SAG·AFTRA
HEALTH PLAN

Summary Plan Description

Effective January 1, 2017

Reprinted December 2018

SAG·AFTRA
HEALTH PLAN

Los Angeles

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New York

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www.sagaftraplans.org/health

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I. Introduction

A Letter from the SAG-AFTRA Health Plan Trustees

In June of 2016, the Trustees of the SAG-Producers Health Plan and the AFTRA Health Fund voted to merge the two plans and form the SAG-AFTRA Health Plan (Plan or Health Plan).

As Trustees of this new Plan, we are proud to provide you with this inaugural Summary Plan Description (SPD), which describes in detail the benefits available to covered Participants and their eligible Dependents as of January 1, 2017. This SPD constitutes the Plan's governing document.

Please review the SPD carefully to get the most out of your Plan benefits. Understanding health benefits can sometimes be daunting, and we have made every effort to present the information as clearly and simply as possible. However, sometimes we must use words and phrases that are legal in nature. We've included a glossary to help clarify those terms and terms from the glossary are capitalized throughout the SPD.

Whenever the benefits in this SPD materially change, you will be sent a notice of modification of your benefits. Keep your SPD and notices together so you have ready access to the most current information about the Plan. You can also find the SPD and any updates online at **www.sagaftraplans.org/health**.

It's important to know that the Plan is a self-funded ERISA plan and therefore not subject to state-mandated insurance laws. In addition, Trustees may (with or without prior 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 Plan. Rights to future benefits, including without limitation, Senior Performers (retiree) benefits, are not promised, vested or guaranteed. The Trustees have the sole and exclusive power and responsibility to make all decisions regarding the Plan and what it covers. The Trustees' decisions regarding the Plan are binding upon SAG-AFTRA, employers, Participants, Dependents and beneficiaries. Plan employees cannot alter benefits and eligibility or other rules, and employees' opinions or interpretations cannot amend what is set forth in this document and are not binding upon the Trustees.

We encourage you to sign up for automatic premium payments, both for your convenience and to eliminate the possibility of late or missed payments. You can do this by registering for a personal account in your Benefits Manager at **www.sagaftraplans.org/health**, where you can also view your earnings, sign up for Plan emails and more. Finally, please inform the Plan if you change your address or marital status or if you wish to add or drop Dependents.

If you have questions, please call the Plan office at (800) 777-4013 or use the secure message center in your Benefits Manager at **www.sagaftraplans.org/health**.

We look forward to providing you and your family with high quality benefits for years to come.

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SAG-AFTRA Health Plan

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Are You Ready for the SAG-AFTRA Health Plan? Here's a Checklist:

1. If you haven't already done so, submit a completed Participant Information Form.
2. Familiarize yourself with this SPD.
3. Find out if you qualify for coverage (see pages 8-15 or 24-29).
4. Review Plan benefits (see pages 46-91).
5. Enroll in coverage (see pages 16-21).
6. Register to manage your benefits through your personal Benefits Manager at **www.sagaftraplans.org/health**.
7. Update / confirm your contact information (see "About the Participant Information Form").
8. Visit **www.sagaftraplans.org/health** for additional information.

About the SAG-AFTRA Health Plan

The Plan is jointly-administered by a Board of Trustees with representation from both SAG-AFTRA and contributing industry employers. The Trustees are responsible for setting the benefits, rules and regulations of the Plan and generally overseeing Plan operations. The Plan's staff, headed by the chief executive officer, is responsible for day-to-day operations of the Plan. The Plan's Trustees and staff are assisted by professional consultants, including legal counsel, investment advisors and managers, health benefit consultants, actuaries and certified public accountants.

The Plan is a separate legal entity from SAG-AFTRA, the union. Please remember that all communications (correspondence, forms, payments, documentation, etc.) regarding your health benefits should be sent directly to the Plan and not to SAG-AFTRA. The Plan is not a subsidiary, department or agent of SAG-AFTRA. No portion of SAG-AFTRA's union dues is used to pay for Plan benefits or operational expenses, except for contributions that SAG-AFTRA makes to the Plan to provide benefits to its own employees.

The benefits provided by the Plan for individuals who have already earned eligibility, including those for Senior Performers and their Dependents, are not vested or guaranteed. The Plan's benefits and eligibility provisions may be modified, reduced or canceled at any time by the Board of Trustees.

About the Participant Information Form

If you perform Covered Employment, you will need to complete a Participant Information Form (PIF) – which is available at **www.sagaftraplans.org/health** – and submit it to the Plan as directed. You may also obtain a PIF by calling the Plan at (800) 777-4013. The PIF is a confidential legal document containing the Participant's signature. It provides basic demographic information which allows us to notify you if you qualify for coverage and to provide you with benefits if you enroll in the Plan. It is also required in order to create an online account to manage your benefits through the Benefits Manager.

You do not need to complete a PIF every time you perform Covered Employment. After you file your initial form you should only file a new PIF if your information changes.

Annual Summary of Earnings Statements

Summary of Earnings statements are mailed to all Participants annually. Your statement will list all SAG-AFTRA Covered Earnings for the previous calendar year that were reported to the Health Plan on your behalf by Contributing Employers.

Since reported earnings can affect your qualification for benefits, it is very important that you review your statement carefully as soon as you receive it. You should confirm that your statement reflects all of the SAG-AFTRA Covered Employment you performed during the previous calendar year. If you believe that it does not, or if you did not receive a Summary of Earnings statement but think you had Covered Employment during the year, notify the Plan immediately to request an earnings review.

What Other Forms Are Required?

In addition to the Participant Information Form, you may need to complete other Plan forms to ensure that your benefits are not interrupted. Three commonly required forms are described below.

- An Authorization for Release of Health Information Form may be required for the Plan to release any information about a Participant or Dependent to another party (see pages 102 and 117).
- A New Dependent Form must be submitted with the required documentation to add new Dependents to your coverage (see page 19).
- A Designation of Beneficiaries Form informs the Plan of who you want to receive any benefits that may be payable from the Plan upon your death (see the following page).

Your Benefits Manager

Once the Plan has your PIF on file, you may register for your Benefits Manager account at **www.sagaftraplans.org/health**. Through the Benefits Manager you can:

- Make changes to your address.
- Enroll qualified Dependents or update/add new Dependent information. A qualified Dependent is a Dependent for whom the Plan has verified the required documentation (see page 19).
- Make premium payments.
- View your earnings history and eligibility for benefits.
- View Claims documents and check the status of a Claim.
- Print health care ID cards.
- Email us using our secure message center.
- Subscribe to Plan emails – by doing so you can receive the following materials via email:
    - Annual Summary of Earnings (see the previous page);
    - Explanation of Benefits (EOBs – see page 132);
    - SPD;
    - Premium payment reminders; and
    - Plan newsletters, including notices of changes to your benefits.

To register visit **www.sagaftraplans.org/health**, click "Register" and follow the prompts. When your registration is complete, you will be assigned a user name. Your password will be emailed to you – but only if the email address you provided during registration matches the email address on file at the Plan. If the email addresses do not match, your password will be mailed to you at the address on record with the Plan. You should receive your password in a few days.

Receiving Plan information online is completely voluntary. If you do not choose to register, you do not need to do anything, and the site's non-secured content will still be available to you. If you do not choose to receive Plan information by email, you will continue to receive required notices and Plan updates via U.S. mail.

Life Events

As a Participant, it is your responsibility to notify the Plan of any life events such as marriage, divorce, death of a spouse or the birth or adoption of a child, or other changes that could affect your health coverage or that of your Dependents. Generally, you have 60 days to notify us of life events (depending on the event), or you may miss certain opportunities available to you. To learn more about life events, refer to the life events section on pages 18-19.

Remember: Notify the Plan of changes to your address separately from any notifications to other organizations.

The SAG-AFTRA Health Plan is separate from SAG-AFTRA (the union) and from the SAG-Producers Pension Plan and the AFTRA Retirement Plan. Notification of changes of address or other information provided to SAG-AFTRA, the SAG-Producers Pension Plan or the AFTRA Retirement Plan does not automatically update your information with the SAG-AFTRA Health Plan – you must contact us separately. Please notify the Health Plan promptly of any changes to your address or contact information and by the required deadline for qualifying life events described on page 18.

Beneficiary Designation Forms

Please remember that you are responsible for filing a new Designation of Beneficiaries Form with the Plan if you have a life event, such as a marriage, a divorce or the death of your beneficiary. The Plan will use the last beneficiary on file in determining who should receive any benefits that may be payable, even if you have divorced or married since filing the form with the Plan. Therefore, it is important to file a new Designation of Beneficiaries Form with the Plan immediately if you wish to change your beneficiary.

Your Rights: Nondiscrimination

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

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

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

Attention: Compliance Department
SAG-AFTRA Health Plan
P.O. Box 7830, Burbank, CA 91510-7830
Phone: (800) 777-4013 • Fax: (818) 953-9880
Email: **complianceofficer@sagaftraplans.org**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Qualifying for SAG-AFTRA Health Plan Coverage

Terms to know for Section II:

Please refer to the Glossary on pages 129-133 for definitions of these and other capitalized key terms.

Age and Service Credits

Age and Service

Alternative Days

Base Earnings Period

Benefit Period

Calendar Quarter

Contributing Employer

Covered Earnings

Covered Employment

Covered Roster Artist

Dependent

Earned Eligibility

Eligibility Days

Network/Station Staff

Participant

The Plan provides an extensive package of health care benefits to eligible Participants and their qualified Dependents. To receive coverage, you must meet the Plan's eligibility requirements and pay the required premiums.

This section describes the Plan's requirements for Earned Eligibility. The sections that follow describe the Plan's premiums and payment rules, and the options that may be available to you if you lose Earned Eligibility.

The Plan does not cover charges for treatment after a Participant's eligibility for coverage has ended, even if the medical condition developed during a period of coverage.

If, as of December 31, 2016, you were enrolled under the AFTRA Health Fund or the Screen Actors Guild–Producers Health Plan and your Benefit Period extended past January 1, 2017, you will continue coverage under the SAG-AFTRA Health Plan for the remainder of your Benefit Period, as long as you pay your premium in full by the due date. You should have received a letter from the Plan outlining your benefits and coverage duration prior to January 1, 2017. If you did not receive a letter, please contact the Plan at (800) 777-4013.

Understanding Covered Earnings

Before reviewing the different ways you can become eligible for coverage, it is important to understand Covered Earnings under the Plan.

Covered Earnings are earnings paid to you and reported to the Plan on your behalf by a Contributing Employer for Covered Employment. Covered Employment is work performed under a Collective Bargaining Agreement that requires the employer to make contributions to the Plan on your behalf with respect to those earnings.

Special Rule for Work Performed Under the Non-Broadcast/Industrial Code

If you are employed by a company in which you or a family member has an ownership or controlling interest, or which you fund directly or indirectly, earnings from that company will not qualify as Covered Earnings for purposes of this Plan unless the project for which the earnings are reported was produced for one or more clients who are third parties (entities not owned, funded or controlled, directly or indirectly, by you, your spouse, parent or child, or by a trust for your benefit or your spouse, parent or child).

Earnings Not Considered for Eligibility (Non-Covered Earnings)

Contributions to the Plan are not required to be made for non-Covered Earnings. As such, non-Covered Earnings do not count toward eligibility for benefits. Examples of non-Covered Earnings include but are not limited to:

- Payments for various penalties and allowances such as meal penalties, payments for rest period violations, traveling, lodging or living expenses, interest or liquidated damages (late fees), reimbursements for special hair or dress, payments for wardrobe damage or reimbursements for the use of a personal automobile or other equipment.
- Payment for services not covered by a SAG-AFTRA Collective Bargaining Agreement, such as producing, directing and writing work.

Additional examples of non-Covered Earnings may be obtained by calling the Plan at (800) 777-4013 or by visiting **www.sagaftraplans.org/health**.

Earned Eligibility Requirements

There are different rules for qualifying for Earned Eligibility depending on what type of Participant you are. Most Participants will qualify based on Covered Earnings, although Covered Roster Artists will qualify under separate rules (see page 15). Eligibility rules for staff of SAG-AFTRA (the union), the SAG-AFTRA Foundation, the SAG-Producers Pension Plan, the AFTRA Retirement Fund and the Industry Advancement and Cooperative Fund are provided in a supplement to this SPD which is distributed to these employees separately but is considered part of the SPD and Plan document as if fully set forth herein.

Qualifying Based on Covered Earnings

There are two levels of coverage – Plan I and Plan II – with some differences in the benefits available under each. The level for which you qualify is determined by which earnings threshold you meet first.

The minimum requirements for Earned Eligibility beginning on or after the first day of any Calendar Quarter in 2017 are outlined below. Calendar Quarters begin on January 1, April 1, July 1 and October 1. These minimum earnings requirements are scheduled to increase 2% each year.

In addition to satisfying one of these requirements, you must pay the Plan premium. Premiums as of January 1, 2017 and payment rules are outlined on pages 30-33.

Plan I Earnings Threshold

You must earn at least $33,000 in Covered Earnings in your Base Earnings Period (see page 12) to receive Earned Eligibility for Plan I health coverage.

