

SUMMARY OF MATERIAL MODIFICATIONS

TO: All Plan Participants

FROM: The Writers' Guild-
Industry Health Fund



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:

- Certain services you receive out-of-network will be subject to network cost-sharing and you will no longer be balance billed for charges above the Plan's Allowed Charge.
- In some cases, if you consent to receive certain services out

PLAN BENEFIT CHANGES

Beginning January 1, 2022, the Writers' Guild-Industry Health Fund (the "Fund") is implementing changes to Plan benefits as required by the *No Surprises Act*, which is a new federal law that protects healthcare consumers from receiving surprise bills from out-of-network providers in certain situations.

What Does this Mean for You?

Under the *No Surprises Act*, out-of-network providers and facilities are generally prohibited from sending you a "balance bill" for any eligible expenses in excess of the Fund's Allowed Charge for services under the following circumstances:

- **Emergency services at an out-of-network health care facility** (unless you consent to out-of-network billing rates for certain post-stabilization services)
- **Non-emergency services provided by an out-of-network provider at an in-network health care facility** (unless you consent to out-of-network billing rates, if applicable)
- **Out-of-network air ambulance services**

In addition to the protections against receiving surprise bills from these out-of-network providers, your cost-sharing will be the same as if you had received services in-network. This means that once you have met your deductible, those cost-sharing amounts will be applied to your ACA Network out-of-pocket (OOP) limit and In-Network Coinsurance OOP limit, as applicable.

What is a Balance Bill? Normally, except for surprise bills covered by the *No Surprises Act*, if you receive services from an out-of-network provider, you are responsible for any amount billed by the out-of-network provider in excess of the Fund's Allowed Charge for the services – this is called a "balance bill."

What is a Surprise Bill? A surprise bill is a type of balance bill. Surprise bills may occur when you are required to unexpectedly seek medical care from an out-of-network facility or if you unknowingly receive out-of-network services while you are at an in-network facility. Under those situations, you may not know that you are receiving out-of-network treatment—hence, the “surprise” when you receive the bill. On the other hand, if you choose to see an out-of-network specialist or if you consent to out-of-network billing rates under certain circumstances, the bill is not a “surprise” and the surprise billing protections would not apply.

A few things to keep in mind:

- These special rules apply only to the types of services listed above. Other out-of-network services remain subject to the normal rules of the Plan.
- These special rules will not apply in certain circumstances if you consent to receiving treatment from an out-of-network provider for either post-stabilization treatment or non-emergency treatment at an in-network facility. If that happens, as with other out-of-network services, you will be responsible for payment of the applicable out-of-network coinsurance, as well as any balance bills for amounts in excess of the Fund’s Allowed Charge for those services.
- Keep in mind that you are always responsible for any expenses or charges billed by any provider or facility that are not medically necessary or are otherwise not Eligible Expenses.

Further details about the *No Surprises Act* changes are set forth in the modified SPD language below.

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The revised language in the chart below replaces the Summary Plan Description (SPD) language on the pages indicated and will be used to interpret plan benefits and the administration of such benefits going forward. The bolded text indicates new or revised language.

SPD Section and Subheading	Page	Revised Language
Section One, Summary of Benefits, Plan Features, Important Notes	2-3	<ul style="list-style-type: none"> • All services are subject to Medical Necessity review at the time of payment. • Calendar-year deductible, office visit copays, hospital copays, and any other copays do not apply toward the Coinsurance Out-of-Pocket Limit. They do apply to the ACA In-Network Out-of-

