause of infertility, consistent with the Plan's rules that apply to covered health benefits. However, the Fund does not cover any subsequent treatment of infertility (services that are intended to create a pregnancy). The Fund's existing coverage for initial office visits and infertility testing has not changed.

- What has changed is that, effective January 1, 2022, the Fund will begin to cover medically necessary infertility treatment with a medical diagnosis of infertility, provided that you receive treatment from a Carrot provider as described in more detail in this SMM.

Infertility treatment must be obtained from an in-network Carrot provider to be eligible for coverage from the Fund. Infertility treatment coverage is limited to a lifetime maximum of $30,000 per eligible Participant and their covered spousal dependent. Cost-sharing is not

imposed on infertility treatment.

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

CARROT - INFERTILITY BENEFIT ADMINISTRATOR

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

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

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

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

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

Enrolling in Carrot

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

Carrot Card

When you enroll in Carrot, you will have the option to request a "Carrot Card," which works

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

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

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

Claims and Appeals

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

Filing a Claim: **You are responsible for submitting claims for covered services provided by in-network Carrot providers.** This is the case regardless of whether you use your Carrot Card or you pay for covered services out of pocket. You or your authorized representative will need to submit your claim directly to Carrot by uploading the paid statement or superbill from your in-network Carrot provider online at: www.app.get-carrot.com. Your claim must include: (1) the name of the individual who received the covered service, (2) the nature and date of the covered service, (3) the amount of the requested reimbursement, and (4) a statement that the covered service has not been reimbursed and is not eligible for reimbursement from another source (with the exception of reimbursement through your Carrot Card).

Deadline to File Claims: Claims for covered services must be submitted to Carrot, which is

the Claims Administrator, within 30 days after the first to occur: (1) the end of the calendar year of the date of service (regardless of when you are billed or pay for the service), or (2) the date your Fund coverage terminates (which is the later of the date you lose earned coverage or COBRA coverage, if you elect COBRA). If you submit your claim after that deadline, your claim will be denied as untimely.

> **Example**: You receive covered infertility treatment from an in-network Carrot provider on June 1, 2022. You must submit your claim to Carrot by January 30, 2023; if you do not submit your claim by that date, it will be denied as untimely.
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> **Example**: You receive covered infertility treatment from an in-network Carrot provider on June 1, 2022. Because you did not meet your earnings minimum, you lose your earned coverage on July 1, 2022. You do not elect COBRA. You must submit your claim to Carrot by July 31, 2022 (30 days after your loss of Fund coverage). If you do not submit your claim by that date, it will be denied as untimely.

Appealing a Denied Claim: If your claim is denied in whole or in part by the Claims Administrator, you or your authorized representative may file an appeal to the Appeals Administrator, which is Carrot. Your appeal should explain why you disagree with the Claims Administrator's determination regarding your claim, and must include your name and address and the date you received notice of your denied claim. You will be provided the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits. All the comments, documents, records, and other information that you submit relating to the claim will be considered by the Appeals Administrator, without regard to whether such information was submitted or considered in the claim determination. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

You should email your written appeal to: support@get-carrot.com with the subject "Appeal Requested for Denied Claim." You have 180 days from your receipt of the claim denial to file a written appeal. If you do not file your appeal within 180 days after receiving the Claims Administrator's decision denying your claim, the Claims Administrator's decision is final and you will not be allowed to pursue a claim in court. The Appeals Administrator will not be the same person who decided the claim that is the subject of your appeal, nor the subordinate of such person.

You will be notified of the decision on your appeal within 60 days after receipt of your appeal. If your appeal is denied by the Appeals Administrator in whole or in part, you have the right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA). Please be advised that you may bring an action under Section 502(a) of ERISA only after you have exhausted the claims and appeals process

as described above. If you do file any lawsuit, it must be brought within two years after your appeal is denied and in the United States District Court for the Central District of California. However, as explained above, if you do not file an appeal within 180 days of receiving the denial of your claim, you will not have a right to bring an action in court under ERISA.

Voluntary Appeal to Benefits Committee

Before filing a lawsuit, you may also submit a voluntary appeal to the Fund's Benefits Committee. While your voluntary appeal to the Benefits Committee is being processed, the limitations period for filing a lawsuit described above is tolled. While you may not bring a lawsuit regarding a claim without first exhausting the claims and appeal procedures, you are not required to first submit a voluntary appeal. To file a voluntary appeal with the Benefits Committee, please mail your written appeal to: Benefits Committee, PWGA Pension and Health, 2900 W. Alameda Avenue, Suite 1100, Burbank, CA 91505-4220. For more information on submitting a voluntary appeal, please contact the Fund Office during normal business hours at: (818) 846-1015 or toll-free (800) 227-7863 or email your questions to: participantservices@wgaplans.org.

External Review

If, after exhausting the appeals procedure, you are not satisfied with the final determination, you may choose to participate in the Fund's external review program as described in the Plan's SPD. Your claim is eligible for external review only if the adverse benefit determination is based on: (1) Clinical reasons, (2) The exclusions for Experimental or Investigational Services or Unproven Services, or (3) As otherwise required by applicable law. For more information on the availability of external review, please contact the Fund Office during normal business hours at: (818) 846-1015 or toll-free (800) 227-7863 or email your questions to: participantservices@wgaplans.org.

COVERED INFERTILITY TREATMENT AND EXCLUSIONS

Covered Infertility Care Expenses

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

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

- Registered with the Society for Assisted Reproductive Technology (SART), or local equivalent

  - Reports data into SART, or local equivalent, on an annual basis
  - At least one board-certified reproductive endocrinologist on staff, or local equivalent
  - Offers vitrification freezing and single embryo transfers for PGS embryos
- Examples of Covered Infertility Care Expenses include but are not limited to:
  - Fertility consultations
  - Semen analysis
  - Short-term fertility preservation for males and females (for example, short-term egg freezing or semen freezing if member is scheduled to undergo procedure that may result in loss of fertility, such as radiation or chemotherapy)
  - Genetic testing related to fertility (e.g., PGT-A, PGT-M)
  - Intrauterine insemination
  - In vitro fertilization
  - Transportation of reproductive material with an approved vendor
  - Short term storage costs for eggs, sperm, and/or embryos
  - Fertility medications obtained through Express Scripts

Exclusions

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

- The following treatments are examples of care that is not covered:
  - Any infertility treatment or services received outside the United States
  - Any infertility treatment or services delivered by any provider or facility that is not in-network with Carrot
  - Any infertility treatment or services without a medical diagnosis of infertility
  - Long-term fertility preservation, including elective egg or sperm freezing
  - Any expenses relating to surrogacy or adoption
  - Infertility-related treatments under the care of primary care providers or OB/GYNs
  - Herbal treatments
  - Nutrition counseling

- General genetic tests
- Physical therapy or fitness-related expenses
- Fertility medications not obtained through Express Scripts

This summary is intended to satisfy the requirement for issuance of a SMM. You should take the time to read this SMM carefully and keep it with the Summary Plan Description ("SPD") that was previously provided to you. If you need another copy of the SPD or if you have any questions regarding these changes to the Plan, please contact the Fund Office during normal business hours at: (818) 846-1015 or toll-free (800) 227-7863 or email your questions to: (Participantservices@wgaplans.org)