Plan II Earnings Threshold

If you do not meet the earnings threshold for Plan I, you may qualify for Plan II health coverage by earning at least $17,000 in Covered Earnings in your Base Earnings Period, or by qualifying under one of the alternate eligibility rules described below.

> If you are at least age 65 and meet the earnings requirement solely through residuals, Medicare will be your primary coverage and your Plan coverage will be secondary. Please see pages 99-101 for information on Coordination of Benefits with Medicare.

Alternative Days Eligibility

If you do not satisfy the Covered Earnings requirements by meeting the earnings thresholds, as set forth above, you may qualify for Plan II coverage under the Alternative Days eligibility rule.

To qualify under the Alternative Days eligibility rule, you must have at least 78 Eligibility Days during your Base Earnings Period. Eligibility Days are determined by dividing your total applicable sessional Covered Earnings by the SAG-AFTRA minimum daily rate, which is based on the type of production.

Sessional Covered Earnings from employment under the Codified Basic (Theatrical) Agreement, Television Programming Agreement, Television Commercials Agreement, Infomercials Agreement, New Media Agreement, Interactive Media Agreement, Corporate/Educational Agreement, Music Videos Agreement, Television Network Code and New Media Network Code (as set forth in the table on the following page) may be used to satisfy the Eligibility Days requirement for Alternative Days eligibility.

Sessional Covered Earnings from employment under the Sound Recordings Code, the Audiobooks Agreement, the Commercial Radio Broadcasting Agreement, the Radio Commercials Agreement, any Regional or Local AFTRA (or SAG-AFTRA) code for Television or Radio Broadcasting or any other AFTRA or SAG-AFTRA Collective Bargaining Agreement side letter or other agreement requiring contributions to be made to the AFTRA Health Plan or to this Plan (with the exception of those identified as counting toward Alternative Days eligibility in the table on the following page) may NOT be used to satisfy the Eligibility Days requirement for Alternative Days eligibility.

Alternative Days eligibility is not available to employees of a radio or television station or network.

Age and Service Eligibility

If you do not satisfy the Covered Earnings requirements by meeting the earnings thresholds set forth on the previous page or the Alternative Days eligibility requirements, set forth above, you may qualify for Plan II coverage under the Age and Service eligibility rule.

To qualify under the Age and Service eligibility rule, you must meet each of the following criteria:

- Be at least age 40 on the first day of your Benefit Period (see page 12);
- Have at least 10 Age and Service Credits; and
- Earn at least $11,600 in Covered Earnings during your Base Earnings Period (as defined in "Earnings Considered for Age and Service Eligibility").

  For eligibility beginning on or after January 1, 2018, you must earn at least $13,000 in Covered Earnings during your Base Earnings Period.

Earned Eligibility based on the Age and Service eligibility rule is not available to employees of a radio or television station or network.

Age and Service Credits

Each year prior to January 1, 2017 for which you qualified for SAG Health Plan Earned Eligibility, including those years for which you chose not to enroll in coverage, will be counted as an Age and Service Credit.

No years of eligibility under the AFTRA Health Fund earned prior to January 1, 2017 will be counted as an Age and Service Credit.

For eligibility beginning on or after January 1, 2017, in order to earn an Age and Service Credit, you must have $17,000 in Covered Earnings during your Base Earnings Period from employment as described below or qualify for Alternative Days eligibility during your Base Earnings Period, even if you opt not to enroll in coverage.

Earnings Considered for Age and Service Eligibility

Covered Earnings from employment under the Codified Basic (Theatrical) Agreement, Television Programming Agreement, Television Commercials Agreement, Infomercials Agreement, New Media Agreement, Interactive Media Agreement, Corporate/Educational Agreement, Music Videos Agreement, Television Network Code and New Media Network Code (as set forth in the table on the following page) may be used to satisfy the Age and Service Covered Earnings requirement and to earn an Age and Service Credit on or after January 1, 2017.

Covered Earnings from employment under the Sound Recordings Code, the Audiobooks Agreement, the Commercial Radio Broadcasting Agreement, the Radio Commercials Agreement, any Regional of Local AFTRA (or SAG-AFTRA) code for Television or Radio

Broadcasting or any other AFTRA or SAG-AFTRA Collective Bargaining Agreement side letter or other agreement requiring contributions to be made to the AFTRA Health Plan or to this Plan (with the exception of those identified as counting toward Age and Service eligibility in the table below) may NOT be used to satisfy the Age and Service Covered Earnings requirement or to earn an Age and Service Credit.

SAG-AFTRA AGREEMENTS		
Agreements	Alternative Days	Age and Service
Codified Basic (Theatrical)	Yes	Yes
Television Programming (Network, Cable, Public, Made for Video, Animation, Exhibit A)	Yes	Yes
Television Commercials	Yes	Yes
Infomercials	Yes	Yes
New Media	Yes	Yes
Interactive Media	Yes	Yes
Corporate/Educational	Yes	Yes
Music Videos	Yes	Yes
Television Network Code (Front-of-the-book)	Yes	Yes
New Media Network Code (Front-of-the-book)	Yes	Yes
Sound Recordings Code	No	No
Audiobooks	No	No
Commercial Radio Broadcasting	No	No
Radio Commercials	No	No
Regional or Local Code for Television or Radio Broadcasting	No	No
Network/Station Staff	No	No

How You First Qualify for Earned Eligibility

Base Earnings Period

Your Base Earnings Period is the first four consecutive Calendar Quarter period during which you qualify for Earned Eligibility as described in this section. Going forward, your Covered Earnings during this same four-quarter period will determine if you continue to qualify for Plan benefits in future years.

You become eligible for 12 months of health coverage once the Plan reviews your Covered Earnings and Eligibility Days. Generally this determination occurs approximately six weeks after the end of your Base Earnings Period. This six-week period is needed for employers to submit reports of your earnings and for the Plan to process these reports.

You cannot qualify for Plan I and Plan II simultaneously. You will be eligible for the Plan for which you first meet the requirements. Subsequent Covered Earnings or Eligibility Days are not considered until your next Base Earnings Period, which will then be used to determine your continuing eligibility status.

Benefit Period

Once you qualify for Earned Eligibility, you are eligible for 12 months of coverage, provided that you pay the required Plan premium (see pages 30-31). This 12-month period of coverage is referred to as your Benefit Period. The Benefit Period begins on the first day of the Calendar Quarter after the Plan determines you are eligible for coverage, as outlined below.

BASE EARNINGS PERIOD	APPROXIMATE ELIGIBILITY DETERMINATION DATE	BENEFIT PERIOD
January 1 – December 31	February 15	April 1 – March 31
April 1 – March 31	May 15	July 1 – June 30
July 1 – June 30	August 15	October 1 – September 30
October 1 – September 30	November 15	January 1 – December 31

Example: Qualifying for Plan II

COVERED EARNINGS CREDITED ON YOUR BEHALF AS OF:	AMOUNT OF COVERED EARNINGS CREDITED TO YOU:
September 30	$0
December 31	$0
March 31	$7,000
June 30	$10,000
Total Covered Earnings	$17,000

In This Example:

- The Participant begins Covered Employment in January.
- By the end of the second Calendar Quarter (June 30), the Covered Earnings meet the Plan II earnings threshold.
- To determine eligibility, the Plan looks back over the four-quarter period ending June 30, which is established as the Base Earnings Period in this example. This is the case even though the Participant did not actually start working until January.
- The Participant's Benefit Period begins October 1.

Example: Qualifying for Plan I

COVERED EARNINGS CREDITED ON YOUR BEHALF AS OF:	AMOUNT OF COVERED EARNINGS CREDITED TO YOU:
December 31	$0
March 31	$4,000
June 30	$10,000
September 30	$19,000
Total Covered Earnings	$33,000

In This Example:

- The Participant begins Covered Employment in January.
- By the end of the third Calendar Quarter (September 30), the Participant satisfies the Plan I requirement.
- To determine eligibility, the Plan looks back at the four-quarter period ending September 30 (since that is when the earnings requirement was met). As such, the Participant's Base Earnings Period becomes October 1 through September 30.
- The Participant's Benefit Period begins January 1.

Learn more about Earned Eligibility:

- Continuing eligibility – Earned Eligibility – page 22.
- Loss of eligibility – Earned Eligibility – page 35.

Network / Station Staff Eligibility

The qualification rules for Plan coverage are different if you are a full-time employee of a radio or TV station or a network that is a Contributing Employer and you have Covered Earnings in that capacity.

You will qualify to enroll for coverage on the first day of the month after you complete 30 days of full-time employment with a Contributing Employer if your scheduled annual Covered Earnings meet either of the earnings thresholds described earlier in this section on page 9.

In addition, if you are a network or station staff employee transferring into the Plan as part of a group from a Contributing Employer's group health plan, you will qualify for coverage immediately (with no 30-day waiting period) upon termination of that employer's coverage if:

- Your scheduled annual Covered Earnings meet either of the earnings thresholds on page 9 and you were enrolled in the employer's plan for at least 30 days immediately preceding the transfer; and
- The transfer was made according to the terms of a Collective Bargaining Agreement with SAG-AFTRA.

Benefit Period

If your coverage starts at the beginning of a Calendar Quarter, your Benefit Period will be the 12-month period beginning on the date your coverage starts. If your coverage start date is not on the first day of a Calendar Quarter, your Benefit Period will be the 12-month period that starts on the Calendar Quarter which follows your coverage start date. The one or two months prior to the start of your initial Benefit Period is called interim eligibility.

COVERAGE START DATE	BENEFIT PERIOD
February 1, March 1 or April 1	April 1 – March 31
May 1, June 1 or July 1	July 1 – June 30
August 1, September 1 or October 1	October 1 – September 30
November 1, December 1 or January 1	January 1 – December 31

Learn more about eligibility for Network/Station Staff:

- Continuing eligibility – Network/Station Staff – page 22.
- Loss of eligibility – Network/Station Staff – pages 35-36.

Covered Roster Artist Eligibility

A special qualification rule applies to certain roster artists, including newly signed roster artists, signed to an exclusive recording agreement with a signatory record label that is party to the Covered Roster Artists side letter agreement to the current SAG-AFTRA National Code of Fair Practice for Sound Recordings (Sound Code). The Sound Code requires the signatory record label to make an annual special payment to the Plan on the roster artist's behalf to provide one year of coverage under Plan II.

Under this alternate eligibility rule, if your royalty earnings from the label over the current and immediately preceding six-month reporting period are insufficient for you to meet the Plan's earnings requirements described on page 9, you will be eligible to enroll in Plan II coverage for one year provided that you pay the premium and the label makes the annual special payment required under the Sound Code. You may also enroll in one year of Plan II coverage if you are a new artist who recently signed a royalty agreement with a signatory label and you do not yet have sufficient earnings to qualify under the earnings requirements described on page 9, provided that you pay the premium and the label makes the required annual special payment to the Plan.

Note that the record label is required to make the special payment on your behalf only if you enroll in the Plan and pay the required premium in full by the due date.

Benefit Period

The special employer payment will provide one year of coverage beginning as described below.

IF YOU SIGN WITH A LABEL	COVERAGE BEGINS	BENEFIT PERIOD
January – June 30	October 1	October 1 – September 30
July 1 – December 31	April 1	April 1 – March 31

Learn more about eligibility for Covered Roster Artists:

- Continuing eligibility – Covered Roster Artists – pages 22-23.
- Loss of eligibility – Covered Roster Artists – page 36.

III. Beginning Coverage

After you become eligible for coverage under the Plan, you may enroll and pay the premium to receive coverage. Family coverage is available to all who qualify under either Plan I or Plan II. Documentation is required for any Dependents you want covered, as outlined in the table on page 19. When the Plan has verified the documentation, your Dependent is considered a qualified Dependent.

Enrolling (or disenrolling) Dependents also affects the amount of your premium. The Plan's premiums for 2017 are listed on page 31. The most up-to-date premiums may also be viewed at www.sagaftraplans.org/health.

Enrollment

There are two types of enrollment under the Plan. You initially enroll in coverage during your Open Enrollment Period, the timing of which varies and is determined based on when you qualify for coverage. As long as you continue to qualify for coverage, each subsequent Open Enrollment Period presents an annual opportunity to add or drop qualified Dependents.

Additionally, the Plan extends special enrollment opportunities to Participants following certain life events, as described later in this section. These opportunities allow you to enroll or make changes to your Dependent elections outside of the Open Enrollment Period. When a covered Dependent no longer qualifies as a Dependent due to a life event, Participants must contact the Plan within 60 days to remove the individual from coverage. If you fail to do so, you could be responsible for any Claims paid by the Plan incorrectly on behalf of the former Dependent.

Open Enrollment Period

You may enroll or make changes to your covered Dependents during your Open Enrollment Period, which begins when you qualify for coverage. Your Open Enrollment Period is based on your type of eligibility and your Benefit Period. Senior Performers are included in the January 1 Benefit Period and the corresponding Open Enrollment Period, as are Dependents covered under the Surviving Dependent benefit. See pages 24-28 to learn more about coverage for Senior Performers or pages 28-29 to learn more about the Surviving Dependent benefit.