		<p>Pocket Limit if services are received in-network or if the out-of-network services are required to be applied toward your ACA In-Network Out-of-Pocket Limit under the No Surprises Act, defined on page [] in the Glossary.</p> <ul style="list-style-type: none"> The Plan's out-of-pocket maximum (after deductible) for Medicare-eligible Certified Retirees who retired prior to March 1, 1997 and who are receiving a benefit from the Producer-Writers Guild of America Pension Plan of greater than \$800 per month is \$400 for in-network providers (with coverage at 85%) and \$600 for out-of-network providers (with coverage at 70%). <p>The ACA out-of-pocket maximum of \$7,350/person and \$14,700 per family per year applies to in-network services and out-of-network services required to be applied toward your ACA In-Network Out-of-Pocket Limit under the No Surprises Act and changes automatically each year to reflect the ACA permitted maximum. You can contact the Fund Office for the current limit.</p>
Section One, Summary of Benefits, Physician Services, Important Notes	5	<ul style="list-style-type: none"> For non-emergency services received from out-of-network providers at in-network facilities, in-network coinsurance rates will apply as required under the No Surprises Act (unless you consent to out-of-network billing rates for those services, if applicable). Assistant surgeons will be considered at a reduced benefit level that is equal to 20% of the surgeon's contract or the Allowed Charge.
Section One, Hospital Services, Emergency Room	6, FN1	<p>Emergency services received at an out-of-network emergency health care facility will be treated as if received in-network and may qualify for in-network coinsurance rates (unless you consent to out-of-network billing rates for certain post-stabilization services) if the condition meets the definition of emergency care on page 71.</p>
Section Three, Medical Benefits, In-Network and Out-of-Network Providers	59	<p>In-network health care providers are doctors and hospitals that have agreed to be part of a Preferred Provider Organization (PPO) and to charge a reduced rate when used by Health Plan Participants. When you use an in-network provider, the provider should not "balance bill" — <i>i.e.</i>, charge more than the contracted rate.</p> <p>Out-of-network providers are doctors and hospitals not affiliated with the Health Plan's PPO, which means they can charge whatever they deem appropriate. You are responsible for the non-covered expenses, any copays, the deductible, and the coinsurance amount, unless you</p>

		<p>see an out-of-network provider under the following circumstances:</p> <ul style="list-style-type: none"> • You receive emergency services at an out-of-network health care facility (unless you consent to out-of-network billing rates for certain post-stabilization services) • You receive non-emergency services from an out-of-network provider at an in-network health care facility (unless you consent to out-of-network billing rates, if applicable) • You receive out-of-network air ambulance services <p>If you visit an out-of-network provider or facility in the situations described above, the out-of-network provider or facility may not bill you for any Eligible Expenses in excess of the Fund's Allowed Charge. In addition, your cost-sharing will be the same as if you had visited an in-network provider or facility, meaning that once you have met your deductible, your coinsurance costs will be applied to your ACA Network Out-of-Pocket Limit and Coinsurance Network Out-of-Pocket Limit. For more information on the items and services covered during your visit, please see page [__].</p> <p>Your health care provider may collect fees at the time services are rendered. Refer to page 61 for additional information.</p>
<p>Section Three, Medical Benefits, Allowed Charge (Out-of-Network Services)</p>	<p>59-60</p>	<p>Anthem Blue Cross negotiates rates with doctors and other health care providers to help you save money. We refer to these health care providers as "in-network" providers. The Fund also pays for services from health care providers who are not in the network. Many plans pay for out-of-network services based on what is called the Allowed Charge.</p> <p>The Allowed Charge (sometimes also referred to as the Allowed Amount or Allowable Charge) is the maximum dollar amount of a charge that the Fund will consider (prior to applying a deductible, coinsurance, or maximum) when determining benefits payable by the Fund. The Fund determines the Allowed Charge as the lowest of the following:</p> <ul style="list-style-type: none"> • With respect to an in-network health care provider or facility, the negotiated fee or rate set forth in the agreement between the network and the Fund; or • With respect to an out-of-network health care provider or facility, the amount the Fund has determined it will allow for eligible, Medically Necessary covered services or supplies from out-of-network providers or facilities, except in the case

