SAG-AFTRA HEALTH PLAN

SENIOR PERFORMERS

HEALTH REIMBURSEMENT ACCOUNT PLAN

SUMMARY PLAN DESCRIPTION

PLAN DOCUMENT

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Effective January 1, 2021

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INTRODUCTION

A Letter from the SAG-AFTRA Health Fund Board of Trustees

In August 2020, the Board of Trustees of the SAG-AFTRA Health Fund decided to change the way in which the Fund offers benefits to our Senior Performer participants and their spouses, including through the adoption of the SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan (the "HRA Plan").

As Trustees, we are proud to provide you with this inaugural Summary Plan Description ("SPD") of the HRA Plan, which describes the benefits available to former participants in the SAG-AFTRA Health Plan (and its predecessor plans) who qualify as Senior Performers and their Spouses and Surviving Spouses, as defined herein, to obtain reimbursement of their Eligible Medical Expenses incurred on and after January 1, 2021.

The HRA Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. This HRA Plan is also intended to be exempt from the Affordable Care Act as a separate "retiree-only" plan pursuant to ERISA Section 732(a) and IRC Section 9831(a)(2). The HRA Plan will be interpreted at all times consistent with these intents.

The material provisions of the HRA Plan as of the January 1, 2021 Effective Date are summarized below, but this SPD is qualified in its entirety by reference to the full text of the formal HRA Plan document, a copy of which is included in this document behind the SPD, starting at page 32. In the event of any conflict between the terms of this SPD and the terms of the HRA Plan document, the terms of the HRA Plan document will control.

Note that capitalized terms used in this SPD are defined the first time they are used or are defined in the "HRA Plan Terms" section at the end of this booklet. Please note that "you," "your" and "my" when used in this SPD refer to you, the Participant, as defined herein. This HRA Plan uses gender-neutral personal pronouns. The singular shall include the plural, and vice versa.

It's important to note that the Board of Trustees may (with or without notice) reduce, modify or discontinue benefits or the qualification rules for benefits at any time, with respect to any individual who is covered, or who may become covered, under the HRA Plan. Rights to future benefits, including but not limited to, Senior Performer benefits, are not promised, vested or guaranteed. The Board of Trustees has the sole and exclusive power and responsibility to make all decisions regarding the HRA Plan and what it provides. The Board of Trustees' decisions regarding this HRA Plan are binding upon SAG-AFTRA, employers and Participants and anyone else purporting to be entitled to a benefit under the HRA Plan. Neither Plan employees nor employees of the Claims Administrator, currently Via Benefits, can alter benefits or eligibility or

other rules, and their opinions or interpretations cannot amend what is set forth in this SPD or the plan document and are not binding upon the Board of Trustees.

Please advise Via Benefits at 1-833-981-1280 if you change your address or marital status. If you have any questions, please contact Via Benefits at 1-833-981-1280 or contact the Plan at 1-800-777-4013.

We look forward to continuing to provide HRA Plan Participants with a high level of benefits and service as we start this new chapter together.

SAG-AFTRA Health Plan Board of Trustees

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PART I
GENERAL INFORMATION ABOUT THE HRA PLAN

What is the purpose of the HRA Plan?

The purpose of the HRA Plan is to reimburse Participants for Eligible Medical Expenses that are not otherwise reimbursed by any other plan or program. Reimbursements for Eligible Medical Expenses paid by the HRA Plan generally are excludable from the Participant's taxable income. Eligible Medical Expenses are defined below.

Who can participate in the HRA Plan?

A Senior Performer, Spouse or Surviving Spouse shall be eligible to participate in the HRA Plan if they meet all requirements to be a Participant as defined the Plan Terms at the end of this SPD, and are not eligible for coverage under the Active Plan. Senior Performers, Spouses or Surviving Spouses who become covered under the HRA Plan are called "Participants."

Can my dependents participate in the HRA Plan?

Only a Spouse or a Surviving Spouse who is eligible for Medicare can participate in the HRA Plan and have their Eligible Medical Expenses reimbursed.

When do I or my Spouse or a Surviving Spouse become a Participant in the HRA Plan?

A Senior Performer (see below for a special rule for Occupational Disability Pensioners), Spouse or Surviving Spouse becomes a Participant in the HRA Plan on the later of the Effective Date of the HRA Plan (January 1, 2021) or the date that they have attained age 65, or for a Spouse or Surviving Spouse otherwise become eligible for Medicare, and have satisfied all of the following requirements:

- They have satisfied the requirements to become a Senior Performer, Spouse or Surviving Spouse, as set forth in the HRA Plan Terms at the end of this SPD, as applicable;
- They have obtained an individual health insurance policy through Via Benefits or have provided satisfactory evidence to the Plan Administrator (or its delegate) that:
    - they obtained an individual health insurance policy through Entertainment Health Insurance Solutions (EHIS) or Artists Health Insurance Resource Center (AHIRC), both joint programs of the Actors Fund and the Motion Picture and Television Fund;
    - they have retiree coverage under another group health plan;
    - they have health coverage under TRICARE; or
    - they reside outside of the United States; and
- They have completed any enrollment forms (which may be electronic) or procedures as specified by the Plan Administrator (or its delegate) from time to time;

provided that the Senior Performer, Spouse or Surviving Spouse is not eligible for coverage under the Active Plan as a Participant or a dependent as a result of current employment status.

A Spouse who meets the above requirements may become a Participant regardless of whether the Senior Performer is a Participant, provided that:

- the Spouse has attained age 65 or is otherwise eligible for Medicare; and
- neither the Senior Performer nor the Spouse is eligible to be covered under the Active Plan as a result of current employment status.

A Surviving Spouse who meets the above requirements may become a Participant only upon the later of:

- The date the deceased Senior Performer, participant or former participant would have turned age 65; or
- The date the Surviving Spouse has attained age 65 or is otherwise eligible for Medicare;

provided that the Surviving Spouse is not eligible for coverage under the Active Plan.

A Senior Performer who is an Occupational Disability Pensioner may become a Participant when they have satisfied all of the following requirements:

- They have satisfied the requirements to become a Senior Performer, Spouse or Surviving Spouse, as set forth in the HRA Plan Terms at the end of this SPD, as applicable;
- They have obtained an individual health insurance policy through Via Benefits or have provided satisfactory evidence to the Plan Administrator (or its delegate) that:
    - they obtained an individual health insurance policy through Entertainment Health Insurance Solutions (EHIS) or Artists Health Insurance Resource Center (AHIRC), both joint programs of the Actors Fund and the Motion Picture and Television Fund;
    - they have retiree coverage under another group health plan;
    - they have health coverage under TRICARE; or
    - they reside outside of the United States; and
- They have completed any enrollment forms (which may be electronic) or procedures as specified by the Plan Administrator (or its delegate) from time to time;

provided that the Surviving Spouse is not eligible for coverage under the Active Plan as a result of current employment status.

How does the HRA Plan work and how much is allocated to my HRA Account?

The HRA Plan will establish one combined HRA Account for the Senior Performer and their Spouse (a "Combined Account"). If, however, the Senior Performer's Spouse is also a Senior Performer, Allocations will be made to each Senior Performer's separate HRA Account.

The amount of your Allocation depends upon what category of Participant you are, the number of Retiree Health Credits you have, and certain other factors set forth in the chart below:

Type of Participant	Maximum Amount Allocated to HRA Account
Senior Performers with at least 20 Retiree Health Credits and their Spouses	Fixed Dollar Amount of $1,140 each
Surviving Spouses of Senior Performers with at least 20 Retiree Health Credits	Fixed Dollar Amount of $1,140
Surviving Spouses of a deceased participant or former participant in the Active Plan, the AFTRA Health Plan or the SAG-Producers Health Plan, who was at least age 50 at death, had at least 20 Retiree Health Credits, and whose age plus Retiree Health Credits equaled at least 75	Fixed Dollar Amount of $1,140
Senior Performers with less than 20 Retiree Health Credits and their Spouses, provided, however, that if the Senior Performer's Spouse is also a Senior Performer and has at least 20 Retiree Health Credits, the Spouse and the Senior Performer will instead each receive an allocation of $1,140 to their separate HRA Accounts	Fixed Dollar Amount of $240 each
Surviving Spouses of Senior Performers with less than 20 Retiree Health Credits	Fixed Dollar Amount of $240
Surviving Spouses of a deceased participant or former participant in the Active Plan, the SAG-Producers Health Plan or the AFTRA Health Plan with less than 20 Retiree Health Credits	Fixed Dollar Amount of $240

Allocations will be credited to HRA Accounts on or about the first business day of each Plan Year, or, if the Senior Performer or Surviving Spouse becomes a Participant after the first day of a Plan Year, on or about the first business day of their participation in the HRA Plan. The amounts allocated to your HRA Account will be prorated for the number of months of participation in your first year of participation.

HRA Accounts will be reduced by the amount of any Eligible Medical Expenses for which the Participant is reimbursed under the HRA Plan. At any time, the Participant may receive reimbursement for Eligible Medical Expenses up to the amount in their HRA Account. Note that the law does not permit Participants to make any contributions to their HRA Accounts other than under the COBRA rules described below.

An HRA Account is merely a bookkeeping account on the HRA Plan's records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the HRA Plan are paid entirely from the SAG-AFTRA Health Fund's general trust assets.

What is an "Eligible Medical Expense"?