Terms to know for Section III:

Please refer to the Glossary on pages 129-133 for definitions of these and other capitalized key terms.

Benefit Period

Calendar Quarter

Contributing Employer

Covered Earnings

Dependent

Earned Eligibility

Open Enrollment Period

Participant

Senior Performer

Surviving Dependent

Important Note:

If you are also eligible for coverage with another entertainment industry health plan and you select Participant Only coverage, your non-covered Dependent(s) may be affected by the Entertainment Industry Coordination of Benefits (EICOB) rules outlined on pages 96-97. If you have any questions, please call the Plan. You might also want to call the other plan to discuss your individual situation.

BENEFIT PERIOD START DATE	APPROXIMATE OPEN ENROLLMENT PERIOD
January 1	December 1 through January 15
April 1	March 1 through April 15
July 1	June 1 through July 15
October 1	September 1 through October 15

You will receive an open enrollment packet and a Dependent Enrollment Form with your qualified Dependents listed. It will include information about the Plan for which you qualify, your Benefit Period, your Open Enrollment Period, the premium amount and billing statement, and how to enroll and disenroll Dependents.

You may make changes to your covered Dependents for any reason during the Open Enrollment Period. You do so by completing and returning the enrollment materials with the required documentation – or by updating your enrollment information online through your Benefits Manager and paying your premium. After open enrollment, you may not make changes to enrollment for you or your covered Dependents – except in the case of life events that change the eligibility for you or your Dependents.

Once your premium is processed, a Notice of Coverage (NOC) will be sent to you within 7 to 10 business days. The NOC mailing includes your health care ID cards, information regarding your benefit coverage and a list of your enrolled Dependents. You may also print health care ID cards by visiting **www.sagaftraplans.org/health** and logging in to your Benefits Manager. The ID cards reflect only the Participant name but are also valid for covered Dependents.

If you think that you have met the requirements for Earned Eligibility but you do not receive an open enrollment packet, contact the Plan at (800) 777-4013 or by logging in to your Benefits Manager and using the secure message center. Earnings are sometimes reported late by Contributing Employers, which may delay the Plan's notification. If this happens to you, Plan staff can help you determine if your earnings have been accurately reported. If we verify that your earnings have not been reported, you will need to provide copies of your pay stubs and/or contracts for review. Once the Plan reviews your proof of earnings and verifies with the employer that the earnings are reportable, you will receive written notification of your eligibility for benefits.

You may also verify that your earnings have been reported to the Plan by logging in to your Benefits Manager account at **www.sagaftraplans.org/health**. Please remember that the Benefits Manager may not reflect total Covered Earnings for any particular Calendar Quarter until approximately 60 days after the quarter ends.

Dependent Coverage

Family coverage is available under both Plan I and Plan II. Once you qualify for Earned Eligibility or Senior Performers coverage as a Participant, coverage is also available to your qualified Dependents. To cover Dependents, you must enroll the Dependents (including providing the necessary documentation) and pay the applicable premium.

Coverage for Dependents will begin the later of:

- The date your coverage begins;
- The date you add your Dependent to your coverage as part of open enrollment; or
- The date the person becomes your Dependent as a result of a life event such as marriage, birth or adoption.

If you qualify for coverage as a Participant, the following individuals are Dependents based on their relationship to you:

- Your legal spouse;
- Your children under age 26, including:
    - Biological children;
    - Legally adopted children and children placed for adoption;
    - Stepchildren;
    - Foster children;
    - Children for whom you or your spouse are the legal guardian; and
- Your unmarried children age 26 or older who continue to be dependent on you or your spouse due to an inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental permanent disability. Such an older child may qualify as a Dependent if he or she was disabled prior to turning age 26 and you were eligible for coverage when your child became disabled – regardless of whether or not you were enrolled in the Plan at that time. The Plan requires periodic certification of permanent disability status by the child's attending Physician.

No family members other than your spouse or children qualify for Dependent coverage. The Plan requires documentation for the Dependents you want to cover to verify their status as a Dependent; refer to the following page to learn more.

Enrollment of an individual who does not meet the Plan's eligibility requirements will be treated as an intentional misrepresentation of a material fact or fraud. You and any individual who obtains benefits from the Plan through misrepresentation or fraud will be held jointly and severally liable for such overpayment, and coverage may be rescinded retroactively to the date the individual was not eligible for coverage.

See pages 121-123 to learn more regarding overpayments of benefits and the Plan's right to recovery.

Life Events and Dependent Coverage

As a Participant, it is your responsibility to notify the Plan of any life events or other changes that could affect your health coverage, such as those described in this section. You have 60 days to notify us of these life events; otherwise you may miss certain opportunities available to you, such as enrolling a new Dependent outside the Open Enrollment Period or preserving your former Dependent's rights under COBRA.

The following are examples of common life events and other changes that may affect your health coverage:

- A new child.
- Marriage.
- Divorce.
- Death of a Participant or Dependent.
- Changes of address.
- Changes to your legal or professional name.
- A change to who you want to designate as your beneficiary.

Notify the Plan of life events or changes to your contact information separately from any notifications to other organizations.

The SAG-AFTRA Health Plan is separate from SAG-AFTRA (the union) and from the SAG-Producers Pension Plan and the AFTRA Retirement Plan. Notification of changes of address or other information provided to SAG-AFTRA, the SAG-Producers Pension Plan or the AFTRA Retirement Plan does not automatically update your information with the SAG-AFTRA Health Plan – you must contact us separately. Please notify us promptly of any changes to your address or contact information and of any qualifying life events by the required deadline described in this section.

Life Events and Documentation / Notification Requirements

Listed below are the life events that may affect your Plan coverage, along with the required documentation.

LIFE EVENT	DOCUMENTATION REQUIRED
Marriage[1]	A completed Dependent Enrollment Form and a copy of the official, state-issued marriage certificate.
Divorce[2]	A copy of the recorded final divorce decree.
Birth	A completed Dependent Enrollment Form and a copy of the official, state-issued birth certificate. Exception: the Plan will accept a copy of the birth certificate from the Hospital to add your biological child who is younger than one year of age for a period of up to 120 days while you obtain an official copy.
Adoption or placement for adoption	A completed Dependent Enrollment Form and a copy of the adoption/ placement papers issued by the court.
Legal guardianship	A completed Dependent Enrollment Form and a copy of the guardianship papers issued by the court.
Physically and/or mentally disabled Dependents age 26 or older	A completed application for permanent disability status and a copy of the attending Physician's history and physical report. Periodic certification of permanent disability status is also required.
Death	A copy of the recorded death certificate.
Loss of other group health coverage	Documentation which shows evidence of the loss of other coverage.

[1] If you are covered under the Surviving Dependent benefit following the death of a Participant and you remarry, your Plan coverage will terminate as described on page 37.

[2] In the event of a divorce, medical expenses incurred by your ex-spouse or stepchild who no longer qualifies as your Dependent on or after the date of the divorce are not covered by the Plan unless they elect and pay for COBRA Continuation Coverage. You and your ex-spouse will be held jointly and severally liable for any overpayment of expenses paid by the Plan from the date of divorce. Please see pages 121-123 for more information regarding overpayment of benefits and the Plan's right of recovery.

Health Coverage Under a Court Order

A medical child support order is a court order that requires a Participant to provide health coverage for a child or children, typically following a divorce. For the Plan to provide benefits in accordance with a medical child support order, the Plan must first determine that the order is a qualified medical child support order (QMCSO). If this applies to you, contact the Plan at (800) 777-4013 to request the current procedures and requirements for enrolling a child as your Dependent under a QMCSO.

Special Enrollment Opportunities

Special enrollment opportunities triggered by certain life events allow you to enroll or make changes to your Dependent elections outside the Open Enrollment Period. Traveling is not considered a life event or special exception; in other words, you cannot enroll yourself or a Dependent outside of the Open Enrollment Period because you intend to travel, even if it is for an extended period of time.

The special enrollment opportunities are described below:

- *Enrolling a new Dependent* – If you gain a new Dependent as a result of marriage, or the birth, adoption, placement for adoption or legal guardianship of a child, you may enroll the Dependent in your coverage provided you notify the Plan within 60 days of the life event and you submit the required documentation as described above.

- *Senior Performers – Spouse turns 65* – Senior Performers also have the opportunity to make changes to their covered Dependents in the event their spouse turns age 65. In the case of Surviving Dependent coverage, the eligible Dependents have the opportunity to re-enroll in the Plan when the spouse turns age 65.

- *Loss of other group health plan coverage* – If you do not enroll in the Plan because you have other group health coverage, you may be allowed to enroll outside your Open Enrollment Period if your other coverage ends because of a termination of employment or reduction in hours, legal separation, loss of Dependent status under the other plan, divorce or death (but not if you lost coverage because you failed to pay required premiums). If the other coverage is under COBRA and you exhaust your COBRA Continuation Coverage, you may also be allowed to enroll in the Plan.

  You must submit a written request for coverage to the Plan within 60 days after your other coverage ends, along with documentation of the loss of coverage. If your Plan coverage is under the Surviving Dependent benefit described on pages 28-29, the only special enrollment opportunity available to you under this provision is when your other coverage ends because of termination of employment or a reduction in hours.

- *CHIP/Medicaid* – CHIP and Medicaid are government programs designed to provide health care coverage for uninsured children and some adults. One of the benefits offered by some state Medicaid or CHIP programs is assistance with paying for health plan premiums.

  Special enrollment opportunities are available to:

  - Participants and their Dependents who lose coverage under Medicaid or CHIP; and

  - Participants and their Dependents who are determined eligible for premium assistance under Medicaid or CHIP.

  If you experience either of these CHIP/Medicaid enrollment events and you would like to enroll in this Plan, you must submit a written request to the Plan within 60 days of the event. If you think you or any of your Dependents might be eligible for Medicaid or CHIP, or if you or your Dependents are already enrolled in Medicaid or CHIP but not receiving premium assistance, contact your state Medicaid or CHIP office or call (877) KIDSNOW

or visit **www.insurekidsnow.gov** to learn how to apply. If you qualify, ask if there is a program that might help you pay the Plan's premium.

For the latest version of the Dependent Enrollment Form and other forms or procedures necessary to enroll during a special enrollment opportunity, visit the Forms section of **www.sagaftraplans.org/health**.

Disenrolling Dependents

If you are disenrolling a Dependent due to divorce or death, you must submit a copy of the final judgment of divorce or recorded death certificate. In the event of divorce, you must notify the Plan in writing within 60 days of the date of your divorce for your ex-spouse or former stepchildren to receive the right to COBRA Continuation Coverage. Medical expenses incurred by your ex-spouse or former stepchildren on or after the date of divorce are not covered by the Plan. You will be billed for any expenses paid by the Plan following the date of divorce if your ex-spouse or former stepchildren do not elect COBRA Continuation Coverage. For additional information, refer to the COBRA section on pages 37-43.

You may also want to update your life insurance beneficiaries after a life event. The Plan will use the last beneficiaries on file in determining who should receive any benefits that may be payable, even if you have divorced or married since filing the Designation of Beneficiaries Form. Therefore, it is important to file a new form with the Plan immediately if you wish to change your beneficiaries.

Also note that naming your beneficiaries in your will or revoking a beneficiary in a divorce decree does not change your beneficiaries for the Plan's life insurance or accidental death and dismemberment benefits. You must complete a new Designation of Beneficiaries Form, which is available from the Forms section of **www.sagaftraplans.org/health**.

Important Note:

Enrolling and disenrolling Dependents can affect the amount of your premium. Premium changes will be effective on the 1st of the month in which the event occurred if enrolling a new Dependent(s) or the 1st of the following month if you are disenrolling a Dependent(s).

Terms to know for Section IV:

Please refer to the Glossary on pages 129-133 for definitions of these and other capitalized key terms.

Age and Service

Alternative Days

Base Earnings Period

Benefit Period

Covered Earnings

Covered Employment

Covered Roster Artist

Earned Eligibility

Eligibility Days

Network/Station Staff

Participant

IV. Continuing Earned Eligibility

Continuing Eligibility – Minimum Earnings, Alternative Days, Age and Service

Your Earned Eligibility for health coverage will continue without interruption as long as you meet the requirements for minimum Covered Earnings, Eligibility Days or Age and Service eligibility during your Base Earnings Period each year and you continue to pay the applicable premium in full by the due date. The first time you qualify for Earned Eligibility, your Base Earnings Period and Benefit Period are established, as described in Section II. These periods will not change unless you fail to meet the eligibility requirement to continue coverage.

If you do not meet the minimum Covered Earnings requirement (or one of the alternate eligibility requirements) in your Base Earnings Period, you no longer qualify for Plan coverage. To qualify for coverage again, you will have to meet one of the eligibility requirements described on pages 9-10 and establish a new Base Earnings Period.

Continuing Eligibility – Network/Station Staff

Generally, if you are covered as a Network/Station Staff Participant, your coverage continues as long as you remain in the same Covered Employment and the terms of your employment continue to meet the initial qualification rules (see page 14), provided you continue to pay the applicable premium in full by the due date.