	<p>of certain out-of-network services protected by the <i>No Surprises Act</i>, as explained below.</p> <ul style="list-style-type: none"> • With respect to services protected by the <i>No Surprises Act</i>, which are: (1) emergency services at an out-of-network health care facility (unless you consent to out-of-network billing rates for certain post-stabilization services), (2) non-emergency services by an out-of-network provider at an in-network health care facility (unless you consent to out-of-network billing rates, if applicable), and (3) out-of-network air ambulance services, the Allowed Charge is the “Qualifying Payment Amount,” which is defined on page [] of the Glossary; in general, it may be similar to the contracted rate with in-network provider; or • With respect to an in-network health care provider or facility whose network contract stipulates that the provider does not have to accept the network negotiated fee or rate for claims involving a third-party payer (including, but not limited to, auto insurance, workers’ compensation or other individual insurance), or where the Fund may be a secondary payer, the negotiated fee or rate that would have been payable by the Fund had the claim been processed as an in-network claim; or • The negotiated discounted amount that an out-of-network provider or facility agreed to, reducing the provider’s original billed charges to a lower, discounted amount; or • The provider’s or facility’s actual billed charge. <p>The Fund will not always pay benefits equal to or based on the provider’s actual charge for health care services or supplies, even after you have paid the applicable deductible, copay, and/or coinsurance. This is because the Fund covers only the Allowed Charge for health care services or supplies.</p> <p>The Allowed Charge is not necessarily reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary, and reasonable charge (UCR), prevailing, or any similar term. The Fund reserves the right to have the billed amount of a claim reviewed by an independent medical review firm or provider to assist in determining the amount the Fund will allow for the submitted claim.</p>
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<p>Section Three, Medical Benefits, Expenses That Do Not Accumulate to the ACA In-Network Out-of-Pocket Limit</p>	<p>63</p>	<p>Under the Plan, each year, you are responsible for paying the following expenses out of your own pocket. These expenses do not accumulate towards the ACA Network Out-of-Pocket Limit or the Coinsurance Out-of-Pocket Limit:</p> <ul style="list-style-type: none"> • All expenses for medical services or supplies that are not covered by the Plan; • All charges in excess of the Allowed Charge determined by the Plan; • All charges in excess of the Plan’s maximum benefits, or in excess of any other limitation of the Plan;

		<ul style="list-style-type: none"> • All expenses for medical services or supplies in excess of Plan benefits; and • In the case of the ACA Network Out-of-Pocket Limit, all expenses for medical services or supplies obtained from out-of-network providers, excluding: <ul style="list-style-type: none"> ○ Emergency services at an out-of-network health care facility (unless, in the case of certain post-stabilization services, you consent to out-of-network billing rates) ○ Non-emergency services received from an out-of-network provider at an in-network health care facility (unless you consented to out-of-network billing rates) ○ Out-of-network air ambulance services
Section Three, Medical Benefits, When You Visit an Out-of-Network Health Care Provider	66	<p>When you visit an out-of-network health care provider, the following principles will generally apply:</p> <ul style="list-style-type: none"> • If you have not met your calendar-year deductible, you will pay the full amount. • If you have met your calendar-year deductible, you will pay the out-of-network coinsurance (which is a higher percentage than the in-network coinsurance) of the Allowed Charge, and a copay, if applicable. • If the physician charges more than the Allowed Charge, or allowed amount, you are also responsible for any charges above this amount. <p>Important Exception: If you receive emergency services at an out-of-network health care facility (unless you consent to out-of-network billing rates for certain post-stabilization services), receive non-emergency services from an out-of-network provider at an in-network health care facility (and do not consent to out-of-network billing rates, if applicable), or need out-of-network air ambulance services, out-of-network providers or facilities may not bill you for any amounts in excess of the Allowed Charge. In addition, your cost-sharing will be the same as if you had seen an in-network provider; and, once you have met your deductible, will be applied to your ACA Network Out-of-Pocket Limit and your Coinsurance Out-of-Pocket Limit.</p>
Section Three, Medical Benefits, Emergency Care	71	<p>No matter where you are, if you have an emergency medical condition — that is, a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute</p>