An Eligible Medical Expense is generally an expense incurred by a Participant for medical care, as that term is defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease), but not everything that is medical care is reimbursable under this Plan. Some common examples of Eligible Medical Expenses include:

- Medications (in reasonable quantities);
- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Chiropractor treatments;
- Hearing aids;
- Wheelchairs;
- Premiums for individual long-term care insurance coverage; and
- Premiums for individual health insurance purchased through Via Benefits or an affiliate, or through Entertainment Health Insurance Solutions (EHIS) or Artists Health Insurance Resource Center (AHIRC), both joint programs of the Actors Fund and the Motion Picture and Television Fund.

Some examples of common items that are <u>not</u> Eligible Medical Expenses include:

- Baby-sitting and childcare;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues (unless specific requirements are satisfied); and
- Cosmetics, toiletries, toothpaste, etc.

If you need information regarding whether an expense is an Eligible Medical Expense under the HRA Plan, contact Via Benefits at 1-833-981-1280. Solely the Plan Administrator (and its delegates) determine what is an Eligible Medical Expense.

Only Eligible Medical Expenses incurred while you and your Spouse are Participants in the HRA Plan may be reimbursed from your HRA Account or Combined HRA Account.

Eligible Medical Expenses are "incurred" when the medical care is provided not when you or your Spouse is billed, charged or pay for the expense. Health insurance premiums are incurred for the coverage period to which they apply. An expense that has been paid but not incurred (e.g., pre-payment to a physician or for premiums) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may not be reimbursed from an HRA Account:

- expenses incurred for qualified long-term care services;
-
- expenses incurred prior to the date that you became a Participant;
- expenses incurred after the date that you cease to be a Participant;
- premiums under an employer's group health plan that are subsidized by the employer;
- expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan; and
- expenses for which you or your spouse claim as a deduction on your federal income tax return.

When do I cease participation in the HRA Plan?

If you are a Senior Performer, you will cease being a Participant in the HRA Plan on the earliest of:

- the date you regain eligibility in the Active Plan;
- the date of your death;
- the date you do not re-enroll in any individual health insurance policy;
- the effective date of any amendment terminating your eligibility under the HRA Plan; or
- the date the HRA Plan is terminated.

If you are a Spouse, you will cease being a Participant in the HRA Plan on the earliest of:

- the date the Senior Performer to whom you are married regains eligibility in the Active Plan;
- the date you do not enroll in any individual health insurance policy;
- the date you divorce the Senior Performer;
- the date of your death;
- the effective date of any amendment terminating your eligibility under the HRA Plan; or
- the date the HRA Plan is terminated.

If you are a Surviving Spouse, you will cease being a Participant in the HRA Plan on the earliest of:

- the date you do not re-enroll in any individual health insurance policy;
- the date of your death;
- the date of your remarriage;
- the effective date of any amendment terminating your eligibility under the HRA Plan; or

- the date the HRA Plan is terminated.

You may not obtain reimbursement of any Eligible Medical Expenses incurred after the date your eligibility ceases. However, you, your surviving spouse or your estate, as applicable, have 180 days after your eligibility ceases to request reimbursement of Eligible Medical Expenses you incurred before your eligibility ceased.

In addition, if you are a Senior Performer participating in the Plan, your Spouse or former Spouse may be eligible to continue coverage under the HRA Plan beyond the date that their coverage would otherwise end if coverage is lost for certain reasons under COBRA. Their continuation of coverage rights and responsibilities are described below.

What happens if I do not use all of the amounts allocated to my HRA Account during the Plan Year?

If you do not use all of the amounts allocated to your HRA Account during a Plan Year, those amounts will be carried over to subsequent Plan Years. If you do not use all of the amounts credited to your HRA Account before your coverage under the HRA Plan ceases, you will not be eligible to receive any reimbursements for Eligible Medical Expenses incurred after your coverage ceases, even if you continue to have a balance in your HRA Account, although you can continue to submit claims for Eligible Medical Expenses incurred prior to your cessation of coverage for up to 180 days, as described above.

How do I receive reimbursement under the HRA Plan?

If you have a claim for premiums for your individual health insurance, you may be able to take advantage of automatic claims substantiation procedures that Via Benefits has in place with most of the insurance carriers. If that applies to the carrier of your insurance, Via Benefits will explain those procedures.

For all other claims, you must complete a reimbursement form and mail or fax it, along with a copy of your insurance premium bill, an explanation of benefits ("EOB") or, if no EOB is provided, a written statement from the service provider, to the Claims Administrator:

Via Benefits
P.O. Box 25181
Lehigh Valley, PA 18002-5181
Phone: 1-833-981-1280
Fax: 1-866-886-0878

The written statement from the service provider must contain the following information regarding the health expenses for which you are requesting reimbursement:

- the name of the Participant;
- the date service or treatment was provided/incurred;
- a brief description of the health care expense;

- the amount of the health expenses incurred;
- the name of the provider to whom the health care expense was paid; and
- a written bill from an independent third party stating that the health care expense has been incurred and the amount of such expense and, at the discretion of the Plan Administrator, a receipt showing payment has been made.

You can obtain a reimbursement form from by calling Via Benefits or by logging into your account. Your claim is deemed filed when it is received by Via Benefits. Your claim for reimbursement must include a statement that you have not been and will not be reimbursed for the claimed expense by insurance or otherwise, and have not been allowed a tax deduction in a prior year (and will not claim a tax deduction) for the expense under Code Section 213.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably practicable following the determination. Claims are generally paid in the order in which they are received by Via Benefits. Claims will be reimbursed for the amount determined by Via Benefits to be Eligible Medical Expenses under the Plan up to the balance in your HRA Account. The Plan Administrator and its delegates, including Via Benefits, reserve the right to verify, to their satisfaction, all claimed medical expenses prior to making reimbursement payments.

Via Benefits will determine the method or mode of reimbursement payments, including whether by direct deposit, written check or otherwise.

Any HRA Account payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) will automatically forfeit twelve (12) months after the check was mailed or the payment was otherwise attempted.

What happens if my claim for benefits is denied?

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after Via Benefits receives your claim. If Via Benefits determines that an extension of this time period is necessary due to matters beyond the control of the HRA Plan, Via Benefits will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified of the additional information required and you will have at least 45 days to provide the additional information.

The notice of denial will contain:

- the reason(s) for the denial and the HRA Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a copy of any internal rule, guideline, protocol or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to the claimant free of charge upon request; and

- a description of the HRA Plan's appeal procedures and the time limits applicable to such procedures.

If your request for reimbursement under the HRA Plan is denied in whole or in part and you do not agree with the initial notice of denial of Via Benefits, you or your authorized representative may file a written appeal with Via Benefits. You must file your appeal with the Via Benefits at the following address no later than 180 days after receipt of the denial notice:

Via Benefits
P.O. Box 25181
Lehigh Valley, PA 18002-5181
Phone: 1-833-981-1280
Fax: 1-866-886-0878

You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim. You or your authorized representative may, upon request and free of charge, have reasonable access to records and other information relevant to your claim for benefits.

If you wish to designate an authorized representative to act on your behalf with respect to your claim for benefits and/or appeal, you must complete Via Benefits Authorization to Release Protected Information Form. Please contact Via Benefits at the number shown above to request this form or download the current version from https://documents.ViaBenefits.com/website/sagaftrahp/Via-Benefits-Authorization-to-Release-Protected-Information-Form.pdf. If you designate an individual to act as your authorized representative, they may complete the reimbursement form for you if you are unable to complete it yourself.

You will be notified in writing of the decision on appeal no later than 60 days after Via Benefits receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by Via Benefits. It will also advise you of your right to a voluntary appeal to the Appeals Committee of the Board of Trustees (described below), as well as your right to bring a civil action under ERISA Section 502(a) if you wish to challenge Via Benefit's denial of your appeal.

If Via Benefits denies your appeal, you may (but you are not required to) file an appeal with the Appeals Committee of the Board of Trustees at the following address no later than 60 days after receipt of ViaBenefit's appeal denial notice:

SAG-AFTRA Health Fund
3601 West Olive Avenue
Burbank, CA 91505
Phone: 1-800-777-4013
Fax: 1-818-953-9880

You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

If you wish to designate an authorized representative to act on your behalf with respect to your appeal, you must complete the SAG-AFTRA Health Plan's Authorization for Release of Health Information Form. Please contact the Plan at the address shown above to request this form or download the current version from the forms section of www.sagaftraplans.org/health.

Your appeal will be considered at the next regularly scheduled meeting of the Appeals Committee of the Board of Trustees. If the request for voluntary appeal to the Appeals Committee is received within thirty (30) days of the next scheduled Appeals Committee meeting, the voluntary appeal will be considered at the second regularly scheduled meeting following receipt of the request. In special circumstances, consideration of the voluntary appeal may be delayed until the third regularly scheduled meeting following the Appeals Committee's receipt of the voluntary appeal.

You will be notified in writing of the decision on your voluntary appeal within five (5) days of the Appeals Committee's determination of your appeal. The notice will contain the same type of information provided in the appeal denial provided by Via Benefits.

Note that you cannot file suit in federal court to claim any benefits due under the HRA Plan, to enforce your rights under the terms of the HRA Plan, or clarify your rights to future benefits under the terms of the HRA Plan unless and until you have exhausted these appeals procedures, other than the voluntary appeal to the Appeals Committee.

