SAG AFTRA
HEALTH PLAN

3601 W. Olive Ave., Burbank, CA 91505
Mailing Address: P.O. Box 7830, Burbank, CA 91510-7830
P (800) 777-4013 • F (818) 953-9880
www.sagaftraplans.org/health

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Notice of Benefit Changes

Please take a few minutes to review this summary of recent changes to the SAG-AFTRA Health Plan, as well as a brief update from the Plan.

We hope you're well.
The past few months have been challenging for many, and we hope you and your loved ones are well.

Because of the COVID-19 crisis, we've collectively made adjustments to our everyday lives; work has come to a stop for many; and we're making every effort to remain positive while facing continued uncertainty around when we'll open again for business as usual.

We're here for you.
The crisis has also affected the SAG-AFTRA Health Plan. We've made many changes to help our participants during this difficult time by adding COVID-19 screening and antibody testing with no cost-sharing and temporarily expanding our telehealth benefits. We've also temporarily reduced premiums through June. More details about these changes can be found below.

We're keeping a close watch.
The Plan's Trustees are actively monitoring the COVID-19 crisis and its impact on our participants' health and the Plan's financial situation. We will communicate with you frequently over the next few months – watch your email and **www.sagaftraplans.org/health/benefits** for updates.

Summary of Material Modifications
This Summary of Material Modifications shows the accumulated changes the Trustees have made to the Health Plan to respond to the COVID-19 crisis, as well as additional general changes to the Health Plan. These changes are:

1. COVID-19 Testing and Screening Coverage Without Cost-Sharing
2. Telehealth Coverage, Including for Reasons Other than COVID-19 Testing and Screening
3. Temporary Premium Reductions
4. Updates to Preauthorization Process
5. Out-of-Network Provider Claims Repricing

We announced many of these changes in prior communications, however, this notice is the formal Summary of Material Modifications ("SMM") notice for your records. In addition, this notice provides information regarding extensions of certain deadlines applicable to participants and their families due to COVID-19. Please keep this notice with your SAG-AFTRA Health Plan summary plan description ("SPD") and other Plan documents.

COVID-19 Testing and Screening Coverage Without Cost-Sharing:

The following will be in effect for dates of service beginning March 18, 2020, and through the end of the declared national emergency and public health emergency ("emergency period") and will apply to in-network and out-of-network providers:

The SAG-AFTRA Health Plan will cover without patient cost-sharing the administration of COVID-19 testing and the cost of any office visits (including in-person and telehealth visits), urgent care visits, and ER visits resulting in an order for or administration of testing, or the evaluation of whether someone needs testing. This testing includes serological tests (tests for antibodies in blood). Such testing must be approved by the FDA or other such approval process specified by applicable law.

Telehealth Coverage, Including for Reasons Other Than COVID-19 Testing and Screening:

Effective for dates of service beginning March 23, 2020, and for the duration of the emergency period, the Plan is eliminating its general telehealth benefits exclusion and expanding telehealth benefits to include office visits, including behavioral health, both in-network and out-of-network, for illnesses and injuries that are otherwise covered under the Plan. The Plan already provides medical telehealth benefits through LiveHealth Online. During the period set forth above, you may access telehealth through LiveHealth Online, and you may also obtain services through video or telephone from any providers for services otherwise covered by the Plan, subject to the Plan's regular payment rules, exclusions and limitations.

Beacon's MDLive network is also available to eligible participants and dependents during the emergency period. MDLive provides online and telephonic visits with Beacon's network behavioral health providers, subject to the $25 co-pay applicable to network provider office visits.

Temporary Premium Reductions

Effective for the April 1 through June 30, 2020 quarterly premium and April through June monthly COBRA premiums only, the Plan is reducing required premiums by 50% for all participants with Earned Eligibility and for all participants enrolled in COBRA coverage who were covered by the Plan as of March 1, 2020. There is no change in the premiums required for Senior Performers, Senior Performers with Earned Active coverage, or for participants newly qualified with Earned Eligibility effective April 1, 2020. Participants who pre-paid the April 1, 2020 Earned Eligibility premium or April, May or June 2020 COBRA premiums must contact the Plan in writing by June 30, 2020 to request a premium credit for the 50% reduction. The premiums can be found at sagaftraplans.org/health/premiums.

Extensions of Deadlines During COVID-19 Emergency Period

The Health Plan will disregard the period from March 1, 2020 until sixty (60) days after the announced end of the COVID-19 national emergency in determining the following periods and deadlines:

- The special enrollment period to request mid-year enrollment in the Health Plan after a loss of coverage or acquiring a new dependent due to birth, marriage, adoption, or placement of adoption;
- The 60-day period for electing COBRA continuation coverage, as well as the date for making COBRA premium payments;
- The date to notify the Health Plan of a COBRA qualifying event or determination of disability;
- The deadline for individuals to file a claim for benefits under the Health Plan's claims procedure;
- The deadline for claimants to file an appeal of an adverse benefit determination under the Health Plan's claims procedure;
- The deadline for claimants to file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination; and
- The deadline for a claimant to file information to perfect a request for external review upon a finding that the request was not complete.