	<p>symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious medical complications, loss of life, serious impairment of bodily functions, or serious dysfunction of a body part — you should always go to the nearest hospital’s emergency room (E/R) or other emergency care facility to get the care you need. Examples of emergencies include, but are not limited to:</p> <ul style="list-style-type: none"> • Broken bones • Burns • Chest pains or severe squeezing sensations in the chest • Major cuts • Seizures or loss of consciousness • Shortness of breath • Sudden paralysis or slurred speech • Suspected medication overdose or poisoning • Uncontrolled bleeding <p>Emergency services means, with respect to an emergency medical condition:</p> <ul style="list-style-type: none"> • An appropriate medical screening examination that is within the capability of an emergency room of a hospital or independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and • Such further medical examination and treatment as are required to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable (regardless of the department of the hospital in which such further examination or treatment is furnished); and • Post-stabilization services, which are services furnished by out-of-network providers or out-of-network facilities after the patient is stabilized as part of outpatient observation or an inpatient/outpatient stay related to the emergency medical condition (regardless of the department of the hospital in which such further examination or treatment is furnished), until: (1) the treating provider or facility
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		<p>determines that the individual is able to travel using non-medical transportation or non-emergency medical transportation; and (2) the individual is provided with appropriate written notice to consent to out-of-network treatment and gives informed consent to such out-of-network treatment.</p> <p>The Fund will charge you the same copayment or coinsurance for emergency services when you obtain those services from an in-network health care facility or from an out-of-network health care facility. Accordingly, emergency services by an out-of-network health care facility will be considered at the in-network coinsurance level, or 85% for the PPO Plan and 70% for the Low Option Plan, subject to the Plan’s \$50 copay and the annual deductible.</p> <p>Notwithstanding any exclusion in the Plan to the contrary, please note the Fund will cover any complication of a dependent pregnancy that meets the definition of emergency services, subject to applicable Fund rules.</p> <p>If you obtain emergency services from an out-of-network health care facility, that facility may not bill you separately if their charges exceed the Plan’s allowances for the services.</p>
<p>Section Three, Medical Benefits, Special Rules for Using Certain Out-of-Network Providers at In-Network Facilities</p>	<p>73</p>	<p>If you receive non-emergency services from an out-of-network provider at an in-network health care facility, the out-of-network provider may not bill you separately if their charges exceed the Fund’s Allowed Charge for such service; and, once you have met the deductible, you will be responsible for the in-network coinsurance for the service (unless you consent to out-of-network billing rates, if applicable).</p> <p>A “visit” to an in-network health care facility includes the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is physically located at the facility.</p> <p>If you go to an out-of-network facility (except in the case of emergency services at an out-of-network health care facility), these rules do not apply and you will be responsible for a higher percentage of the cost (the out-of-network coinsurance) and any amount over the Allowed Charge. Also, please see pages 71 and 87 to find out what expenses and charges are covered for emergency</p>

		care.
Section Three, Medical Benefits, Emergency Room Services	87	<p>The Fund will charge you the same copayment or coinsurance for emergency services whether you obtain those services from an in-network health care facility or from an out-of-network health care facility. Accordingly, emergency services provided by an out-of-network health care facility (unless you consent to out-of-network billing rates for certain post-stabilization services, if applicable) will be considered at the in-network coinsurance level or 85% for the PPO Plan and 70% for the Low Option Plan, subject to a copay (the copay is waived if you are admitted to the hospital, though the hospital admission copay applies) and the annual deductible.</p> <p>If you obtain emergency services from an out-of-network health care facility, that facility may not bill you separately if their charges exceed the Fund's Allowed Charge for those services. Coverage for the emergency services at the in-network coinsurance level must meet the definition of emergency services as noted on page 71.</p>
Section Nine, Administrative Information, Claims and Appeals Rule, External Review Process, first paragraph	179	<p>If, after exhausting the Fund's internal appeals process, you are not satisfied with the final determination, you may choose to participate in the external review process. This process only applies if the adverse benefit determination is based on:</p> <ul style="list-style-type: none"> • Clinical reasons; • A rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time; • The exclusions for experimental or investigational services or unproven services; • Non-quantitative treatment limitations that provide to the provision of medical benefits; • Compliance with the surprise billing protections under the <i>No Surprises Act</i>; or • As otherwise required by applicable law.
Health Fund Glossary, Balance Billing	208	<p>Occurs when a health care provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. If you use an out-of-network provider, you may be balance billed by that provider. However, you may not be balance billed by an out-of-network provider if you receive services under the following circumstances: (1) Emergency services</p>