The decision of the Board of Trustees or its delegate (the Appeals Committee or Via Benefits) shall be final and binding, subject to applicable law. The Board of Trustees (or its delegate) has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret this HRA Plan and to decide all matters arising in connection with the operation or administration of the HRA Plan. Without limiting the generality of the foregoing, the Board of Trustees (or its delegate) has the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the HRA Plan to Participants;
- Formulate, interpret and apply rules, regulations and policies necessary to administer the HRA Plan or other plan documents in accordance with their terms;
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the HRA Plan or other plan documents;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the HRA Plan or other plan documents;
- Process and approve or deny benefit claims and rule on any benefit exclusions; and
- Decide questions as to whether expenses are eligible for reimbursement from the HRA Plan.

Any claim or action that is filed in a court or other tribunal against or with respect to the HRA Plan and/or the Board of Trustees must be brought within 90 days of the denial of a benefit claims, or with respect to any other matter, within 90 days of the action or inaction giving rise to the claim.

What happens if I die?

Combined Accounts and Surviving Spouse Accounts

If a Senior Performer with a Combined HRA Account dies with no Surviving Spouse, their HRA Account is immediately forfeited upon death, but the deceased Senior Performer's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Senior Performer and their Spouse prior to their death, so long as such claims are submitted within 180 days of the Senior Performer's death.

If the Senior Performer with a Combined HRA Account dies with a Surviving Spouse, the Senior Performer's HRA Account shall continue and the Surviving Spouse can continue to submit Eligible Medical Expenses for reimbursement so long as the Surviving Spouse remains entitled to receive allocations to the HRA Account.

Once the Surviving Spouse dies, the HRA Account will be immediately forfeited, but the deceased Surviving Spouse's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Surviving Spouse prior to their death, so long as such claims are submitted within 180 days of the Surviving Spouse's death.

Separate Accounts

If a Senior Performer who is married to another Senior Performer dies, the HRA Account of the deceased Senior Performer is immediately forfeited upon death, but the deceased Senior Performer's estate or representatives may submit claims for Eligible Medical Expenses incurred by the deceased Senior Performer before their death. Any remaining amounts in the deceased Senior Performer's HRA Account, after payment of any claims for reimbursement made on behalf of the Senior Performer, shall be credited to the surviving Senior Performer spouse's HRA Account in a one-time allocation.

If a Surviving Spouse dies their HRA Account shall be immediately forfeited, but the Surviving Spouse's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Surviving Spouse before the Surviving Spouse's death within 180 days of their death.

Are my benefits taxable?

The HRA Plan is intended to meet the requirements of existing federal tax laws, under which the benefits you receive under the HRA Plan generally are not taxable to you. However, the tax treatment to any given Participant is not guaranteed, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

What happens if I receive an overpayment under the HRA Plan or a reimbursement is made in error from my HRA Account?

If it is determined that a Participant received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that was paid by another medical plan or for an expense that is not in fact an Eligible Medical Expense, or if you miscalculated your true out-of-pocket prescription drug expenses for purposes of the

Catastrophic Coverage Reimbursement), will be required to refund the overpayment or erroneous reimbursement to the Plan Administrator.

If you do not refund the overpayment or erroneous payment, the Plan Administrator reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any allocations due to you or take other actions to recoup the overpayment/erroneous payment.

How long will the HRA Plan remain in effect?

Although the Board of Trustees expects to maintain the HRA Plan indefinitely, it has the right to modify or terminate the program at any time for any reason, including the right to change the classes of persons eligible for participation, and to reduce or eliminate the amounts that will be credited to HRA Accounts in the future.

How does the HRA Plan interact with other medical plans?

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied).

What Is Catastrophic Coverage Reimbursement?

Catastrophic Coverage Reimbursement begins after you have accumulated covered qualifying Medicare Part D prescription drug expenses equal to the true out-of-pocket (TrOOP) limit set by the Centers for Medicare and Medicaid Services (CMS) for the applicable Plan Year.

Catastrophic Coverage Reimbursement can be obtained by contacting Via Benefits and requesting a claim form.

Once you have accumulated sufficient covered qualifying Medicare Part D prescription drug expenses for Catastrophic Coverage Reimbursement, all further eligible claims for qualifying Medicare Part D prescription drug expenses incurred during that Plan Year will be reimbursed by the HRA Plan without any dollar limits. Claims must be incurred during the applicable Plan Year and submitted within the time frame set forth in this SPD for other qualifying HRA claims. All other HRA Account provisions set forth in this SPD continue to apply.

What is "continuation coverage" and how does it work?

Under the federal law called "COBRA," a Spouse or former Spouse of a Senior Performer may elect to continue coverage under the HRA Plan for a limited time after the date they would otherwise lose coverage because of a divorce or legal separation from the Senior Performer, or the death of the Senior Performer under certain circumstances. These are called "qualifying events."

Note that the Spouse or former Spouse is required to notify the Plan Administrator in writing of a divorce or legal separation from the Senior Performer within 60 days of the event or they will lose the right to continue coverage under the HRA Plan. The Plan Administrator will notify the Spouse of a Senior Performer's death as soon as practicable following its determination of the Senior Performer's death, although the Spouse will not cease to be a Participant in the Plan unless they:

- fail to meet the definition of Surviving Spouse;
- fail to re-enroll in an individual insurance policy;
- remarry or
- die.

If a Spouse or former Spouse elects to continue coverage, they are entitled to the level of coverage under the HRA Plan in effect immediately preceding the qualifying event. They may also be entitled to an increase in their HRA Account equal to the amounts credited to the HRA Accounts of similarly situated Participants (subject to any restrictions applicable to similarly situated Participants) so long as they continue to pay the applicable premium, described below.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event. Payment will be due within 45 days of the Spouse's or former Spouse's election to continue coverage.

Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the HRA Account is exhausted;
- The date the Spouse or former Spouse notifies the Plan Administrator that they wishes to discontinue coverage;
- Any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the Spouse's or former Spouse's election to continue coverage, that they become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary; or
- The Plan Administrator ceases to provide any group health plan.

Who do I contact if I have questions about the HRA Plan?

If you have any questions about the HRA Plan, you should contact Via Benefits or the SAG-AFTRA Health Fund.

Via Benefits
P.O. Box 25181
Lehigh Valley, PA 18002-5181

Phone: 1-833-981-1280
Fax: 1-866-886-0878

SAG-AFTRA Health Fund
3601 West Olive Avenue
Burbank, CA 91505
Phone: 1-800-777-4013
Fax: 1-818-953-9880

PART II

ERISA RIGHTS

This HRA Plan is an employee welfare benefit plan as defined in ERISA. ERISA provides that you, as a Plan Participant, will be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the HRA Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the HRA Plan 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 all documents governing the operation of the HRA Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.
- Receive a summary of the SAG-AFTRA Health 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 HRA Plan Coverage

Continue HRA Plan coverage for your eligible spouse if there is a loss of coverage under the Plan as a result of a qualifying event. However, your spouse will have to pay for such coverage. Review this SPD and the documents governing the HRA Plan for the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for HRA Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your HRA Plan, called "fiduciaries" of the HRA Plan, have a duty to do so prudently and in the interest of the HRA Plan 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 from the HRA Plan, or from exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a benefit under HRA Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the HRA Plan

review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the HRA Plan and do not receive them 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 because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the HRA Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the HRA Plan'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 (e.g., if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the HRA Plan, 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 obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PART III

NOTICE OF PRIVACY PRACTICES

The SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan (the "Plan") is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to that information. The Plan understands that your health information is personal and we are committed to protecting it. This Notice of Privacy Practices gives you information on how the Plan protects your health information, when we may use and disclose it, your rights to access and request restrictions to the information, and the Plan's obligation to notify you if there has been a breach of your health information.

Definitions

"Health information" generally means information: (i) about your physical or mental health or condition, health care provided to you, or the payment of health care provided to you, whether past, present, or future; (ii) that is created, received, transmitted or maintained by the Plan; and (iii) that identified you or could be used to identify you.

A "breach" is any access, use or disclosure of your unsecured health information in a manner not permitted by the Privacy Rule that compromises the security or privacy of your health information.

Uses and Disclosures

In many instances, the Plan requires a court order or your written authorization to disclose your health information. However, the Plan is permitted by law to disclose your health information without your authorization or court order, as follows:

- Treatment: The Plan does not provide medical care or services; rather, it reimburses for such care and services that are covered under the terms of the Plan.
- Payment: The Plan may use or disclose your health information for purposes of processing claims for reimbursement, verifying your eligibility, and other payment activities.

In some circumstances it may be necessary for the Plan to disclose your health information, including your eligibility for Plan benefits and specific claim information to other covered entities such as other health plans.

The Plan may also disclose your health information and your Dependents' health information on payment-related correspondence, such as information regarding Plan reimbursements which are sent to you.

- Health care operations: The Plan may use or disclose your health information for purposes of overall Plan operations. For example, the Plan may obtain proposals from vendors in an effort to select appropriate private exchanges or insurance arrangements for Plan Participants. It may be necessary to provide the companies with certain health information, particularly in regard to catastrophic illnesses.

The Plan is prohibited from using or disclosing health information that is your genetic information for purposes of: (i) determining your eligibility for benefits under the Plan; (ii) computing any premium or contribution amounts under the Plan; (iii) applying any pre-existing condition exclusion; and (iv) any other activities relating to the creation, renewal or replacement of a contract for health benefits. The Plan may, however, use genetic information for determining the medical appropriateness of providing a benefit you have requested under the Plan.

- Reminders: The Plan may use your health information to provide you with reminders.

- Business associates: The Plan may disclose your health information to business associates. Business associates are entities retained or contracted by the Plan, such as Via Benefits, to perform certain functions on our behalf or provide services to us that involve the use or disclosure of health information. The Plan has a contract with each business associate, whereby they agree to protect your health information and keep it confidential.