Please see the Health Plan SPD for additional information regarding special enrollment, COBRA, and the Health Plan's claims and appeals procedures.

Updates to Pre-Authorization Process

As set forth on pages 62-63 of the Health Plan SPD, certain procedures have mandatory pre-authorization requirements. Even in cases where pre-authorization is not specifically required, it is strongly recommended that you obtain pre-authorization in order to determine whether a treatment will be covered by the Health Plan. Payment for Plan benefits is based on, among other considerations, whether the treatment or procedure is medically necessary or experimental/investigational (as defined in the Health Plan SPD). While a claim will not be denied simply because it was not pre-authorized, going through the pre-authorization process can assist in detecting any issues before the service is performed, so that you can avoid coverage issues later.

The following are examples of services for which we strongly advise you to obtain pre-authorization in advance due to the nature of the services:

- Eyelid surgery
- Genetic testing
- Outpatient monitored anesthesia care
- Nasal surgery
- Neuropsychological testing
- Reconstructive surgery
- Sleep study
- Spinal surgery
- TMJ therapy

Any potentially Investigative or Experimental testing and treatment (see pages 131-132 of the SPD for a definition of Investigative or Experimental)

Effective immediately, Anthem is assisting the Health Plan in performing pre-authorizations. Anthem maintains an extensive list of items for which it performs pre-authorizations. That list can be found at www.anthem.com/ca/provider/prior-authorization/ and is available upon request from the Plan Office.

Participants may submit requests for pre-authorization of services not on the Anthem list directly to the Plan.

Also, please refer to the SPD's prescription drug benefits for information regarding pre-authorization for medications, which is not handled by Anthem.

If you have any questions regarding pre-authorization, please contact the Plan Office.

Out-of-Network Provider Claims Repricing

The Plan offers one of the broadest networks by providing access to Anthem's BlueCard PPO network, and you receive the best value from your benefits when you visit a network provider. We understand that sometimes participants and dependents need to seek care from an out-of-network provider, and the benefits payable under the Plan for out-of-network providers are set forth in the Plan's SPD (though there are no benefits payable for non-network facilities, except for certain emergency services in the emergency room).

Out-of-network claims are generally subject to higher out-of-pocket costs for participants and their families because the non-network provider has not agreed upon a rate for their services in advance. In an effort to assist with that issue, we have partnered with a team led by WellRithms, Inc. to review and reprice certain out-of-network claims and to provide you with services to assist you if you are balance billed by an out-of-network provider. The team consists of WellRithms, which reviews and reprices selected non-network claims on behalf of the Health Plan; MedWatch, which advocates on your behalf if you receive a balance bill from a provider on a claim that WellRithms repriced; and Shield Services, which works with the Plan on certain disputed non-network claims. WellRithms reviews certain non-network claims to determine a rate for the claim that your cost-sharing (i.e., deductible and coinsurance) is applied to so that your out-of-pocket costs are limited. If WellRithms reprices your claim, it will be reflected in the comments on your Explanation of Benefits (EOB). If WellRithms has repriced a claim and your out-of-network provider is attempting to seek payment from you for more than your cost-sharing amount, please contact the Health Plan, and we will work with you and MedWatch to attempt to resolve the issue with the provider.

If you have any questions regarding the changes described in this notice, please contact the Health Plan office.

You should take the time to read this notice carefully and share it with your family. It is very important that you retain this notice, which is intended to serve as a Summary of Material Modification (SMM) to the Health Plan, with the 2017 SPD and prior notices issued after the SPD. While every effort has been made to make the SMM as complete and as accurate as possible, it does not restate the existing terms and provisions of the Health Plan

other than the specific terms and provisions it is modifying. If any conflict should arise between this summary and the terms of the SPD (other than with respect to the specific terms and provisions this summary is modifying), or if any point is not discussed in this summary or is only partially discussed, the terms of the applicable SPD will govern in all cases. The Board of Trustees or its duly authorized designee reserves the right, in its sole and absolute discretion, to interpret and decide all matters under the Health Plan. The Board also reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Health Plan or any benefits provided under the Health Plan (or qualification for such benefits), in whole or in part, at any time and for any reason (including, but not limited to, with respect to retirees).

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Section 1557 Non-discrimination Notice

The SAG-AFTRA Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The SAG-AFTRA Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. The SAG-AFTRA Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the SAG-AFTRA Health Plan's Compliance Department. If you believe that the SAG-AFTRA Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Attention: Compliance Department

SAG-AFTRA Health Plan

P.O. Box 7830

Burbank, CA 91510-7830

Phone: (800) 777-4013

Fax: (818) 953-9880

Email: complianceofficer@sagaftraplans.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, (800) 368–1019, (800) 537–7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 777-4013

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (800) 777-4013

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 777-4013

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 777-4013 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 777-4013

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 (800) 777-4013

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 1 (800) 777-4013

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1 (800) 777-4013

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1 (800) 777-4013

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1 (800) 777-4013

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1 (800) 777-4013

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1 (800) 777-4013

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1 (800) 777-4013 まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1 (800) 777-4013

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. ب 1 (800) 777-4013 تماس بگیرید.