Continuing Eligibility – Covered Roster Artists

As long as you remain a Covered Roster Artist and continue to pay the required premium in full by the due date and your record label continues to make the annual special payment, you will continue to be covered by the Plan.

Qualifying First as a Covered Roster Artist and Then Based on Covered Earnings

As long as you enroll as a Covered Roster Artist, your initial Benefit Period and Base Earnings Period are established and will not change. If you qualify based upon Covered Earnings by the end of your Base Earnings Period, you may continue your coverage for a second year (and for each subsequent year that you qualify) based upon your Covered Earnings, regardless of whether or not

you continue as a Covered Roster Artist. For additional information about how Base Earnings periods and Benefit Periods are determined, see page 12.

Qualifying First Based on Covered Earnings and Then as a Covered Roster Artist

If you enroll in the Plan after qualifying based upon Covered Earnings, and then you are signed by a record label as a roster artist, your coverage based upon Covered Earnings will continue until the end of your Benefit Period as long as you continue to pay the applicable premium in full by the due date. If at that point you no longer qualify for coverage based upon Covered Earnings, and you qualify for coverage as a Covered Roster Artist as described on page 15, then you may continue your coverage for the remainder of the period covered by the roster artist special payment.

If you have questions about the specific qualification dates pertaining to your label and your qualification for coverage under the special Covered Roster Artists side letter, please contact the Sound Recording department of the SAG-AFTRA union office.

V. Senior Performers Coverage

When you retire, you may qualify for coverage as a Senior Performer based upon your work history. Benefits for Senior Performers are the same as those provided to Participants with Earned Eligibility under Plan I, except that the life insurance benefit for Senior Performers is $5,000 instead of $10,000 and no accidental death and dismemberment benefits are provided.

It is important to note that benefits for Senior Performers are offered through the SAG-AFTRA Health Plan and are not part of the benefits provided by the AFTRA Retirement Plan or the SAG-Producers Pension Plan. Like all benefits under the SAG-AFTRA Health Plan, Senior Performers benefits are not guaranteed and may be amended, modified or terminated at any time for those who are or may become covered by these benefits.

Senior Performers Eligibility

The Plan offers coverage to retirees (and their qualified Dependents) who meet each of the following criteria:

- Are age 65 or older;
- Are receiving a pension from either the SAG-Producers Pension Plan or the AFTRA Retirement Plan (if you are eligible for a pension from both of these plans, you only need to take your pension from the SAG-Producers Pension Plan); and
- Have at least 20 Retiree Health Credits (see below). Retirees with less than 20 Retiree Health Credits may be eligible when they turn 65 if, as of January 1, 2017, they had at least 15 qualifying years under the AFTRA Health Plan or at least 15 pension credits under the SAG-Producers Pension Plan, and they were at least age 55.

Certain retirees with less than 15 qualifying years under the AFTRA Health Plan or 15 pension credits under the SAG-Producers Pension Plan may also be eligible for Senior Performers coverage when they turn 65, provided they are receiving a pension from the SAG-Producers Pension Plan or the AFTRA Retirement Plan. This includes:

- Participants who were born on or before January 1, 1943 with at least 10 qualifying years under the AFTRA Health Plan.
- Participants who were born before December 1, 1937 and, as of December 1, 1992:

Terms to know for Section V:

Please refer to the Glossary on pages 129-133 for definitions of these and other capitalized key terms.

Benefit Period

Earned Active Eligibility

Earned Eligibility

Open Enrollment Period

Participant

Retiree Health Credit

Senior Performer

Surviving Dependent

Special Grandfathering Rule for Those With AFTRA or SAG Retiree Health Coverage

If, as of December 31, 2016, you are eligible for or are receiving health coverage under either the AFTRA Health Plan's Senior Citizen Health Program or the SAG-Producers Health Plan's Senior Performers benefit, including occupational disability pensioners receiving Senior Performers coverage under the SAG-Producers Health Plan, you will be eligible for Senior Performers coverage under Plan I of the SAG-AFTRA Health Plan beginning January 1, 2017.

  - were vested in a regular annuity based on at least 10 years of service 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 all the requirements in effect at that time for retiree coverage under the AFTRA Health Plan.

- Participants who had at least 10 pension credits under the SAG-Producers Pension Plan as of December 31, 2001, and who were at least age 55 as of December 31, 2002.

As you meet Earned Eligibility requirements throughout your career, you may also earn Retiree Health Credits. As of January 1, 2017, if you earn at least $22,000 in Covered Earnings during a calendar year, you earn a Retiree Health Credit for that year. Effective January 1, 2018, and on January 1 of every year thereafter through 2022, the Covered Earnings threshold to earn a Retiree Health Credit is scheduled to increase by $1,000.

Retiree Health Credits Earned Prior to January 1, 2017

The AFTRA Health Plan and the SAG-Producers Health Plan had different eligibility rules for retiree health coverage. Under the AFTRA Plan, participants had to accrue at least 15 qualifying years in order to be eligible for retiree benefits. Under the SAG Plan, participants had to accrue at least 15 SAG-Producers Pension Plan pension credits in order to be eligible for retiree benefits. Pension credits earned under the SAG-Producers Pension Plan's Alternative Eligibility Program did not count toward retiree health eligibility.

Participants who have accrued AFTRA Health Plan qualifying years and/or SAG pension credits toward retiree health coverage prior to January 1, 2017 will be able to carry forward those years/credits to the SAG-AFTRA Health Plan as follows.

Participants Who Have Accrued AFTRA Qualifying Years Only

If you have accrued AFTRA Health Plan qualifying years toward retiree health coverage and you have not accrued any pension credits under the SAG-Producers Pension Plan, you will carry forward all your AFTRA Health Plan qualifying years earned as of January 1, 2017.

Participants Who Have Accrued SAG Pension Credits Only

If you have accrued SAG-Producers Pension Plan pension credits toward retiree health coverage and you have not accrued any qualifying years under the AFTRA Health Plan, you will carry forward all your SAG pension credits earned as of January 1, 2017.

Participants Who Have Accrued AFTRA Qualifying Health Years and SAG Pension Credits

Generally, if you have accrued both qualifying health years and pension credits toward retiree health benefits, you will be able to carry forward the greater of:

- Your qualifying years under the AFTRA Health Plan; or
- Your pension credits under the SAG-Producers Pension Plan.

The Plan in which you had the greater number of years or credits will be your base plan. You may also be able

to carry forward additional years or credits from the other plan that were earned during the period 2009 through 2016, provided they do not overlap with any of the years or credits in your base plan. If you have the same number of years or credits in both plans, your base plan will be set as the plan which yields the greatest number of Retiree Health Credits when combined with the non-overlapping years or credits from 2009 through 2016 under the other plan. Please see the examples below.

Example I

If, as of December 31, 2016 you have earned:

AFTRA	2006	2007	2008	2009	2010	2011
Qualifying Years	✓	None	✓	✓	✓	✓
SAG	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Pension Credits	✓	None	✓	None	None	None

AFTRA Health Plan qualifying years:	5 (base plan)
SAG-Producers Pension Plan pension credits:	2
Non-overlapping SAG credits from 2009-2016:	0
Your Retiree Health Credits as of January 1, 2017:	5 + 0 = 5

Example II

If, as of December 31, 2016 you have earned:

AFTRA	2008	2009	2010	2011	2012	2013	2014	2015
Qualifying Years	✓	✓	None	None	✓	None	✓	✓
SAG	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Pension Credits	✓	None	✓	✓	✓	✓	None	✓

AFTRA Health Plan qualifying years:	5
SAG-Producers Pension Plan pension credits:	6 (base plan)
Non-overlapping AFTRA years from 2009-2016:	2 (in 2009 and 2014)
Your Retiree Health Credits as of January 1, 2017:	6 + 2 = 8

Important Note:

AFTRA qualifying years were earned based on a 12-month period from December through November. For the purpose of determining non-overlapping years, an AFTRA qualifying year will be considered to have been earned during the year applicable to the period January through November. For example, an AFTRA qualifying year that was earned from December 1, 2006 through November 30, 2007 will be considered a 2007 year.

Example III

If, as of December 31, 2016 you have earned:

AFTRA	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Qualifying Years	None	None	✓	✓	✓	✓	✓	✓	✓	✓
SAG	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Pension Credits	✓	✓	✓	None	✓	✓	✓	✓	None	✓

AFTRA Health Plan qualifying years:	8
SAG-Producers Pension Plan pension credits:	8
Non-overlapping AFTRA years from 2009-2016:	2 (in 2009 and 2014)
Non-overlapping SAG credits from 2009-2016:	0
Retiree Health Credits as of January 1, 2017 with AFTRA as the base plan:	8 + 0 = 8
Retiree Health Credits as of January 1, 2017 with SAG as the base plan:	8 + 2 + 10
Your Retiree Health Credits as of January 1, 2017:	10

Participants who have earned a qualifying year under the AFTRA Health Plan or a pension credit under the SAG-Producers Pension Plan as of December 31, 2016 will receive a letter from the Plan indicating their number of Retiree Health Credits. If you have not received your letter by February 2017, or if you have questions about your Retiree Health Credits please contact the Plan at (800) 777-4013.

Occupational Disability Pensioners

Occupational disability pensioners under the SAG-Producers Pension Plan are eligible for Senior Performers health coverage at any age, provided they have at least 15 Retiree Health Credits. Occupational disability pensioners may not count any AFTRA Health Plan qualifying years toward the 15 Retiree Health Credit requirement.

In order to be eligible for an occupational disability pension, your injury must have occurred while working under a Collective Bargaining Agreement for which contributions were made to the SAG-Producers Pension Plan. For a complete description of the occupational disability pension requirements, please refer to the SAG-Producers Pension Plan SPD.

Enrollment for Senior Performers Coverage

Senior Performers coverage will begin on the first day of the month in which you meet the eligibility requirements, unless you have Earned Eligibility, in which case your Senior Performers coverage will begin on the first day of the month following the month in which you lose Earned Eligibility. For occupational disability pensioners, coverage begins when Medicare disability coverage begins. You must pay the required premium (see page 31 for Senior Performers premiums as of January 1, 2017).

Eligibility will continue each calendar year – the Benefit Period for all of those with Senior Performers coverage under the Plan. Enrollment for Senior Performers coverage is handled in the same manner as enrollment for Earned Eligibility coverage. For additional information, including when you can make changes to your covered Dependents, refer to pages 16-21.

Coordination of Benefits With Medicare

Senior Performers coverage will provide coverage secondary to Medicare for Hospital and medical benefits – unless you regain Earned Active Eligibility. You must be enrolled in Medicare Parts A and B to qualify for full Plan coverage. If your spouse is age 65 or older, or qualifies for Medicare due to disability, your spouse must also be enrolled in Medicare Parts A and B to receive Dependent coverage under the Plan (when the Participant is a Senior Performer). You and your spouse do not need to enroll in a Medicare Part D Prescription Drug Program, as pharmacy benefits are included with Senior Performers coverage. Please refer to pages 92-94 and 99-101 for additional information about coordinating benefits with Medicare.

Regaining Earned Active Eligibility

Your Senior Performers eligibility may be replaced with Earned Active Eligibility:

- If you meet the minimum Covered Earnings threshold for Earned Eligibility and your earnings include at least one sessional reporting;
- If you meet the Alternative Days requirement;
- If you become a Covered Roster Artist; or
- If you become a Network/Station Staff.

You will receive earned Plan I coverage and Medicare will become secondary to the Plan. Please refer to "Coordination of Benefits With Medicare" and on pages 99-101.

Surviving Dependent Eligibility Following the Death of a Participant

The Surviving Dependent benefit provides Senior Performers health benefits to your eligible Dependents when you die, provided you meet certain requirements at the time of your death. An eligible Dependent includes your Dependent children and your surviving spouse, provided you and your spouse were married for at least 12 months immediately preceding your death.

The Surviving Dependent benefit is provided to your Dependents if at least one of the following applies:

- You were at least age 65 at death and had at least 20 Retiree Health Credits;
- You were at least age 65 at death, had at least 15 qualifying years under the AFTRA Health Plan or at least 15 pension credits under the SAG-Producers Pension Plan as of December 31, 2016, and were age 55 or older on December 31, 2016; or
- You were at least age 50 at death, had at least 20 Retiree Health Credits, and your age plus Retiree Health Credits was at least 75. Coverage for your

Dependents will begin on the date you would have turned 65.

Coverage for your surviving spouse will continue until your spouse remarries or dies, provided the Plan premium is paid. Coverage for Dependent children will continue until they no longer meet the Plan's definition of a Dependent (see page 18).

The Plan requests verification of the marital status of all surviving spouses covered under this benefit annually during the Open Enrollment Period. Eligibility for this coverage will not be extended unless the Plan receives a completed questionnaire.

In some cases, Dependents may be able to continue coverage under COBRA after their eligibility for Surviving Dependent benefits ends (see "Special Rules for Dependents" on page 39). Your Dependents will be notified by the Plan if this additional coverage is available.