- Trustees, for purposes of fulfilling their fiduciary duties: The Plan may disclose your health information to the Plan's Trustees who serve on the Appeals Committee in connection with appeals that you file following a denial of a benefit Claim or a partial payment. Trustees may also receive your health information if necessary for them to fulfill their fiduciary duties with respect to the Plan. Such disclosures will be the minimum necessary to achieve the purpose of the use of disclosure. In accordance with the Plan documents, such Trustees must agree not to use or disclose your health information with respect to any employment-related actions or decisions, or with respect to any other benefit plan maintained by the Trustees.

- Personal representatives: Unless you object, the Plan will disclose your health information to personal representatives appointed by you, and, in certain cases, a family member, close friend or other person in an emergency situation when you cannot give your authorization. The Plan will disclose only health information that is directly relevant to your health care or payment related to your health care, or as necessary for notification purposes.

• Workers' Compensation: The Plan may disclose your health information to comply with laws relating to Workers' Compensation or other similar programs that provide benefits for work-related injuries and illnesses.

• Legal proceedings: The Plan may disclose your health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal. In addition, the Plan may disclose your health information 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 health information to notify you and give you an opportunity to object to this disclosure.

• Secretary of Health and Human Services: The Plan will disclose your health information to the Secretary of Health and Human Services (HHS) or any other officer or employee of HHS to whom authority has been delegated for purposes of determining the Plan's compliance with required privacy practices.

• Health care oversight: The Plan may disclose your health information 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.

• Military activity and national security: When the appropriate conditions apply, the Plan may use or disclose health information 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. The Plan may also disclose your health information to authorized federal officials conducting national security and intelligence activities including the protection of the President of the United States.

• Public health activities: The Plan may disclose your health information to a public health authority in connection with public health activities including, but not limited to: preventing or controlling disease, injury or disability; reporting disease or injury; reporting vital events such as births or deaths; conducting public health surveillance, public health investigations and public health interventions; at the direction of a public health authority, to an official of a foreign government agency acting in collaboration with a public health authority; or reporting child abuse or neglect.

• Coroners, funeral directors and organ donation: The Plan may disclose your health information to a coroner or medical examiner for identification purposes or other duties authorized by law. The Plan may also disclose your health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. The Plan may disclose such information in reasonable anticipation of death. Your health information may be used and disclosed for cadaveric organ, eye or tissue donation and for transplant purposes.

• Disaster relief: The Plan may disclose your health information to any authorized public or private entities assisting in disaster relief efforts.

• Food and Drug Administration (FDA): The Plan may disclose your health information to a person or company subject to the jurisdiction of the FDA with respect to an FDA-regulated product or activity for which that person has responsibility, or for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity.

• Abuse or neglect: The Plan may disclose your health information to any public health authority authorized by law to receive reports of child abuse or neglect. In addition, if the Plan reasonably believes that you have been a victim of abuse, neglect or domestic violence we may disclose your health information 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.

• Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may disclose your health information to the institution or law enforcement official if the health information is necessary for the institution to provide you with health care or protect the health and safety of you or others, or for the security of the correctional institution.

• Criminal activity: Consistent with applicable federal and state laws, the Plan may disclose your health information if it believes 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. The Plan may also disclose your health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

• As required by law: The Plan will disclose your health information as required by law.

Use and Disclosure with Your Permission

The Plan may not use or disclose your health information for any purposes other than the ones outlined above without your written authorization. Types of uses and disclosures that require your written authorization include:

• Personal representatives: In situations where you wish to appoint a personal representative to act on your behalf or make medical decisions for you in situations where you are otherwise unable to do so, the Plan will require your written authorization before disclosing your health information to that individual. The Plan will recognize your previous written authorization designating such individual to act on your behalf and receive your health information until you revoke the authorization in writing.

• Trustee(s) as your representative: In some circumstances you may request that a Trustee receive your health information if you request the Trustee to assist you in your filing or perfecting of a Claim for benefits under the Plan. In these situations the Plan will first request that you complete a written authorization before disclosing the health information.

• 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 written communications from the Plan with respect to you and your eligible Dependents. In such cases the Plan requires that you first file a written authorization with the Plan. The Plan will recognize your written authorization designating such individuals and will continue to send communications from the Plan to such parties. If you do not want the Plan to continue such communications, you must notify the Plan 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.

• Psychotherapy notes: The Plan may not use or disclose the contents of psychotherapy notes without your written authorization.

• Marketing: Marketing means situations where the Plan receives financial compensation from a third party to communicate with you about a product or service and is only allowed if you give your written authorization. Marketing would include instances when an individual or entity tries to sell you something based on your health information. The Plan does not engage in marketing and will not use your health information for this purpose.

• Sale of health information: The sale of an individual's health information for financial compensation requires that individual's written authorization. The Plan does not sell health information.

In situations where your written authorization is required in order for the Plan to use or disclose your health information, you may revoke that authorization, in writing, at any time, except to the extent that the Plan has already taken action based upon the authorization. Thereafter, the Plan will no longer use or disclose your health information for the reasons covered by your written authorization.

Your Rights Regarding Your Health Information

As a Participant, you have the following rights with regard to your personal health information:

• Right to inspect and copy – You have the right to review and copy health information that the Plan has about you in a designated record set for as long as the Plan maintains the information. You have the right to request a copy of your health information in electronic form, including in an unencrypted or unsecured form if you so desire. You have the right to request that a copy of your health information be provided to a third party. You must send a written request to the Plan's Privacy Officer using the Plan's access request form. You may obtain a copy of the Plan's access form by contacting the Plan's Privacy Officer using the telephone number, email address or mailing address listed on the following page. The Plan may charge you a fee to provide you with copies of your health information. If the Plan will charge you a fee, it will notify you before it makes /the copies. The Plan is allowed to charge only a reasonable, cost-based fee for the labor and supplies associated with making the copy, whether on paper or in electronic form. The Plan may deny

your request to inspect and copy your health information in certain limited circumstances. If you are denied access to your health information, you will be provided written notice of the denial and may request the Plan to review the denial.

- Right to receive confidential communications – The Plan normally provides health information to Participants via U.S. mail. You may request that the Plan communicate your health information to you in a different way. Your request must be made in writing to the Plan's Privacy Officer and explain the reasons for your request. In certain cases, the Plan may deny your request.

- Right to request consideration of restrictions – You may request additional restrictions on how your health information is used and disclosed. You may also request that any part of your health information not be disclosed to family members, friends or others who may be involved in your care or for notification purposes as described in this Notice. Your request must be made in writing to the Plan's Privacy Officer and explain the reasons for your request. The Plan is not required to agree to the restrictions you request. If the Plan agrees, it must honor the restrictions you request.

- Right to amend –If you believe the health information the Plan maintains about you is incorrect, you have the right to request an amendment to it. Your request must be made in made in writing to the Plan's Privacy Officer and explain the reasons for your request. In certain cases, the Plan may deny your request. If the Plan denies your request for amendment, you have the right to file a statement of disagreement with the decision.

- Right to receive an accounting of disclosures – You have the right to request a listing of the disclosures the Plan has made of your health information without your authorization for purposes other than treatment, payment of Claims and health care operations (subject to exceptions, restrictions, and limitations noted in the Privacy Rule). Your request must be made in writing to the Plan's Privacy Officer and must specify the period for which you are requesting the disclosures (which cannot be for a period longer than six years prior to the date of your request). In certain cases, the Plan may charge a fee for this request. The Plan will notify you of the cost in advance and you may choose to withdraw or modify your request at that time.

- Right to notification in the event of breach – A breach occurs when there is an impermissible use or disclosure that compromises the security or privacy of your health information such that the use or disclosure poses a significant risk of financial, reputational or other harm to you. The Plan takes extensive measures to ensure the security of your health information; but in the event that a breach occurs, or if the Plan learns of a breach by a business associate, the Plan will promptly notify you of such breach.

- Right to obtain a paper copy of the Plan's Privacy Notice – If you received this Notice electronically (via email or the internet), you have the right to request a paper copy at any time.

Genetic Information

Genetic information is information about an individual's genetic tests, the genetic tests of family members of the individual, the manifestation of a disease or disorder in family members of the individual, or any request for or receipt of genetic services by the individual or a family member of the individual. The term genetic information also includes, with respect to a pregnant woman (or a family member of a pregnant woman), genetic information about the fetus and, with respect to an individual using assisted reproductive technology, genetic information about the embryo.

Federal law prohibits the Plan and health insurance issuers from discriminating based on genetic information. To the extent that the Plan uses your health information for underwriting purposes, federal law also prohibits the Plan from disclosing any of your genetic information. The Plan will not use or disclose any of your genetic information for this purpose.

Complaints

If you believe your privacy rights have been violated you have the right to file a formal complaint with the Plan's Privacy Officer and/or with the Secretary of the U.S. Department of Health and Human Services. You cannot be retaliated against for filing a complaint.

Effective Date

The effective date of this Notice of Privacy Practices is January 1, 2021. The Plan is required by law to abide by the terms of this Notice until replaced. The Plan reserves the right to make changes to this Notice and to make the new provisions effective for all health information the Plan maintains. If revised, a new Notice of Privacy Practices will be provided to all Participants eligible for or covered by the Plan at that time.

For Questions or Additional Information Regarding Privacy Practices and Complaints

To request additional copies of this Notice of Privacy Practices, to obtain further information regarding our

privacy practices and your rights, or to file a complaint, please contact the Plan's Privacy Officer. This Notice is also available online at www.sagaftraplans.org/health.