		<p>at an out-of-network health care facility (unless you consented to out-of-network billing rates for certain post-stabilization services, if applicable); (2) Non-emergency services from an out-of-network provider at an in-network health care facility (unless you consented to out-of-network billing rates, if applicable); and (3) Out-of-network air ambulance services.</p> <p>If you think you have received a balance bill from an out-of-network provider in error, you may contact the Fund Office at (818) 846-1015.</p>
Section Eleven, Health Fund Glossary, Emergency	211	<p>A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious medical complications, loss of life, serious impairment of bodily functions, or serious dysfunction of a body part.</p>
Section Eleven, Health Fund Glossary, Out-of-Pocket Limits	217	<p>For the Coinsurance Out-of-Pocket Limit, this is the maximum amount you pay in coinsurance each Plan Year for eligible medical expenses. There are separate In-Network and Out-of-Network Limits.</p> <p>For the ACA Network Out-of-Pocket Limit, this is the maximum amount you pay for your deductible, copays, and coinsurance each Plan Year for in-network eligible expenses, and out-of-network eligible expenses required to be applied to your ACA Network Out-of-Pocket Limit under the No Surprises Act.</p>

The following language in the chart below will be added to the Summary Plan Description and will be used to interpret plan benefits and the administration of such benefits going forward.

SPD Section and Subheading	New Language
Section Three, Medical Benefits, In-Network and Out-of-Network Providers	<p>Provider Directory</p> <p>To help you find care from in-network providers and facilities, Anthem maintains a provider directory. Anthem updates its provider directory every ninety (90) days and will respond to your inquiry about the network status of a provider or facility within one business day. If you receive inaccurate</p>

	<p>information from Anthem or the Fund office about a provider or facility's network status, you will be liable only for in-network coinsurance for the services underlying your inquiry. It is your responsibility to confirm that the provider or facility that you have selected is in-network at the time you receive services.</p> <p>To find an in-network provider, call the Fund Office at (818) 846-1015 or (800) 227-7863 or Anthem Blue Cross at (800) 810-BLUE (2583) or view the network's provider listings at <i>pwga.org</i> ("Health/Find a Participating Provider").</p> <p>Continuity of Coverage</p> <p>The Fund provides continuity of coverage in situations where a termination of a contractual arrangement changes the in-network status of a provider or facility to out-of-network (except in the case of a termination of the contract for failure to meet applicable quality standards or for fraud).</p> <p>If you are a "Continuing Care Patient," you will be notified of the contract termination and your right to elect continued transitional care from the provider or facility; and, you will be allowed ninety (90) days of continued coverage from the provider or facility at in-network cost-sharing to allow you time to transition to a new in-network provider or facility.</p> <p>A Continuing Care Patient is an individual, who, with respect to a provider or facility, is undergoing: (1) a course of treatment for an acute illness (serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm) or chronic illness or condition (life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time); (2) is undergoing a course of institutional or inpatient care from the provider or facility; (3) is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility; (4) is pregnant or undergoing a course of treatment for the pregnancy from the provider or facility; or, (5) is or was determined to be terminally ill (under SSA § 1862(dd)(3)(A)) and is receiving treatment for such illness from such provider or facility.</p>
<p>Section Nine, Administrative Information, Claims and Appeals</p>	<p>Claims Subject to Surprise Billing Protections</p> <p>The Claims Administrator will make an initial payment or notice of denial of payment for emergency services at out-of-network health care facilities, non-emergency services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services within (30) calendar days of receiving a claim from the out-of-network provider or facility that</p>

	includes all necessary information to decide the claim.
Section Eleven, Health Fund Glossary	<p>No Surprises Act</p> <p>A federal law that may protect you from receiving surprise bills for out-of-network services in three specific situations: (1) emergency services at an out-of-network health care facility (unless you consented to out-of-network billing rates for certain post-stabilization services); (2) non-emergency services provided by an out-of-network provider during your visit to an in-network facility (unless you consented to out-of-network billing rates, if applicable); and (3) out-of-network air ambulance services.</p>
Section Eleven, Health Fund Glossary	<p>Qualifying Payment Amount</p> <p>Qualifying Payment Amount (QPA) means the Fund’s median contracted rate for the item or service in the same geographic region, as adjusted under DOL Regulation 2590.716-6(c).</p>

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