Surviving Dependent eligibility may be replaced with Earned Active Eligibility if the Participant met one of the requirements outlined on the previous page under "Regaining Earned Active Eligibility" for a subsequent Benefit Period. If this happens, the Dependents will receive earned Plan I coverage.

If you and your spouse BOTH have Senior Performers coverage under the Plan and one of you dies, the surviving spouse will not receive Surviving Dependent coverage. This is because the surviving spouse will continue to receive his or her own Senior Performers health coverage – which pays secondary to Medicare – as long as the required premiums are paid on time.

Note: Survivng Dependent benefits are not guaranteed and may be amended, modified or terminated at any time.

Special Grandfathering Rule for Those With Surviving Dependent Health Coverage From the AFTRA Health Plan or the SAG-Producers Health Plan

If, as of December 31, 2016, you are eligible for or are receiving health coverage as a surviving dependent under either the AFTRA Health Plan's Senior Citizen Health Program or the SAG-Producers Health Plan's extended spousal benefit, you will be eligible for Surviving Dependent coverage under Plan I of the SAG-AFTRA Health Plan beginning on the later of January 1, 2017, or the date the Participant would have turned 65.

VI. Paying Premiums

This section describes the premium payment rules for Earned Eligibility, Senior Performers coverage and the Surviving Dependent benefit. The premium payment rules for COBRA Continuation Coverage are outlined on pages 40-42.

All Participants must pay a premium for Plan coverage. The amount of your premium depends on the type of coverage or plan option for which you qualify, as well as how many Dependents you enroll.

Premium Changes and Dependent Coverage

As a Participant, it is your responsibility to notify the Plan when you acquire new Dependents, marry or divorce. A new Dependent cannot be added to your coverage until we receive a Dependent Enrollment Form and the required documentation. For additional information about notification requirements and deadlines related to enrolling or disenrolling Dependents, refer to the "Life Events and Dependent Coverage" section on pages 18-21.

Premium changes related to a change in your covered Dependents are effective as follows:

- If you are enrolling a new Dependent outside the Open Enrollment Period, the premium change will be effective back to the 1st day of the month in which the life event occurred.
- If you are disenrolling a Dependent outside the Open Enrollment Period, the premium change is effective on the 1st day of the month following the month in which the event occurred.

Earned Eligibility Premium

For most Participants with Earned Eligibility, including Network/Station Staff and Covered Roster Artists, the premium is due quarterly. This premium also applies to those covered under the total disability extension described on pages 43-44. The premiums below are effective as of January 1, 2017 and are subject to adjustment in the Trustees' sole discretion. For the most up-to-date premiums, always visit **www.sagaftraplans.org/health**.

Terms to know for Section VI:

Please refer to the Glossary on pages 129-133 for definitions of these and other capitalized key terms.

Age and Service

Alternative Days

Covered Roster Artists

Dependent

Earned Active Eligibility

Earned Eligibility

Network/Station Staff

Open Enrollment Period

Participant

Retiree Health Credit

Senior Performer

Surviving Dependent

Important Note:

If your Plan coverage is terminated because you do not pay your premium, your coverage under other entertainment industry health plans may be reduced or eliminated due to the EICOB rules (see pages 96-97). Please contact the other health plan for further information.

COVERAGE ELECTIONS	PLAN I	PLAN II	PLAN II ALTERNATIVE DAYS	PLAN II AGE AND SERVICE
Participant Only	$300 per quarter	$357 per quarter	$357 per quarter	$456 per quarter
Participant Plus One Dependent	$348 per quarter	$408 per quarter	$408 per quarter	$525 per quarter
Participant Plus Two or More Dependents	$375 per quarter	$447 per quarter	$447 per quarter	$570 per quarter

Premium Payroll Deduction Available to Some Network/Station Staff

If you are a Network/Station Staff Participant, the station or network that employs you may deduct Plan premiums from your paycheck. If this is the case, you are not required to make separate quarterly premium payments, though it is your responsibility to ensure that the payments are being made on your behalf. To learn if this option is available to you, contact your employer's Human Resources department.

Senior Performers and Surviving Dependent Premiums

Premiums for Senior Performers and Surviving Dependent coverage are due monthly, unless you pay by mail (see page 33), in which case premiums are due quarterly. The premiums below are effective as of January 1, 2017. The amounts for Participants with less than 20 Retiree Health Credits change each January 1 and are set at 25% of the estimated cost of Senior Performers coverage. Premiums are subject to adjustment at the Trustees' sole discretion. For the most up-to-date premiums, visit **www.sagaftraplans.org/health**.

SENIOR PERFORMERS OR DECEASED PARTICIPANTS WITH:	WITH NO SPOUSE OR WITH SPOUSE AGE 65 OR OLDER[3]	WITH SPOUSE UNDER AGE 65[3]
20 or more Retiree Health Credits	$60 per month ($180 per quarter)	$120 per month ($360 per quarter)
15-19 Retiree Health Credits[4]	$170 per month ($510 per quarter)	$170 per month ($510 per quarter)

[3] Includes coverage for Dependent children.

[4] Also applies to Senior Performers and Surviving Dependents with less than 15 Retiree Health Credits who were grandfathered into the Plan as of January 1, 2017.

Senior Performers with 20 or more Retiree Health Credits who have a spouse who is eligible for Medicare but under age 65 will pay the $60 monthly premium. This also applies to a surviving spouse covered under the Surviving Dependent benefit, provided the Participant had 20 or more Retiree Health Credits. Contact the Plan to be sure you are billed the correct premium.

The Senior Performers premium for a Participant with at least 20 Retiree Health Credits will automatically adjust to the lower premium rate effective the first of the month in which the spouse turns age 65. This also applies to a surviving spouse covered under the Surviving Dependent benefit.

Special Rules for Senior Performers Who Regain Earned Eligibility

If you are a Senior Performer who regains Earned Active Eligibility, you will pay the lowest premium for which you qualify. The premium is due quarterly unless you are paying through pension deduction (see the following page). This also applies to Surviving Dependents if the Participant qualified for a subsequent Benefit Period of Earned Active Eligibility.

For example, a single Senior Performer with 20 Retiree Health Credits regains Earned Active Eligibility by satisfying the minimum earnings requirement with earnings that include at least one sessional reporting. Although his or her coverage will change to earned active coverage, he or she will continue to pay the $60 Senior Performers monthly amount ($180 per quarter) since it is lower than the earned premium amount ($300 per quarter).

This special rule also applies to Participants who are at least age 65 but have not actually retired and begun receiving a pension, provided:

- They have at least 20 Retiree Health Credits;
- As of January 1, 2017, they were at least age 55 and had at least 15 AFTRA qualifying years or 15 SAG pension credits; or
- They meet the rules outlined on pages 24-25 for Participants with 10 AFTRA qualifying years/ service credits or 10 SAG pension credits.

Payment Options

You may pay the premium in advance, regardless of your method of payment (except for automatic payments, which are described below). However, you may not pay the premium for any period beyond your current Benefit Period.

Automatic payment – The automatic payment option deducts your quarterly Earned Eligibility premium or monthly Senior Performers/Surviving Dependent premium from your U.S. checking or savings account. Payments are deducted on approximately the 25th of the month prior to the due date. The Plan will continue to deduct the premium as long as you remain continuously eligible for coverage, even if there is a change in the premium because you experience a change in your eligibility type or benefit plan, or if the Trustees make a change to the premium. To sign up for the automatic premium payment option, visit **www.sagaftraplans.org/health**.

Pay online – You may pay your premium online by check or with a credit/debit card. Simply visit **www.sagaftraplans.org/health** and enter your U.S. checking or savings account number or your credit/debit card information. You will receive electronic confirmation that your payment has been received.

For your protection, online payments and phone payments are non-recurring. This means the Plan will not automatically charge your credit card or debit your account everytime a payment is due. For recurring payments that you do not have to initiate, choose the automatic payment option.

Pay by phone – You may pay your premium by telephone 24/7 with a credit/debit card by calling the Plan at (800) 777-4013 and following the prompts. You will receive a confirmation number indicating that your payment has been received. For your security, this is an automated system; Plan staff will not be able to take your credit card information.

Pay by mail – A quarterly premium billing statement will be sent to you a few weeks before the due date. Make your check, money order or cashier's check from a U.S. bank payable to the SAG-AFTRA Health Plan and send it with your coupon in the envelope provided to the address below.

SAG-AFTRA Health Plan
Payment Center
P. O. Box 30110
Los Angeles, CA 90030-0110

To help ensure that your premium payment is processed correctly, please write your SAG-AFTRA Health Plan health care ID number (found on your premium billing statement) on your check. Your payment must be received no later than the due date to be on time. **Do not send your payment to the Plan's regular mailing address or to the SAG-AFTRA union office.**

Any check or debit returned to the Plan for any reason will be assessed a fee. You may replace the premium payment and pay the fee using any of the payment options outlined above.

Deduction from monthly pension – If you are eligible for Senior Performers coverage, you may choose to have the monthly premium automatically deducted from your monthly AFTRA Retirement Plan or SAG-Producers Pension Plan pension benefit. This option provides convenience and helps ensure that your health coverage will continue uninterrupted so long as you remain eligible.

Premium Due Dates

Your premium is due on the first day of each Calendar Quarter for Earned Eligibility coverage. For those with Senior Performers or Surviving Dependent coverage, the premium is due on the first day of each month unless you are paying by mail. In this case your premium is due on the first day of each Calendar Quarter. For example, the quarterly payment for the first quarter of a calendar year (January through March) is due on January 1. While there is a 15-day grace period, this should only be used for unforeseen circumstances. Coverage will not be granted until your premium is processed.

If the Plan does not receive your premium by the due date, you are not entitled to coverage until your next Benefit Period. If your coverage is terminated due to your non-payment, you will not be offered COBRA Continuation Coverage, nor will you be offered any other Plan coverage options.

For example, if your Benefit Period is January 1 through December 31 and you fail to pay your first quarterly premium by the end of the grace period on January 15, you will not be entitled to Plan coverage until the following January 1, provided you re-qualify for coverage at that time by meeting the eligibility requirements.

Late Payment Waivers

If your payment is not received by the due date, including the grace period, you may reinstate your coverage by using a late payment waiver. The Plan allows one late payment waiver per Benefit Period, with a maximum of two late payment waivers per lifetime for Earned Eligibility. Individuals with Senior Performers or Surviving Dependent coverage are eligible for one late payment waiver per Benefit Period. Participants may use a late payment waiver up to the last day of the quarter for which the payment is due.

To use a late payment waiver, simply make your payment:

- Online at **www.sagaftraplans.org/health**;
- By phone at (800) 777-4013; or
- By submitting your payment with your billing coupon.

When your payment is received after the grace period, the Plan will apply one of your late payment waivers (if available), and your coverage will be reinstated retroactively.

SAG-AFTRA Foundation Grant Program

The SAG-AFTRA Foundation is a separate legal entity from the SAG-AFTRA Health Plan that provides charitable, educational and humanitarian services for SAG-AFTRA members. The Foundation, established in 1985, also offers services to SAG-AFTRA members as well as opportunities to those interested and able to assist those who need help. Based on rules determined solely by the Foundation, individuals who have a catastrophic illness or injury and who, due to financial need, cannot afford the Plan's premium may be offered financial grants to help pay the premium.

Grant Qualification Requirements

To qualify for a SAG-AFTRA Foundation grant the individual must be a Participant or Dependent under the Plan. The applicant must qualify for Earned Eligibility, Senior Performers benefits, Surviving Dependent benefits or COBRA Continuation Coverage and must meet the following requirements:

1. The applicant has a catastrophic illness or injury, which means an illness or injury which prevents you from performing the material and substantial duties of your regular occupation, and the effects of which are likely to be of long or indefinite duration. With respect to a minor Participant or Dependent, catastrophic illness or injury means an illness or injury which prevents you from engaging in most of the normal activities of a person of like age and gender in good health, and the effects of which are likely to be of long or indefinite duration.

2. The applicant must be suffering from a financial hardship that prevents the individual from being able to afford the premium payments.

Grant Benefits

If the Foundation approves a grant for Earned Eligibility, Senior Performers benefits or Surviving Dependent benefits, grant funds will automatically be applied to the cost of the premium of the Plan for which you qualified – either Plan I or Plan II.

If a grant is approved for COBRA Continuation Coverage, the grant funds will be applied to the cost of the COBRA premium for the medical portion of Plan II. The applicant is responsible for paying the dental portion of the COBRA premium. If additional COBRA Continuation Coverage is desired, such as choosing to enroll in Plan I, the additional premium amount must be paid by the applicant.

Coverage will terminate on the earlier of:

- The date the applicant no longer qualifies for Plan coverage;
- The date on which the grant funds have been exhausted; or
- The date the applicant stops paying his or her portion of the premium (if applicable).

Contact the Plan for an application or more information about the SAG-AFTRA Foundation and other assistance organizations.