Part IV

GENERAL HRA PLAN INFORMATION

Name of Plan:	SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan
Effective Date:	January 1, 2021
Name, address, and telephone number of the Plan Sponsor:	Board of Trustees of the SAG-AFTRA Health Fund 3601 West Olive Avenue, Suite 200 Burbank, CA 91505 Phone: 1-800-777-4013 Fax: 1-818-953-9880
Name, address, and telephone number of the Plan Administrator: The Plan Administrator has the exclusive right to interpret the HRA Plan and to decide all matters arising under the HRA Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the HRA Plan and the SPD issued in connection with the HRA Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals or committees.	Board of Trustees of the SAG-AFTRA Health Fund 3601 West Olive Avenue, Suite 200 Burbank, CA 91505 Phone: 1-800-777-4013 Fax: 1-866-886-0878
Agent for Service of Legal Process:	Legal process may be served on the Trustees or theChief Executive Officer at: SAG-AFTRA Health Fund Street Address: 3601 West Olive Avenue Burbank, CA 91505 Mailing Address: P.O. Box 7830

	Burbank, CA 91510-7830
Sponsor's federal tax identification number:	95-6024160
Plan Number:	501
Plan Year:	January 1 through December 31
Claims Administrator: All reimbursement forms, and supporting documentation, must be provided to the Claims Administrator.	Via Benefits P.O. Box 25181 Lehigh Valley, PA 18002-5181 Phone: 1-833-981-1280 Fax: 1-866-886-0878
Funding:	Benefits are paid from the SAG-AFTRA Health Fund out of its general assets. No assets are segregated or earmarked for the purpose of providing benefits hereunder. No person shall have any right, title or claim to such assets prior to their payment pursuant to the terms of the HRA Plan.

PART V

HRA PLAN TERMS

Whenever used in this HRA Plan, the following terms shall have the meanings set forth below:

Active Plan	The SAG-AFTRA Health Plan
Allocation	The amount credited to a Participant's HRA Account for the provision of benefits under the Plan.
Board of Trustees	The joint labor-management Board of Trustees of the SAG-AFTRA Health Fund that has adopted the HRA Plan. The Board of Trustees is responsible for setting the benefits, rules and regulations of the HRA Plan and generally overseeing the HRA Plan's operations, with the assistance of its staff, professional consultants and advisors, the Claims Administrator, and other providers.
Catastrophic Coverage Reimbursement	Coverage provided under the HRA Plan for qualifying prescription drug expenses beginning only after the Participant accumulates covered Part D expenses in an amount equal to the true out of pocket (TrOOP) limit set by CMS for the applicable Plan Year. https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/catastrophic-coverage
Claims Administrator	The entity with which the Board of Trustees has entered into a contract for the purpose of processing claims under the HRA Plan. At the time this SPD is first effective, the Claims Administrator is ViaBenefits. References to Via Benefits include any successor to Via Benefits with whom the Board of Trustees may contract in the future.
CMS	The U.S. Center for Medicare and Medicaid Services.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.
Code	The Internal Revenue Code of 1986, as amended from time to time.

Committee — Any committee duly appointed and authorized by the Board of Trustees.

Effective Date — January 1, 2021

ERISA — The Employee Retirement Income Security Act of 1974, as amended from time to time.

Eligible Medical Expense — Certain expenses incurred by a Participant for medical care as defined in Code Section 213(d) and the rules, regulations and Internal Revenue Service interpretations thereunder, including premiums for health care insurance coverage and for long-term care insurance coverage. Eligible Medical Expenses shall not include expenses reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement or any amount claimed as a deduction on the federal income tax return of the Participant. Eligible Medical Expenses are incurred when the medical care is provided, not when the Participant is formally billed, charged for, or pays the expenses. Notwithstanding the above, the HRA Plan will pay for or reimburse individual health insurance premiums only if the coverage is purchased through the ViaBenefits Medicare Marketplace, or through Entertainment Health Insurance Solutions and Artists Health Insurance Resource Center (both joint programs of the Actors Fund and the Motion Picture and Television Fund), as determined by Via Benefits.

HIPAA — The Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including its regulations and other guidance promulgated thereunder, as of the applicable time that such regulations and guidance are effective.

HRA Account — The notional account established for a Participant to hold their Allocations. Each HRA Account is a notional account that merely reflects bookkeeping entries for any specific Participant. No earnings shall be credited at any time with respect to any HRA Account.

HRA Plan — The SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan, as same may be amended from time to time.

Participant	A Senior Performer, a Spouse, or a Surviving Spouse who has satisfied the eligibility requirements of the HRA Plan and has not, for any reason, become ineligible to participate in the HRA Plan.
Plan Administrator	The Board of Trustees
Plan Sponsor	The Board of Trustees
PHI	Protected health information as described under HIPAA, and generally includes individually identifiable health information held by or on behalf of the HRA Plan.
Retiree Health Credits	Credit toward eligibility for coverage under this HRA Plan as a Senior Performer as maintained in the records of the Plan Administrator. Retiree Health Credits are the Retiree Health Credits as recognized by Board of Trustees immediately prior to January 1, 2021 plus Retiree Health Credits earned on or after such date. Effective January 1, 2021, a participant in the Active Plan will earn a Retiree Health Credit if they earn at least $26,000 in covered earnings reported to the Active Plan during a calendar year. Effective January 1, 2022 the earnings threshold increases to $27,000.
Senior Performer	Anyone who satisfies the following eligibility requirements: • A former participant in the Active Plan who has satisfied the following requirements as of their attainment of age 65 or thereafter: o Completed 20 Retiree Health Credits; and o Started their pension from the SAG-Producers Pension Plan or the AFTRA Retirement Fund. • A former participant in the SAG-Producers Health Plan or the AFTRA Health Plan who has satisfied the following requirements as of their

attainment of age 65 or thereafter, and who, as of January 1, 2017:

- had attained age 55;
- started their pension from the SAG-Producers Pension Plan or AFTRA Retirement Fund; and
- had at least 15 qualifying years under the AFTRA Health Plan or at least 15 pension credits under the SAG-Producers Pension Plan.

- A former participant in the AFTRA Health Plan who has satisfied the following requirements as of their attainment of age 65:
  - was born on or before January 1, 1943; and
  - has at least 10 qualifying years under the AFTRA Health Plan.

- A former participant in the AFTRA Health Plan who has satisfied the following requirements as of their attainment of age 65:
  - was born before December 1, 1937 and, as of December 1, 1992;
    - was vested in a regular annuity based on at least 10 years of credit under the AFTRA Retirement Plan (including at least five base years in which covered earnings were at least $2,000 or more); or
    - met the requirements in effect at that time for retiree coverage under the AFTRA Health Plan.

- A former participant in the SAG-Producers Health Plan who has satisfied the following requirements as of their attainment of age 65:

- had at least 10 pension credits under the SAG-Producers Pension Plan as of December 31, 2001; and

- was at least age 55 as of December 31, 2002.

- An "Occupational Disability Pensioner" under the SAG-Producers Pension Plan who has at least 15 Retiree Health Credits earned under the SAG-AFTRA Health Plan and the SAG-Producers Health Plan. Occupational Disability Pensioners may not count any AFTRA Health Plan qualifying years as Retiree Health Credits for this purpose.

Spouse

The person who is legally married under any applicable state or foreign law to a Senior Performer determined as of the applicable time by Via Benefits and/or the Plan Administrator.

Surviving Spouse

The Spouse of

- A deceased Senior Performer; or

- A deceased participant or former participant in the Active Plan, the AFTRA Health Plan or the SAG-Producers Health Plan, who was at least age 50 at death, had at least 20 Retiree Health Credits, and whose age plus Retiree Health Credits equaled at least 75.

who was married to the Senior Performer, participant or former participant for the twelve months immediately preceding the death of the Senior Performer, participant or former participant.

SAG-AFTRA HEALTH PLAN
SENIOR PERFORMERS
HEALTH REIMBURSEMENT ACCOUNT
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INTRODUCTION

The Board of Trustees of the SAG-AFTRA Health Fund hereby adopts this SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan (the "Plan") for the purpose of allowing former participants in the SAG-AFTRA Health Plan (and its predecessor plans) who qualify as Senior Performers and their Spouses and Surviving Spouses, as defined herein, to obtain reimbursement of eligible medical expenses incurred by such Senior Performers, Spouses and Surviving Spouses. The Plan is intended to qualify as a "health reimbursement arrangement" as that term is defined under IRS Notice 2002-45 and a medical reimbursement plan under Code Sections 105 and 106. This Plan is also intended to be exempt from the Affordable Care Act as a separate "retiree-only" plan pursuant to ERISA Section 732(a) and Code Section 9831(a)(2). The Plan will be interpreted at all times in a manner consistent with such intent.

ARTICLE I
DEFINITION OF TERMS

1.1 Definitions. Whenever used in this Plan, the following terms shall have the meanings set forth below:

(a) "Active Plan" means the SAG-AFTRA Health Plan.

(b) "Allocation" means the amount credited to a Participant's HRA Account for the provision of benefits under the Plan as provided in Section 3.2.

(c) "Board of Trustees" means the joint labor-management Board of Trustees of the SAG-AFTRA Health Fund that has adopted the Plan. The Board of Trustees is responsible for setting the benefits, rules and regulations of the Plan and generally overseeing the Plan's operations, with the assistance of its staff, professional consultants and advisors, the Claims Administrator, and other providers.

(d) "Catastrophic Coverage Reimbursement" means coverage provided under the Plan under Section 4.5 for qualifying prescription drug expenses beginning only after the Participant accumulates covered Part D expenses in an amount equal to the true out of pocket (TrOOP) limit set by CMS for the applicable Plan Year.

(e) "Claims Administrator" means the entity with which the Board of Trustees has entered into a contract for the purpose of processing claims under the Plan. At the time this document is executed, the Claims Administrator is Via Benefits. References to Via Benefits shall include any successor Claims Administrator hired by the Board of Trustees.

(f) "CMS" means the United States Center for Medicare and Medicaid Services.

(g) "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

(h) "Code" means the Internal Revenue Code of 1986, as amended from time to time.

(i) "Committee" means any committee duly appointed and authorized by the Board of Trustees.

(j) "Effective Date" means January 1, 2021.

(k) "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

(l) "Health Care Expense" means an expense incurred by a Participant for medical care as defined in Code Section 213(d) and the rules, regulations and Internal Revenue Service interpretations thereunder. Health Care Expenses are incurred when the medical care is provided, not when the Participant is formally billed, charged for, or pays the expenses. Notwithstanding the foregoing, Health Care Expenses shall not include:

(1) expenses reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement or any amount claimed as a deduction on the federal income tax return of the Participant;

(2) premiums to an employer's group health plan that are subsidized by an employer; or

(3) individual health insurance premiums other than for insurance that is purchased through the Via Benefits Medicare Marketplace, or through Entertainment Health Insurance Solutions or Artists Health Insurance Resource Center (both joint programs of the Actors Fund and the Motion Picture and Television Fund), as determined by the Claims Administrator.

(4)

(m) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including its regulations and other guidance promulgated thereunder, as of the applicable time that such regulations and guidance are effective.

(n) "HRA Account" means the notional account established for a Participant to hold their Allocations. No earnings shall be credited at any time with respect to any HRA Account.

(o) "Participant" means a Senior Performer, a Spouse, or a Surviving Spouse who has satisfied the eligibility requirements of Article II hereof and has not, for any reason, become ineligible to participate in the Plan.

(p) "Plan" means the SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan, as set forth herein, and as same may be amended from time to time.

(q) "Plan Administrator" means the Board of Trustees.

(r) "Plan Sponsor" means the Board of Trustees.

(s) "Plan Year" means the calendar year.

(t) "PHI" means protected health information as described in 45 C.F.R. § 160.103, and generally includes individually identifiable health information held by or on behalf of the Plan.

(u) "Retiree Health Credits" means credit toward eligibility for coverage under this Plan as a Senior Performer as maintained in the records of the Plan Administrator. Retiree Health Credits shall be the Retiree Health Credits as recognized by the SAG-AFTRA Health Fund immediately prior to January 1, 2021 plus Retiree Health Credits earned on or after such date. Effective January 1, 2021, a participant in the Active Plan will earn a Retiree Health Credit if they earn at least $26,000 in covered earnings reported to the Active Plan during a calendar year. Effective January 1, 2022, the foregoing earnings threshold increases to $27,000.

(v) "Senior Performer" means any individual who satisfies the following eligibility requirements:

(1) A former participant in the Active Plan who has satisfied the following requirements as of their attainment of age 65 or thereafter:

(i) Completed 20 Retiree Health Credits; and

(ii) Commenced receipt of a pension from the SAG-Producers Pension Plan or the AFTRA Retirement Fund.

(2) A former participant in the SAG-Producers Health Plan or the AFTRA Health Plan who has satisfied the following requirements as of their attainment of age 65 or thereafter, and who, as of January 1, 2017:

(i) had attained age 55;

(ii) commenced receipt of a pension from the SAG-Producers Pension Plan or AFTRA Retirement Fund; and

(iii) had at least 15 qualifying years under the AFTRA Health Plan or at least 15 pension credits under the SAG-Producers Pension Plan.

(3) A former participant in the AFTRA Health Plan who has satisfied the following requirements as of their attainment of age 65:

(i) was born on or before January 1, 1943; and

(ii) has at least 10 qualifying years under the AFTRA Health Plan.

(4) A former participant in the AFTRA Health Plan who has satisfied the following requirements as of their attainment of age 65:

(i) was born before December 1, 1937 and, as of December 1, 1992;

(ii) was vested in a regular annuity based on at least 10 years of credit under the AFTRA Retirement Plan (including at least five base years in which covered earnings were at least $2,000 or more); or

(iii) met the requirements in effect at that time for retiree coverage under the AFTRA Health Plan.

(5) A former participant in the SAG-Producers Health Plan who has satisfied the following requirements as of their attainment of age 65:

(i) had at least 10 pension credits under the SAG-Producers Pension Plan as of December 31, 2001; and

(ii) was at least age 55 as of December 31, 2002.

(6) An Occupational Disability Pensioner under the SAG-Producers Pension Plan who has at least 15 Retiree Health Credits earned under the SAG-AFTRA Health Plan and/or the SAG-Producers Health Plan. Occupational Disability Pensioners may not count any AFTRA Health Plan qualifying years as Retiree Health Credits for this purpose.

(w) "Spouse" means the person who is legally married under any applicable state or foreign law to a Senior Performer determined as of the applicable time by the Claims Administrator and/or Plan Administrator.

(x) "Surviving Spouse" means (1) the Spouse of a deceased Senior Performer, or (2) the Spouse of a deceased participant or former participant in the Active Plan, the AFTRA Health Plan or the SAG-Producers Health Plan, who was at least age 50 at death, had at least 20 Retiree Health Credits, and whose age plus Retiree Health Credits equaled at least 75; provided, however, that a Surviving Spouse will not be eligible for benefits hereunder until the date on which the deceased Senior Performer or deceased participant or former participant would have attained their 65th birthday, and provided further, that the Surviving Spouse will be eligible for benefits hereunder only if they have attained their 65th birthday or otherwise are eligible for Medicare and were married to the Senior Performer, participant or former participant for the twelve months immediately preceding the death.

1.2 Gender and Number. This Plan uses gender-neutral person pronouns. The singular shall include the plural, and vice versa.

ARTICLE II
PARTICIPATION

2.1 Eligibility to Participate. A Senior Performer, Spouse, or Surviving Spouse shall become a Participant in this Plan when they meet the following requirements:

(a) For a Senior Performer other than an Occupational Disability Pensioner described in Section 1.1(v)(6), have reached age 65;

(b) For a Spouse or a Surviving Spouse, have reached age 65 or otherwise become eligible for Medicare;

(c) Have obtained an individual health insurance policy through Via Benefits or provided satisfactory evidence to the Plan Administrator or its delegate that:

(1) They have obtained an individual health insurance policy through Entertainment Health Insurance Solutions or Actors Health Insurance Resource Center, both joint programs of the Actors Fund and the Motion Picture and Television Fund;

(2) They have retiree coverage under another group health plan;

(3) They have health coverage under TRICARE; or

(4) They reside outside the United States; and

(d) Have completed any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator or its delegate from time to time;

provided that the Senior Performer, Spouse or Surviving Spouse is not eligible for coverage under the Active Plan as a Participant or a dependent as a result of current employment status.

2.2 Special Rule for Spouses. A Spouse may become a Participant regardless of whether the Senior Performer is a Participant, provided that the Spouse has attained age 65 or is otherwise eligible for Medicare and that neither the Senior Performer nor the Spouse is eligible for coverage under the Active Plan as a result of current employment status.

2.3 Cessation of Participation. A Participant shall cease to be a Participant on the earliest of:

(a) with respect to a Senior Performer and their Spouse, the date the Senior Performer regains eligibility in the Active Plan;

(b) with respect to a Senior Performer, the date of their death;

(c) the date a individual does not re-enroll in any individual health insurance policy, unless they satisfy one of the exceptions listed above;

(d) with respect to a Spouse, the date they divorce the Senior Performer or die;

(e) with respect to a Surviving Spouse, the date of their remarriage or death;

(f) the effective date of any Plan amendment that renders them ineligible to participate; or

(g) the termination of the Plan.

Reimbursement from the Participant's HRA Account after cessation of participation shall be governed by Article IV.

ARTICLE III
FUNDING

3.1 Funding. The benefits provided herein shall be provided by the SAG-AFTRA Health Fund out of its general assets, and no assets shall be segregated or earmarked for the purpose of providing benefits hereunder, nor shall any person have any right, title or claim to such assets prior to their payment hereunder. As such, each HRA Account established pursuant to the Plan shall be a notional account which merely reflects bookkeeping entries and does not represent assets that are actually set aside for the exclusive purpose of providing benefits to the Participant under the terms of the Plan. In no event may any benefits under the Plan be funded with Participant contributions, except with respect to COBRA Continuation Coverage.

3.2 Allocations. The following annual amounts will be credited on behalf of Participants; provided that allocations for Senior Performers and Spouses will be made to a combined HRA Account, unless the Spouse is also a Senior Performer, in which case the Senior Performer and the Spouse will each receive an allocation to their separate HRA Accounts. The amounts will be prorated for the number of months of participation in their first year of participation.