VII. Loss of Coverage and Extended Coverage Opportunities

When you lose Earned Eligibility due to a reduction in Covered Earnings or because you no longer meet other eligibility criteria, you will receive a notice from the Plan which outlines available benefits and options for continued coverage. If you die, the Plan will mail this information to your covered Dependents or your beneficiaries.

All notices will be mailed to the address that the Plan has on file. This is one reason why it is important to keep us informed of your current address. If you move, visit **www.sagaftraplans.org/health** and log in to your Benefits Manager to update your contact information securely. You may also complete a Participant Information Form (PIF) and send it to the Plan as directed on the Form. The PIF is available at **www.sagaftraplans.org/health** or by calling the Plan at (800) 777-4013.

Loss of Eligibility for Coverage

Loss of Earned Eligibility – Participants

The termination rules for Participants with Earned Eligibility vary depending on how you qualified for coverage. In addition, Plan coverage may be terminated because of a Plan amendment that changes the eligibility requirements.

Minimum Covered Earnings, Alternative Days, Age and Service

You will lose Earned Eligibility as a Participant at the end of your 12-month Benefit Period if you have not satisfied the minimum Covered Earnings requirement in your Base Earnings Period, or if you no longer meet one of the alternate requirements for Earned Eligibility described on pages 9-15.

Network/Station Staff

If you are a full-time employee of a radio or TV station or network, then the following rules determine the end of coverage:

- If you have been continuously enrolled in the Plan for less than five years (not including COBRA or the total disability extension), your coverage will end on the last day of the Calendar Quarter following the quarter in which your employment ends.

Terms to know for Section VII:

Please refer to the Glossary on pages 129-133 for definitions of these and other capitalized key terms.

Base Earnings Period

Benefit Period

COBRA Continuation Coverage

Covered Roster Artist

Dependent

Earned Eligibility

Network/Station Staff

Participant

Senior Performer

Surviving Dependent

Totally Disabled

When you lose eligibility for coverage, you may be able to continue your coverage under one of these provisions below:

- COBRA Continuation Coverage: see pages 37-43; or
- Total disability extension: pages 43-44.

- If you have been continuously enrolled in the Plan for five or more years (not including COBRA or the total disability extension), your coverage will end on the last day of the last Benefit Period for which you qualify based on your Covered Earnings under the general rules for Participants (see page 12).

Covered Roster Artists

If you are a Covered Roster Artist, your coverage will end on the date you are no longer a Covered Roster Artist, unless you qualify for coverage by meeting at least the minimum Covered Earnings requirement or one of the alternate requirements for Earned Eligibility described on pages 9-14.

Loss of Earned Eligibility - Dependents

In general, coverage for your Dependents ends when your coverage terminates – or sooner if a covered individual no longer qualifies as a Dependent. In the case of divorce, coverage for any individual who no longer qualifies as a Dependent will end on the date of the divorce. For any covered child who ages out of Dependent status, coverage ends on the last day of the month in which the individual turns 26. Any Dependents who lose eligibility for coverage may be eligible for one of the programs listed on the previous page.

In the event of your death during your Earned Eligibility Benefit Period, your covered Dependents may continue until the end of the Earned Eligibility Benefit Period that was accrued as a result of your reported Covered Earnings or employment, provided the Dependents pay the required Plan premium. Thereafter, coverage may be extended under the Surviving Dependant benefit or under one of the programs listed on the previous page. Please refer to Surviving Dependent eligibility on pages 28-29 for additional information.

Loss of Eligibility for Senior Performers Coverage

If you die while you have Senior Performers coverage, your covered Dependents will continue their health benefits until:

- The end of the month in which your death occurs, if your Dependents qualify for Surviving Dependent coverage. Surviving Dependent coverage will begin on the first day of the month which follows the month in which your death occurs; or
- The later of (i) the end of the calendar year in which your death occurs, or (ii) six months following your death, if your Dependents are not eligible for Surviving Dependent coverage.

Conversion of Life Insurance Benefit After Loss of Earned Eligibility – Plan I Only

A life insurance conversion policy is available through Metropolitan Life Insurance Company (MetLife) to Participants in Plan I who lose Earned Eligibility. If you are losing Plan I Earned Eligibility and gaining Senior Performers eligibility, you may convert $5,000 of your life insurance benefit. If you are not gaining Senior Performers eligibility, you may convert $10,000 of your life insurance benefit. However, if you have received an accelerated life insurance payment, the amount you may convert will be reduced by the amount of the benefit you have already received.

To convert your life insurance benefit as described above, you must submit an application and payment to MetLife within 31 days of the date you lose coverage. For applications call MetLife at (877) 275-6387.

Only the life insurance benefit may be converted when you lose Plan I eligibility. Health benefits, including accidental death and dismemberment benefits, are not eligible for conversion.

Loss of Surviving Dependent Eligibility

If you have extended coverage as a surviving spouse and you remarry, your coverage will end on the date you remarry.

Coverage for Dependent children will end when they no longer meet the Plan's definition of a Dependent (see page 18).

If your eligibility for the Surviving Dependent benefit ends, you and any covered Dependent children may be eligible for COBRA Continuation Coverage. See "Special Rules for Dependents" on page 39 for additional information.

Extended Coverage Opportunities

In accordance with federal law, the Plan provides Participants and covered Dependents an opportunity to extend their coverage under COBRA once their eligibility ends. This and other extended coverage opportunities are described on the pages that follow.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Coverage

When you lose Earned Eligibility because of a qualifying event, (defined under "What is COBRA Continuation Coverage?") you and your covered Dependents may choose to continue Plan benefits by enrolling in COBRA Continuation Coverage.

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. The length of time you are allowed to have COBRA Continuation Coverage depends on several factors, including which qualifying event caused the loss of Earned Eligibility.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What is COBRA Continuation Coverage?

COBRA Continuation Coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA Continuation Coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for that coverage.

Loss of coverage due to failure to pay the Plan premium is not a qualifying event, and neither is the termination of Earned Eligibility as the result of a contribution or Dependent verification audit. This means that COBRA Continuation Coverage is not available to you if your Earned Eligibility ends for these reasons.

You and your covered Dependents may have the right to COBRA Continuation Coverage when qualifying events occur as described below:

- As a Participant, you may qualify for COBRA Continuation Coverage under the Plan because of the following qualifying events:
  - You lose Earned Eligibility due to:
    - » a reduction in your Covered Earnings or Eligibility Days;
    - » a change in your qualification as a Covered Roster Artist; or
    - » the termination of your employment for any reason other than gross misconduct.
  - You change from Plan I to Plan II due to a reduction in your Covered Earnings.

- As a Dependent spouse or child, you may qualify for COBRA Continuation Coverage when you lose Earned Eligibility coverage under the Plan because of the following qualifying events:
  - The Participant loses Earned Eligibility due to:
    - » a reduction in his or her Covered Earnings or Eligibility Days;
    - » a change in his or her qualification as a Covered Roster Artist;
    - » the termination of his or her employment for any reason other than gross misconduct; or
    - » his or her death.
  - A change from Plan I to Plan II due to a reduction in the Participant's Covered Earnings.
  - A divorce from the Participant.
  - A loss of Dependent child status as defined by the Plan.

As a Dependent covered by the Plan when Earned Eligibility ends, you may be eligible to enroll individually in COBRA Continuation Coverage even if the Participant does not elect COBRA Continuation Coverage.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries after the Plan has been notified that a qualifying event has occurred. The employer must notify the Plan of the following qualifying events within 30 days of their occurrence: the end of employment, reduction of hours of employment or the death of the employee. For purposes of the Plan, generally notice of these qualifying events is required from employers of full-time Network/Station Staff and Covered Roster Artists.

You or your Dependents (depending on the circumstances) must notify the Plan in writing in the event of a divorce or a child's losing Dependent status under the Plan. Your Dependents may also want to notify the Plan in the event of your death, particularly if you were not a full-time Network/Station Staff, or a Covered Roster Artist.

For the Dependent to receive individual rights to COBRA Continuation Coverage, notification must be made within 60 days of the later of:

- The date the event occurred; or
- The date coverage terminates as a result of the qualifying event.

If you or your Dependents do not notify the Plan in writing within the required time period or if you do not submit the required documentation, the individual losing eligibility as a Dependent will forfeit his or her right to enroll in COBRA Continuation Coverage.

How Long is COBRA Continuation Coverage Provided?

Once the Plan receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA Continuation Coverage. Participants may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

COBRA Continuation Coverage is a temporary continuation of coverage that generally lasts for 18 months due to loss of Earned Eligibility. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Eighteen months of COBRA Continuation Coverage is available to Participants (and their covered Dependents) who lose eligibility or change from Plan I to Plan II due to a reduction in Covered Earnings or Eligibility Days, a change in the Participant's qualification as a Covered Roster Artist, or the termination of employment for any reason except gross misconduct. Participants who are entitled to Medicare prior to the date they lose Earned Eligibility should call the Plan at (800) 777-4013 for information concerning their maximum COBRA period.

Thirty-six months of COBRA Continuation Coverage are available to qualified Dependents who lose their Dependent status due to the death of a Participant, a divorce from a Participant or loss of Dependent child status as defined by the Plan.

There are ways in which the 18-month period of COBRA Continuation Coverage can be extended:

Social Security Disability Extension

If you or anyone in your family covered under the Plan is determined by Social Security to be totally disabled and you notify the Plan in a timely fashion, you and your entire family may be entitled to an additional 11 months of COBRA Continuation Coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. You must provide the Plan with a copy of your determination letter from the Social Security Administration before the 18-month period of COBRA Continuation Coverage expires in order to receive this extension.

Second Qualifying Event Extension

If your family experiences another qualifying event during the 18 months of COBRA Continuation Coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any Dependent children getting COBRA Continuation Coverage if the Participant dies, gets divorced, or if the Dependent child no longer meets the Plan's definition of a Dependent child. This extension is only available if the second qualifying event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Special Rules for Dependents

Individuals who became a Dependent after the Participant's enrollment (for example, in the case of marriage, birth or adoption) may be added to the Participant's coverage. However, except for newborn and adopted children, they will not be entitled to COBRA Continuation Coverage on an individual basis.

If your Dependents lose their status as eligible Dependents while you, the Participant, are enrolled in COBRA or Senior Performers coverage, they may also qualify for individual COBRA Continuation Coverage. Additionally, individual COBRA Continuation Coverage may be available if a Dependent loses Dependent status while enrolled in Surviving Dependent coverage. This would include situations in which a surviving spouse remarries.

Individual COBRA Continuation Coverage for your Dependents is only available if they were covered under the Plan on the date Earned Eligibility was lost and, if applicable, on the date Dependent status was lost. The maximum length of the individual Dependent COBRA Continuation Coverage is 36 months from the date Earned Eligibility was lost.

If you lose Earned Eligibility after you become entitled to Medicare, your Dependents will be entitled to COBRA Continuation Coverage. The maximum period of COBRA Continuation Coverage available will end on the later of:

- 18 months from the loss of your Earned Eligibility; or
- 36 months from your Medicare entitlement date.

Enrollment Options

If you lose Plan I Earned Eligibility, you will be offered a one-time opportunity to enroll in COBRA Continuation Coverage under either Plan I or Plan II. You may not change your selection after your enrollment is complete. If you lose Plan II Earned Eligibility you will be offered the opportunity to enroll in Plan II COBRA Continuation Coverage.

COBRA Continuation Coverage is identical to the coverage provided to Participants with Earned Eligibility for both Plan I and Plan II, except that

Important Note:

If your Earned Eligibility changes from Plan I to Plan II, you may choose COBRA Plan I coverage in lieu of Plan II Earned Eligibility coverage – but not both.

COBRA Participants are not entitled to life insurance or accidental death and dismemberment benefits.

Enrollment Process

When you lose Earned Eligibility, the Plan will send you a termination notice describing the available COBRA Continuation Coverage, along with enrollment materials. This is the time during which you can choose the Dependents you would like to cover and the corresponding premium. You can enroll Dependents who were not enrolled under your earned coverage, although these Dependents are not entitled to COBRA Continuation Coverage on an individual basis. If you do not enroll in COBRA Continuation Coverage following the loss of your Earned Eligibility, the Dependents that were covered under the Plan when your Earned Eligibility ended may enroll individually (and spouses may enroll their children with or without enrolling themselves), provided they enroll within the 60-day time limit described on this page.

COBRA enrollment forms may be downloaded from the forms section of **www.sagaftraplans.com/health**. Your completed COBRA enrollment form must be received by the Plan within 60 days of the later of:

- The date your coverage terminated; or
- The date of your COBRA enrollment offer.

You will have additional opportunities to change your Dependent enrollment during the annual Open Enrollment Period or if you experience a change in family status or other special enrollment qualifying event. See page 20 for coverage changes.

COBRA Premiums

The premium required for COBRA Continuation Coverage is based on the Plan for which you qualify (Plan I or Plan II) and the number of Dependents you choose to enroll. COBRA premium rates are determined in accordance with federal law and may change once per year – or more frequently if significant Plan changes occur. The premium is based on a three-tier structure: individual only, individual plus one Dependent or individual plus two or more Dependents.