(a) Fixed Dollar Amount of $1,140, each, for Senior Performers with at least 20 Retiree Health Credits and their Spouses;

(b) Fixed Dollar Amount of $1,140 for Surviving Spouses of Senior Performers with at least 20 Retiree Health Credits;

(c) Fixed Dollar Amount of $1,140 for Surviving Spouses of a deceased participant or former participant in the Active Plan, the AFTRA Health Plan or the SAG-Producers Health Plan, who was at least age 50 at death, had at least 20 Retiree Health Credits, and whose age plus Retiree Health Credits equaled at least 75;

(d) Fixed Dollar Amount of $240, each, for Senior Performers with fewer than 20 Retiree Health Credits and their Spouses; provided, however, that if the Senior Performer's Spouse is also a Senior Performer and has at least 20 Retiree Health Credits, the Spouse and the Senior Performer will each instead receive an allocation of $1,140 to their separate HRA Accounts;

(e) Fixed Dollar Amount of $240 for Surviving Spouses of Senior Performers with fewer than 20 Retiree Health Credits;

(f) Fixed Dollar Amount of $240 for Surviving Spouses of a deceased participant or former participant in the Active Plan, the SAG-Producers Health Plan or the AFTRA Health Plan with fewer than 20 Retiree Credits.

3.3 Timing of Allocation. Allocations will be credited to HRA Accounts on or about the first business day of each Plan Year, or, if the Senior Performer or Surviving Spouse becomes a Participant after the first day of a Plan Year, on or about the first business day of their participation in the Plan.

3.4 Carryover of Accounts. Allocations remaining in an HRA Account (after the expiration of the claims run-out period) at the end of a Plan Year shall be carried over to subsequent Plan Years.

ARTICLE IV
BENEFITS

4.1 Provision of Benefits. The Plan will reimburse Participants for Health Care Expenses, up to the unused amount in the Participant's HRA Account. A Participant shall be entitled to reimbursement under this Plan only for Health Care Expenses incurred after they become eligible to participate in the Plan and before their participation has ceased. In no event shall any benefits under this Plan be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Health Care Expenses.

4.2 Amount of Reimbursement. At all times during a Plan Year, a Participant shall be entitled to benefits under this Plan for payment of Health Care Expenses in an amount that does not exceed the balance of their HRA Account. Each reimbursement hereunder shall be a deduction to such HRA Account available to pay Health Care Expenses under the Plan.

4.3 Expense Reimbursement Procedure. Reimbursement for Health Care Expenses shall be made in accordance with this Section 4.3.

(a) *Timing:* A Participant desiring to receive reimbursement for Health Care Expenses under this Plan shall submit a written claim form to the Claims Administrator. Upon loss of eligibility as provided in Section 2.3, coverage under the Plan ceases, the Participant shall receive no further Allocations under the Plan, and their Health Care Expenses incurred after such date will not be reimbursed hereunder even if Allocations remain in the Participant's HRA Account. The Participant may submit claims for reimbursement for Health Care Expenses incurred prior to their loss of eligibility, provided the Participant files such claims within 180 days following such loss of eligibility.

(b) *Claims Substantiation:* The Plan Administrator may require the Participant to furnish a bill, receipt, cancelled check, and/or other written evidence or certification of payment or of obligation to pay Health Care Expenses. The Claims Administrator will reimburse the Participant from the Plan for expenses that it determines are Health Care Expenses up to the balance in the Participant's HRA Account at such intervals as the Plan Administrator may deem appropriate (but not less frequently than quarterly). The Plan Administrator or its delegate reserves the right to verify to its satisfaction all claimed Health Care Expenses prior to reimbursement. Each request for reimbursement shall include the following information, except where the Claims Administrator has in place with an insurance carrier an automatic substantiation procedure with respect to premium payments, in which case, the Claims Administrator will follow such procedures:

(1) the amount of the Health Care Expense for which reimbursement is requested;

(2) the date the Health Care Expense was incurred;

(3) a brief description and the purpose of the Health Care Expense;

(4) the name of the Participant for whom the Health Care Expense was incurred;

(5) the name of the person, organization or other health care provider to whom the Health Care Expense was or is to be paid;

(6) a statement that the Participant has not been and will not be reimbursed for the Health Care Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such Health Care Expense under Code Section 213; and

(7) a written bill from an independent third party stating that the Health Care Expense has been incurred and the amount of such expense and, at the discretion of the Plan Administrator, a receipt showing payment has been made.

Claims will be charged to the HRA Account of the Participant who submits the claim. The Plan Administrator may establish such other rules as it deems desirable regarding the frequency of reimbursement of expenses, the minimum dollar amount that may be requested for reimbursement and the maximum amount available for reimbursement during any single month.

(c) *Timing*: The Claims Administrator shall review such claim and respond thereto within thirty (30) days after receiving the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify the claimant within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review the claim. If such an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that the claimant will need to provide to the Claims Administrator. The claimant will have no less than 45 days from the date they receive the notice to provide the requested information. The Claims Administrator shall provide to every claimant who is denied a claim for benefits (in whole or in part) written or electronic notice setting forth in a manner calculated to be understood by the claimant:

(1) the specific reason or reasons for the denial;

(2) specific reference to pertinent plan provisions on which denial is based;

(3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and

(5) a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.

(d) *Claims Denied*: Claims that are partially or wholly denied may be appealed to the Plan Administrator as provided in Section 6.4.

(e) *Mode of Reimbursement*. The Claims Administrator shall determine the method or mode of reimbursement payments, including whether by direct deposit, written check or otherwise.

(f) *Forfeiture of Unclaimed Reimbursements.* Any HRA Account payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) shall automatically forfeit twelve months after the check was mailed or the payment was otherwise attempted.

4.4 Death.

(a) *Senior Performer with Combined HRA Account*.

(1) In the event a Senior Performer with a combined HRA Account dies with no Surviving Spouse, the Senior Performer's HRA Account shall be immediately forfeited upon their death; provided, however, that the Senior Performer's estate or representatives may submit claims for Health Care Expenses incurred by the Senior Performer and their Spouse prior to their death, as long as such claims are submitted no later than 180 days after the Senior Performer's death.

(2) In the event a Senior Performer with a combined HRA Account dies with a Surviving Spouse, the Senior Performer's HRA Account shall continue, and such Surviving Spouse may continue to submit Health Care Expenses for reimbursement in the normal course as long as the Surviving Spouse remains entitled to receive Allocations to the HRA Account after the Senior Performer's death. Following the death of the Surviving Spouse, the HRA Account shall be immediately forfeited; provided, however, that the estate or representatives of the Surviving Spouse may submit claims for Health Care Expenses incurred by the Surviving Spouse prior to the Surviving Spouse's death, as long as such claims are submitted no later than 180 days after the Spouse's death.

(b) *Separate HRA Accounts.*

In the event a Senior Performer who is married to another Senior Performer dies, the estate or representatives of the deceased Senior Performer may submit claims for Health Care Expenses incurred by the Senior Performer prior to their death, as long as such claims are submitted no later than 180 days after the deceased Senior Performer's death. The deceased Senior Performer's HRA Account shall be forfeited and a one-time allocation of the remaining amount in the deceased Senior Performer's HRA Account shall be made to the deceased Senior Performer's Surviving Spouse's separate HRA Account.

(c) *Surviving Spouses*.

In the event a Surviving Spouse dies, their HRA Account shall be immediately forfeited upon their death; provided, however, that the Surviving Spouse's estate or representatives may submit claims for Health Care Expenses incurred by the Surviving Spouse prior to

their death, as long as such claims are submitted no later than 180 days after the Surviving Spouse's death.

4.5 Catastrophic Coverage Reimbursement. Once a Participant has accumulated covered qualifying Part D prescription drug expenses equal to the true out of pocket (TrOOP) limit set by the CMS for the applicable Plan Year, all qualifying Part D prescription drug expenses incurred thereafter for the remainder of the Plan Year shall be reimbursed by the Claims Administrator with no dollar limit. Such Participant must apply for this reimbursement with the Claims Administrator by following the requirements established by the Claims Administrator for such purpose from time to time.

ARTICLE V
CONTINUATION COVERAGE

5.1 Definitions. For purposes of this Article, the following terms shall have the meanings set forth below:

(a) "COBRA Continuation Coverage" means the continuation of the Plan benefits being provided to a Qualified Beneficiary immediately prior to a Qualifying Event.

(b) "Election Period" means a period of at least 60 days' duration that begins not later than the date on which the Qualified Beneficiary's coverage under the Plan would otherwise terminate by reason of a Qualifying Event and that ends 60 days after the later of: (1) the date such coverage would otherwise end, or (2) the date that the Qualified Beneficiary receives notice of their right to continued coverage under the Plan pursuant to Section 5.4.

(c) "Qualified Benefits" means the HRA benefit under this Plan.

(d) "Qualified Beneficiary" means a Spouse, former Spouse.

(e) "Qualifying Event" means any of the following events which, but for this Article, would result in the loss of coverage of a Qualified Beneficiary:

(1) the death of a Participant; or

(2) the divorce or legal separation of a Participant and their Spouse.

(f) "Similarly Situated Beneficiary" means, in the case of any Qualified Beneficiary who has a Qualifying Event, an individual who has the same coverage options under the Plan that the Qualified Beneficiary would have had if the Qualifying Event had not occurred; provided that determinations of similar status shall be made by the Plan Administrator in accordance with and taking into account the factors permitted under Code Section 4980B and the regulations issued thereunder to the extent such law or regulations apply.

5.2 COBRA Continuation Coverage. The Spouse or former Spouse may elect COBRA Continuation Coverage under the Plan pursuant to this Article if the Spouse or former Spouse is no longer eligible for Qualified Benefits because of a Qualifying Event described in Section 5.1(e).