The SAG-AFTRA Foundation offers financial grants to individuals who have a catastrophic illness or injury and who, due to financial need, cannot afford the COBRA premium. See page 34 for additional information.

Time Limit for First COBRA Premium Payment

Your first COBRA premium payment is due on the first day of the month immediately following the date on which your Earned Eligibility terminates. You are encouraged to submit your first payment with your Enrollment Form. However, you have 45 days from the last day of your 60-day enrollment period to make the payment. Coverage will not be granted and Claims will not be considered for payment until your premium is received.

Additionally, coverage will not be verified to any Hospital or Physician before your premium payment is received and processed, and Providers will be advised that you are still in your COBRA enrollment or grace period.

Your first payment must include all premiums required to keep your coverage continuous from the date you lost Earned Eligibility. For example, if you lost Earned Eligibility on December 31, and you make your first premium payment in February, your payment must include the premium for both January and February.

Once your premium is processed, your Notice of Coverage containing your health care ID cards will

be sent to you within 10 business days. You can also print health care ID cards by logging in to your Benefits Manager at **www.sagaftraplans.org/health**.

COBRA Premium Due Dates

After the Plan processes your COBRA enrollment, a confirmation letter and payment coupons will be mailed to you. You will be sent a new set of payment coupons annually. After your first payment, all subsequent premium payments are due on the first of each month. As required by federal law, there is a 30-day grace period following each due date. However, you should submit the payment by the due date, as coverage will not be granted and Claims will not be considered for payment until your premium is received and posted.

If you make a change in your COBRA Continuation Coverage, as outlined on the following page, you will receive new payment coupons which reflect your new coverage and premium amount. If you do not receive your coupons within 30 days after enrollment or a change in coverage, please contact the Plan. If you fail to pay your premium by the due date (plus the 30-day grace period) and you do not have an available late payment waiver, you will forfeit your rights to COBRA Continuation Coverage.

COBRA Premium Payment Procedures

There are several ways to pay your monthly COBRA Continuation Coverage premium. You may pay the premium for more than one month at a time. However, you may not pay the premium for any period beyond the current calendar year.

Automatic payment – The automatic payment plan deducts your monthly premium automatically each month from a U.S. checking or savings account. Payments are deducted on or about the 25th of the month prior to the due date on the 1st. The Plan will continue to deduct the monthly premium as long as you remain continuously eligible for COBRA Continuation Coverage, even if the premium changes. You can sign up online or download an enrollment form at **www.sagaftraplans.org/health**.

If you were previously enrolled in the automatic payment plan during your Earned Eligibility, your automatic payments will not continue under COBRA Continuation Coverage. You must complete a new enrollment form for automatic COBRA premium payments.

Pay online – You may pay your premium online with a check or a credit/debit card. Simply visit **www.sagaftraplans.org/health** and enter your checking or savings account number or your credit/debit card information. You will receive an email confirmation that your payment has been received.

For your protection, online payments and phone payments are non-recurring. This means the Plan will not automatically charge your credit card or debit your account everytime a payment is due. For recurring payments that you do not have to initiate, choose the automatic payment option.

Pay by phone – You may pay your premium by telephone 24/7 with a credit/debit card by calling the Plan at (800) 777-4013 and following the prompts. You will receive a confirmation number indicating your payment has been received. For your security, this is an automated system; Plan staff will not be able to take your credit card information.

Pay by mail – Make your check, money order or cashier's check from a U.S. bank payable to the SAG-AFTRA Health Plan and send it with your coupon in the envelope provided to the address below.

SAG-AFTRA Health Plan
Payment Center
P. O. Box 30110
Los Angeles, CA 90030-0110

To help ensure that your premium payment is processed correctly, please write your SAG-AFTRA Health Plan health care ID number (found on your premium billing statement) on your check. Your payment must be received no later than the due date to be on time.

Do not send your payment to the Plan's regular mailing address or to the SAG-AFTRA union office.

Any check or debit returned to the Plan for any reason will be assessed a fee. You may replace the premium payment and pay the fee using any of the other payment options described previously.

COBRA Late Payment Waiver

If your COBRA Continuation Coverage is terminated because your payment was not received by the due date, including the 30-day grace period, you can reinstate your coverage by using a late payment waiver within 60 days after the premium due date. The Plan allows one late payment waiver per COBRA Continuation Coverage period.

To use a late payment waiver, simply make your payment:

- Online at **www.sagaftraplans.org/health**;
- By phone at (800) 777-4013; or
- By submitting your payment with your billing coupon.

You must include payment for all the months required to bring your account current. When your payment is received after the grace period, the Plan will apply your late payment waiver (if available) and your coverage will be reinstated retroactively.

COBRA Continuation Coverage Changes

Annual Open Enrollment

If you are enrolled in COBRA Continuation Coverage, your Benefit Period is January 1 through December 31 and your Open Enrollment Period will generally occur from December 1 through January 15. During open enrollment you will have an opportunity to change your Dependent enrollment. You can make these changes by visiting the Plan's website at **www.sagaftraplans.org/health** or by completing the Dependent Enrollment Form you receive in your open enrollment packet and returning it to the Plan.

Change in Family Status

You may make Dependent enrollment changes outside of the Open Enrollment Period if you have a change in family status. A change in family status is defined as an increase or decrease in the number of your Dependents, which results from birth, adoption, marriage, divorce, death or loss of Dependent "child" status as defined by the Plan.

If one of these events occurs you will be permitted to change your Dependent's enrollment status and change your premium tier, if applicable. Submit a written request within 60 days of the change in family status along with the documents establishing proof of Dependent status (see page 19 for proof documents and pages 20-21 for special enrollment opportunities). Once the Plan receives your request and required documentation, your change will be processed and you will receive a new set of billing coupons and health care ID cards to confirm your new coverage and premium rate.

Coordinating COBRA Benefits With Other Plans

You and your Dependents may enroll in COBRA Continuation Coverage even if you or your Dependents are covered by another group health plan on the date Earned Eligibility is terminated in this Plan. You should contact the Plan to determine which plan will be primary and secondary.

If your Earned Eligibility changes from Plan I to Plan II, you may choose COBRA Plan I coverage in lieu of Plan II Earned Eligibility coverage – but not both.

If you or your spouse is covered by Medicare, you may also enroll in COBRA Continuation Coverage. **Medicare will be your primary plan and this Plan will be your secondary plan**. Please see the section on "Coordination of Benefits with Medicare," pages 99-101 for important information on how your benefits will be affected if you do not enroll in Medicare when you are eligible to do so.

Termination of COBRA Continuation Coverage

Your COBRA Continuation Coverage will terminate on the earlier of:

- The first of the month for which you do not pay your premium by the due date;
- The first of the month after the month in which Social Security determines you are no longer totally disabled if your extended COBRA Continuation Coverage is based on you being totally disabled;
- The first of the month following the expiration of the maximum COBRA Continuation Coverage period for which you qualify;
- The first of the month for which you qualify for Earned Eligibility, unless you have enrolled in Plan I COBRA Continuation Coverage and your Earned Eligibility is for Plan II; or
- The date on which the Plan no longer provides health coverage.

Total Disability Extension

If you or your enrolled Dependent is considered Totally Disabled when Earned Eligibility or COBRA Continuation Coverage ends, the disabled individual may be entitled to an extension of coverage for a maximum of 12 months beginning with the first month following the month that existing coverage ends. The disabled individual must pay the required Plan premium, as outlined on pages 30-33. If the disabled individual qualifies for Medicare, he or she must enroll in Medicare Parts A and B. The Plan will pay benefits as if Medicare was the primary coverage even if the disabled individual does not enroll in Medicare (see pages 99-101).

Coverage is available under this provision only if the disabled individual is considered Totally Disabled as defined by the Plan and is not covered by any other group health plan, with the exception of Medicare. If you lose Earned Eligibility in Plan I but satisfy one of the Plan II requirements, you are not entitled to the Plan I total disability extension (because you are eligible under Plan II).

All requests for the total disability extension must be approved by the Plan's medical consultant.

Total Disability Coverage Benefits

Only the disabled individual may be covered under the total disability extension. Other family members are not covered. However, family members may be entitled to coverage under COBRA.

How the Plan Defines "Totally Disabled"

An adult Participant or adult Dependent is "Totally Disabled" if he or she is prevented, solely because of sickness or accidental bodily injury, from performing the material and substantial duties of his or her regular occupation. A minor Participant or minor Dependent is "Totally Disabled" if he or she is presently suffering from a sickness or accidental bodily injury, the effects of which are likely to be of long or indefinite duration and which will prevent him or her from engaging in most of the normal activities of a person of like age and sex in good health.

Special Grandfathering Rule for Those With a Total Disability Extension of Health Coverage From the AFTRA Health Plan or the SAG-Producers Health Plan

If, as of December 31, 2016, you are receiving health coverage under the total disability provision of either the AFTRA Health Plan or the SAG-Producers Health Plan, you will be eligible to continue coverage under the SAG-AFTRA Health Plan through the end of the maximum total disability coverage period allowed under your prior plan.

For the most part, the disabled individual will be entitled to the same benefits that he or she was receiving prior to the disability – Plan I or Plan II. For Participants, this includes life insurance (in Plan I only) and accidental death and dismemberment benefits. However, dental benefits are not included with disability coverage, nor may they be paid for separately.

Length of Total Disability Coverage Extension

The total disability extension is available for a maximum of 12 months and will be granted only once for the same disability. If you regain Earned Eligibility during extended disability coverage, you will be able to use any remaining months of the total disability extension when you subsequently lose Earned Eligibility, provided that you are still considered Totally Disabled from the same disability. This provision also applies to Dependents on the total disability extension.

If you recover from one disability, regain Earned Eligibility, and subsequently become Totally Disabled from a new and different disability, you will be entitled to another 12 months of total disability extension for the new disability.

If your total disability ends during the middle of the month, as commonly occurs in the case of pregnancy, you must pay the full monthly Plan premium. The amount will not be prorated.

Option to Choose COBRA Continuation Coverage or Total Disability Extension

If you or your Dependent is Totally Disabled at the time Earned Eligibility ends, you have two choices for coverage as described below:

- **Option 1** – Enroll in COBRA Continuation Coverage
  If this option is selected, the Totally Disabled individual may continue coverage under the total disability extension when the maximum number of months of COBRA Continuation Coverage have elapsed – provided he or she is still considered Totally Disabled and is not covered under another group health plan.

- **Option 2** - Elect coverage under the total disability extension
  If this option is chosen, the disabled individual may continue coverage under COBRA when the maximum number of total disability extension months have elapsed.

If you choose Option 2 and your Dependents do not enroll in COBRA Continuation Coverage while you are covered under the total disability extension, they may be added to your COBRA Continuation Coverage following the total disability extension.

If you choose Option 2 and you gain Dependents during the 12-month period, you may change your coverage from the disability coverage – which does not include Dependent coverage – to COBRA Continuation Coverage. However, in doing so, you will forfeit the remaining months of coverage under the total disability extension, and you will not be entitled to return to disability coverage after your COBRA Continuation Coverage ends (unless you become Totally Disabled due to a new disability).

Extended Coverage for Military Service

In accordance with the Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA), the Plan provides certain benefits for Participants who have military service. Congress enacted USERRA to provide protection to individuals who are members of the uniformed services. Uniformed services are defined as:

- The Armed Forces, Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training or full-time National Guard duty;
- The Commissioned Corps of the Public Health Services; and
- Any other category of persons designated by the president in time of war or national emergency.

You will have the choice of using your Earned Eligibility before continuing coverage under COBRA. Alternatively, you may immediately enroll in COBRA Continuation Coverage and freeze your Earned Eligibility for up to five years of uniformed service. In either case, the Earned Eligibility or COBRA premium will be waived for up to 24 months while you are in military service.

Upon your return from military service, you may use any frozen Earned Eligibility that remains, provided you notify the Plan of your intent to resume coverage and that coverage is resumed within one year of your return from uniformed service. Please contact the Plan for additional information if you are going to serve or have served in the military.

VIII. Benefits Under the SAG-AFTRA Health Plan

Terms to know for Section VIII:

Please refer to the Glossary on pages 129-133 for definitions of these and other capitalized key terms.

Allowable Charges/Allowance

Case Management

Claim

Coinsurance

Contract Rate

Copay

Cosmetic Surgery

Covered Expenses

Custodial Care

Deductible

Dentist

Durable Medical Equipment (DME)

Experimental or Investigative Procedure

Explanation of Benefits (EOB)

Hospital

In-network Level of Benefits

In-network Provider

Medically Necessary/Medical Necessity

Out-of-network Provider

Physician

Provider

The Plan provides an extensive package of benefits that help you pay for everyday medical costs and wellness services, as well as expenses resulting from illness or injury. Both Plan I and Plan II pay toward covered Physician charges, Hospital and surgical expenses, laboratory and radiology charges, mental health and substance abuse treatment and prescription drugs, among other medical expenses. Plan I and Plan II differ, however, in certain aspects with regard to the extent of the benefits available for these expenses.