5.3 Period of Coverage. A Qualified Beneficiary who elects COBRA Continuation Coverage under the Plan shall be provided coverage identical to that being provided at that time to a Similarly Situated Beneficiary. COBRA Continuation Coverage under this Plan shall continue for up to 36 months, but shall be terminated earlier upon the occurrence of any of the following events:

(a) The date the Qualified Beneficiary's HRA Account is exhausted;

(b) The date the Qualified Beneficiary notifies the Plan Administrator that they wish to discontinue coverage;

(c) Any required monthly premium is not paid when due or during the applicable grace period;

(d) The date, after the date of the Qualified Beneficiary's COBRA election, that they become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the Qualified Beneficiary; or

(e) The Board of Trustees ceases to provide any group health plan to any participant.

5.4 Notices.

(a) Qualified Beneficiaries must notify the Plan Administrator in writing within 60 days of a Qualifying Event described in Section 5.1(e)(2) .

(b) Within 14 days of its receipt of any notice required by subsection (a) of this Section, or as soon as practicable following its determination that a Participant has died, the Plan Administrator shall notify the Qualified Beneficiary of their right to COBRA Continuation Coverage under the Plan. Any notification to a Spouse or former Spouse by the Plan Administrator shall also be treated as notification to all other Qualified Beneficiaries residing with said Spouse at the time such notification is made. Notice from the Plan Administrator shall be deemed complete upon placement of the notice of Election Period in the United States mail, provided there is sufficient postage for first class mailing and said notice is addressed to the Qualified Beneficiary's last known primary residence (any address other than the Qualified Beneficiary's last known primary residence shall only be known to the Plan Administrator if the Qualified Beneficiary specifically notifies the Plan Administrator of the change in address).

5.5 Election of Coverage. Upon notification by the Plan Administrator of their right to COBRA Continuation Coverage under the Plan, a Qualified Beneficiary must affirmatively elect COBRA Continuation Coverage before the expiration of the Election Period.

5.6 Contributions. A Qualified Beneficiary who elects COBRA Continuation Coverage under the Plan shall be required to pay a premium for any period of continued coverage, such premium to be 102% of the cost to the Plan of coverage for Similarly Situated Beneficiaries. The first required payment must be paid within 45 days of the date the COBRA Continuation Coverage is elected under Section 5.5.

ARTICLE VI
ADMINISTRATION

6.1 Plan Administrator. The Plan Administrator shall be responsible for the performance of all reporting and disclosure obligations under ERISA, and all other obligations required to be performed by the plan administrator under ERISA or the Code, except such obligations and responsibilities as may be delegated to such person or entity as the Plan Administrator designates. The Plan Administrator shall be the designated agent for service of legal process with respect to the Plan.

6.2 Duties of the Plan Administrator.

(a) The Plan Administrator shall have the sole discretion and authority to control and manage the operation and administration of the Plan.

(b) The Plan Administrator (or, where applicable and duly authorized by the Plan Administrator, the Chief Executive Officer of the SAG-AFTRA Health Fund or any Committee or the Claims Administrator) shall have the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply and interpret this Plan and to decide all matters arising in connection with the operation or administration of the Plan.

(c) Without limiting the generality of the foregoing, the Plan Administrator (or, where applicable and duly authorized by the Plan Administrator, the Chief Executive Officer or any Committee or the Claims Administrator) shall have the sole and absolute discretionary authority to:

(1) take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan to Participants;

(2) formulate, interpret and apply rules, regulations and policies necessary to administer this Plan in accordance with its terms;

(3) decide questions, including legal or factual questions relating to the calculation and payment of benefits under the Plan;

(4) resolve and/or clarify any ambiguities, inconsistencies and omissions arising under this Plan; and

(5) process, and approve or deny, benefit claims and rule on any benefit exclusions.

All determinations made by the Plan Administrator (or, where applicable and duly authorized by the Plan Administrator, the Chief Executive Officer or any Committee or the Claims Administrator) with respect to any matter arising under the Plan shall be final and binding on all parties affected thereby, subject to Section 6.4.

(d) The Plan Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:

(1) to prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;

(2) to prepare and distribute information explaining the Plan to Participants;

(3) to receive from Participants such information as shall be necessary for the proper administration of the Plan;

(4) to keep records of elections, claims, and disbursements for claims under the Plan, and any other information required by ERISA or the Code;

(5) to appoint individuals, third parties, or committees to assist in the administration of the Plan and to engage any other agents as it deems advisable;

(6) to promulgate election forms and claims forms to be used by Participants, which may be electronic in nature;

(7) to determine and enforce any limits on benefit elections hereunder; and

(8) to correct errors and make equitable adjustments for mistakes made in the administration of the Plan, specifically, and without limitation, to recover erroneous overpayments made by the Plan to a Participant, in whatever manner the Plan Administrator deems appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant.

6.3 Allocation and Delegation of Duties.

(a) The Plan Administrator shall have the authority to allocate, from time to time, by instrument in writing filed in its records, all or any part of its responsibilities under the Plan to one or more of its Trustees, Committees, employees, or officers, or to the Claims Administrator, as may be deemed advisable, and in the same manner to revoke such allocation of responsibilities. In event of such allocation, any and all discretionary authority or control vested in the Plan Administrator with respect to such allocated responsibility shall be delegated to such Trustees, Committees, employee, or officer, or to the Claims Administrator. In the exercise of such allocated responsibilities, any action of the Trustees, Committees, employees, officers, or the Claims Administrator to whom responsibilities are allocated shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of such Trustees, Committees, employees, or officers or the Claims Administrator with respect to such allocated responsibilities. The Trustees, Committees, employees, officers and Claims Administrator to whom responsibilities have been allocated shall periodically report to the Plan Administrator concerning the discharge of the allocated responsibilities.

(b) The Plan Administrator shall have the authority to delegate, from time to time, by written instrument filed in its records, all or any part of its responsibilities under the Plan to such person or persons other than those enumerated in Section 6.3(a) as it may deem advisable (and may authorize such person or persons to delegate such responsibilities to such other person or persons as the Plan Administrator shall authorize) and in the same manner to revoke any such delegation of responsibility. Any action of the delegate in the exercise of such delegated responsibilities shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall periodically report to the Plan Administrator concerning the discharge of the delegated responsibilities.

6.4 Appeal Procedure.

(a) Within 180 days of receipt by a claimant of a notice under Section 4.3 denying a claim in whole or in part, the claimant or their duly authorized representative may request in writing a full and fair review of the claim by the Claims Administrator, as delegate of the Plan Administrator. In connection with such review, the claimant or their duly authorized representative may, upon request and free of charge, have reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits, and may submit issues and comments in writing. The Claims Administrator shall make a decision promptly, but not later than 60 days after the Claims Administrator's receipt of a request for review. The decision on review shall be in writing, in a manner calculated to be understood by the claimant, and shall include:

(1) specific reasons for the decision;

(2) specific references to the pertinent Plan provisions on which the decision is based;

(3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;

(4) a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; information about the claimant's right to a voluntary appeal to the Plan Administrator, as set forth in 6.4(b), below; and

(5) a statement describing the voluntary appeal procedure under Section 6.4(b) and a statement of the claimant's right to bring a civil action under ERISA Section 502(a).

(b) A claimant may voluntarily take part in one more level of review of the denied appeal, to be completed by the Plan Administrator or its delegate. Any such review will be completed at the next scheduled meeting of the Plan Administrator or its delegate. If the request for voluntary appeal is received within 30 days of the next scheduled meeting of the Plan Administrator or its delegate, it will be considered at the second regularly scheduled meeting following receipt of the voluntary request for review. In special circumstances consideration of the appeal may be delayed until the third regularly scheduled meeting following the Plan Administrator's receipt of the voluntary appeal.

(c) The decision of the Plan Administrator, or its delegate, shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. The Plan Administrator, or its authorized delegate, shall be afforded such discretionary authority as set forth in the Restated Agreement and Declaration of Trust Establishing the SAG-AFTRA Health Fund. If claimant challenges the decision of the Plan Administrator, or its delegate, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before a claimant can pursue the claim in federal court. Facts and evidence that become known after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

(d) Any claim, suit or action relating to an alleged wrongful denial of Plan benefits (in whole or in part) or any other matter must be brought within 90 days of the date the appeal was denied or the date of the action or inaction complained of.

ARTICLE VII
GENERAL PROVISIONS

7.1 Amendment and Termination. The Board of Trustees reserves the right to amend, modify, or terminate this Plan at any time, including but not limited to the right to modify persons eligible for participation, benefits paid by the Plan, and the amount of Allocation to be credited, and the right to reduce or eliminate existing HRA Accounts.

7.2 Liability. Benefits under the Plan are paid by the SAG-AFTRA Health Fund out of its general assets.

7.3 Alienation of Benefits. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated and any attempt to do so shall be void and unenforceable.

7.4 Facility of Payment. If the Plan Administrator deems any person incapable of receiving benefits to which they are entitled by reason of minority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Plan Administrator to disburse it, whose receipt shall be complete acquittance therefor. Such payments shall, to the extent thereof, discharge all liability of the Plan Administrator, Plan Sponsor and the SAG-AFTRA Health Fund.

7.5 Status of Benefits. The Board of Trustees makes no commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable. Any Participant, by accepting a benefit under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

7.6 Applicable Law. The Plan shall be construed and enforced according to the laws of the California, to the extent not preempted by any Federal law.

7.7 Capitalized Terms. Capitalized terms shall have the meaning set forth in Article 1 (or, if not defined therein, as defined elsewhere in the Plan).

7.8 Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.