The Plan's benefits are subject to the exclusions and limitations described throughout this SPD. Services also must be Medically Necessary in order to be covered. As such, the Plan's benefits may not cover all treatment prescribed by your Physician.

The Plan's Provider Networks Offer Savings and Convenience

For medical and Hospital care, the Plan uses the Anthem Blue Cross Preferred Provider Organization (PPO) network, which includes the nationwide BlueCard PPO network. Physicians and facilities within The Industry Health Network (TIHN), operated by UCLA Health, are also In-network Providers under the Plan. Beacon Health Options provides the network for mental health and substance abuse care. Additionally, Express Scripts, Delta Dental and VSP provide the networks for pharmacy, dental and vision care respectively.

The Plan's Hospital Benefit Is Limited to Care From In-network Hospitals Only

This means you must seek medical care from Hospitals in the BlueCard PPO or TIHN networks to receive coverage. **No coverage will be provided for services provided by out-of-network Hospitals and facilities under any circumstances, except for emergencies as described on page 52.** Similarly, inpatient and alternative levels of care for mental health and substance abuse services are limited to facilities within the Beacon Health Options network, except for emergencies, as described on page 52.

For outpatient services covered under the medical benefits, the Plan pays different levels of benefits for services from In-network and Out-of-network Providers. As such, you minimize out-of-pocket costs by using Providers within the Plan's networks.

When you choose In-network Providers, in addition to receiving a higher level of benefits, you will also avoid surprises like "balance billing" for amounts over the Allowable Charge. Balance billing occurs when a Provider bills you for an amount above the Plan's Allowance. While In-network Providers are contractually prohibited from balance billing you, the practice is common when you receive care from Out-of-network Providers. Some states have protections for patients against such surprise billing by Out-of-network Providers, but you can avoid balance billing by using In-network Providers. Choosing In-network Providers saves money for you and the Plan, which benefits all Participants.

In-network Providers also offer the convenience of completing and submitting Claims for you. All you must do is verify that the Provider is in the network prior to each visit (go to **www.sagaftraplans.org/health** for links to the most up-to-date online Provider directories) and show your health care ID card when you arrive for your appointment. The Provider will also usually collect your Copay at this time.

After the Claim is processed, the Plan's payment will be made directly to the Provider. You will receive a notification from the Plan that the payment has been made, which is called an Explanation of Benefits (EOB). EOBs are not bills. They simply provide information to help you understand how your Claims are processed.

Remember that just because you obtain care from an In-network Provider, it does not mean all services are automatically covered. If you have questions regarding coverage for a particular procedure, treatment, diagnostic test or medical supply item, contact the Plan at (800) 777-4013.

Plan Ahead to Avoid Surprises When Using Out-of-network Providers

Seeking care outside of the Plan's networks can be costly since Out-of-network Providers may charge whatever they wish for services. However, if you choose to use Out-of-network Providers, the FAIR Health website offers helpful information and planning tools. The FAIR Health site estimates your potential medical expenses based on actual Provider charges in your local area.

www.fairhealthconsumer.org

FAIR Health is a national independent, not-for-profit corporation whose database of medical and dental services powers a free website for consumers. You can use this tool to get a real-world cost estimate that you can use to gain an informed understanding of how much you might need to pay in out-of-network costs for specific treatments and procedures.

It is important to note, however, that some Out-of-network Providers charge far more than the FAIR Health amount. It is important to ask your Provider how much he or she will charge for a service or procedure before services are rendered.

Also note that the FAIR Health site does not take into account the Plan's benefits, limitations or exclusions. Therefore, you must treat the information as an estimate only.

In addition to the BlueCard PPO and TIHN networks for Hospital and medical care, the Plan also uses other networks of preferred Providers for different benefits, as described below. Providers in all of these networks are credentialed and carefully monitored to ensure that they continue to meet high professional standards and that they provide appropriate care.

- **Medical and Hospital Care**
  The Anthem Blue Cross / BlueCard PPO network nationwide
  (800) 810-BLUE (2583)
  www.sagaftraplans.org/health
  ("Find In-network Providers")

  The Industry Health Network (TIHN)
  (800) 876-8320
  www.uclahealth.org/mptf/locations

- **Mental Health and Substance Abuse Services**
  Beacon Health Options
  (866) 277-5383
  www.achievesolutions.net/sag-aftra

- **Prescription Drugs, Including Specialty Drugs Through Accredo, Express Scripts' Specialty Pharmacy**
  Express Scripts
  (800) 903-4728
  www.express-scripts.com

- **Dental Care**
  Delta Dental
  (800) 846-7418
  www.deltadentalins.com/sag-aftra

- **Vision Care**
  Vision Service Plan (VSP)
  (800) 877-7195
  www.vsp.com

- **Smoking Cessation**
  Optum's Quit for Life®
  (866) QUIT-4-LIFE ((866) 784-8454)
  www.quitnow.net/sag-aftra

If you need Hospital or medical services and the nearest two BlueCard PPO Providers of any type are more than 25 miles from where you live, you are considered to be outside a network area; as such, you will receive the Plan's In-network Level of Benefits for these services even when obtained from Out-of-network Providers. However, if you travel to an in-network area, you must use In-network Providers to obtain the higher level of benefits. These same rules apply if you need mental health or substance abuse treatment and live more than 25 miles from two facilities or Providers of any type who participate in the Beacon Health Options network.

If an individual who lives in an in-network area is being treated for a serious condition that requires a specialist's care, and there are no in-network specialists in his or her area, the individual will receive the In-network Level of Benefits for services rendered by that specialist. Conditions such as cancer, cardiac disease, eating disorders and schizophrenia are considered serious conditions under this provision. It does not include situations of a non-serious nature, such as those requiring chiropractic services, acupuncture services or treatment for generalized anxiety disorder. The preference for a Provider who will be present during a home birth also does not qualify as a serious condition. In order for you to receive the In-network Level of Benefits for home births, the Provider must be an In-network Provider.

You are responsible for the lower in-network Deductibles, Copays and Coinsurance – plus the difference between the Plan's Allowance and the billed amount. For Out-of-network Providers, the Plan's Allowance will be used to determine the amount the Plan will consider in determining the benefits payable, instead of the lower in-network contracted amount which is used for In-network Providers. While Plan staff will do its best to answer any questions you have concerning the Plan's Allowance over the phone, you may not rely on any information obtained in that manner. Only information in writing signed on behalf of the Board of Trustees can be considered official.

Important Note:

The Providers in these networks can change on an ongoing basis. New Providers are added and sometimes other Providers drop out. Some Providers offer services at more than one location and not all locations may be in-network. Also, not all Providers within a facility or practice may participate in the network. It is your responsibility to make sure that the Provider you are using is in the network at the location where you receive services at the time you receive care.

The Industry Health Network (TIHN)

The Plan has also contracted with The Industry Health Network (TIHN), UCLA's network of area Hospitals, specialists and primary care Physicians centered around UCLA/Motion Picture & Television Fund (MPTF) Health Centers. It is available to all Participants and covered Dependents, although its Health Centers are located only in Southern California. Its network of Physicians and outpatient Health Centers offers the least expensive option for quality care because when you use a TIHN primary care Physician (PCP), the Plan's annual Deductible does not apply. Also, if you use TIHN facilities for non-emergency care, you will have a lower annual Hospital Deductible. Please note that TIHN facilities do not provide emergency care.

To take advantage of these benefits, make an appointment with a PCP at one of the UCLA/MPTF Health Centers. The PCP will coordinate your care and, if necessary, will refer you to a specialist in TIHN. Without the PCP's referral, TIHN level of benefits will not apply. This means you will have higher Deductibles. You must see the PCP in person to receive a referral to a specialist; you cannot just call the PCP.

In order to receive services through UCLA/MPTF Health Centers you must be at least 13 years of age. For children under 13, you may obtain a TIHN referral to a pediatrician by calling TIHN customer service at (800) 876-8320.

To establish a relationship with a PCP, please contact one of the conveniently located Health Centers and make an appointment.

Bob Hope Health Center
335 North La Brea Avenue
Los Angeles, CA 90036
(323) 634-3850

Jack H. Skirball Health Center
MPTF Wasserman Campus
23388 Mulholland Drive
Woodland Hills, CA 91364
(818) 876-1050

Santa Clarita Health Center
25751 McBean Parkway, #210
Valencia, CA 91355
(661) 284-3100

Simi Valley Health Center
2655 First Street, #360
Simi Valley, CA 93065
(805) 583-7640

Toluca Lake Health Center
4323 Riverside Drive
Burbank, CA 91505
(818) 556-2700

Westside Health Center
1950 Sawtelle Boulevard, #130
Los Angeles, CA 90025
(310) 996-9355

Comprehensive Out-of-pocket Maximum

	PLAN I		PLAN II	
	In-network	Out-of-network	In-network	Out-of-network
2017 Comprehensive Out-of-pocket Maximum	$7,150 per person; $14,300 per family	No maximum	$7,150 per person; $14,300 per family	No maximum

The comprehensive out-of-pocket maximum is the maximum amount you could pay in any calendar year — including all Copays, Coinsurance and Deductibles — for Hospital, medical, prescription drugs, mental health and substance abuse services from In-network Providers under the Plan. There is no comprehensive out-of-pocket maximum for out-of-network care. The Plan's comprehensive out-of-pocket maximum is set in accordance with the Affordable Care Act (ACA) and updated annually.

If your eligibility changes from Plan I to Plan II during a calendar year, any charges that applied toward your comprehensive out-of-pocket maximum under Plan I will apply toward your Plan II comprehensive out-of-pocket maximum. If your eligibility changes from Plan II to Plan I during a calendar year, the reverse is also true.

Hospital Benefits (Including Mental Health and Substance Abuse)

HOSPITAL BENEFITS AT-A-GLANCE	PLAN I		PLAN II	
In-network Coverage Only (Except for Emergencies)	TIHN	BlueCard PPO/ Beacon Health Options	TIHN	BlueCard PPO/ Beacon Health Options
Deductible	$150 per person; $300 per family	$250 per person; $500 per family	$150 per person; $300 per family	$500 per person; $1,000 per family
Copays	$100 per admission; $100 per outpatient surgery; $100 per emergency room visit[5]; the emergency room Copay is waived if patient is immediately confined		$100 per admission; $100 per outpatient surgery; $100 per emergency room visit[5]; the emergency room Copay is waived if patient is immediately confined	
Plan Pays	90% of Contract Rate		80% of Contract Rate	
Your Coinsurance	10% of Contract Rate		20% of Contract Rate	
Coinsurance Out-of-pocket Limit	$1,750 per person; $3,500 per family		$2,000 per person; $4,000 per family	

[5] TIHN benefits are not available for emergency room care.

The Plan uses the national BlueCard PPO network (through a contract with Anthem Blue Cross of California) and The Industry Health Network (TIHN) for all Hospital benefits except mental health and substance abuse care. The Plan uses the Beacon Health Options network for mental health and substance abuse benefits. Out-of-network Hospital services are covered only in the event of an emergency. See the following page for a description of emergency treatment and when coverage for services from Out-of-network Providers may be available.

Annual Hospital Deductible

Hospital charges are subject to an annual Deductible based on the calendar year. The Hospital Deductible is separate from the Deductibles for the other benefits provided by the Plan, such as the medical, prescription drug and dental Deductibles.

As outlined in the table on the previous page, the amount of the Hospital Deductible varies depending on which network you use and whether you are covered under Plan I or Plan II.

The family Deductible is satisfied when at least two or more family members have combined Covered Expenses that exceed the amount of the family Deductible in a calendar year. However, the Plan will not apply more than the individual Deductible amount to any one family member. For example, if a Plan I Participant has a spouse and a child who each have a BlueCard PPO Hospital stay in the same year, the $500 family Deductible is satisfied once the family has paid a total of $500 in Covered Expenses. However, the Plan will not apply more than $250 (the amount of the individual Deductible) toward the Deductible for either the spouse or the child.

The Plan applies Covered Expenses toward your Deductible as it processes Claims, rather than according to the date of service. Providers submit their Claims in accordance with their own billing schedules, and Claims are frequently received out of order with regard to date of service, particularly when multiple Providers are used.

If you go to a Hospital for emergency treatment, your Deductible is based on the BlueCard PPO Deductible. This Deductible applies even if you called or visited TIHN first and they told you to go to the emergency room. The Hospital Deductible for TIHN applies only to non-emergency Hospital care received through TIHN facilities.

If your eligibility changes from Plan I to Plan II during a calendar year, any charges that applied toward your Deductible under Plan I will apply toward your Plan II Deductible. If your eligibility changes from Plan II to Plan I during a calendar year, the reverse is also true.

Copays, Coinsurance and Out-of-Pocket Limits

There is a $100 Copay required when you use the Hospital as an inpatient, for outpatient surgery, or in the emergency room. Once the Copays and Deductible are satisfied, the Plan provides reimbursement of Covered Expenses from in-network Hospitals based on the percentage shown in the table on the previous page. You are responsible for the Coinsurance amount.

The Coinsurance out-of-pocket limit is the maximum amount you and your family could pay for Covered Expenses during a calendar year after your Deductible and Copays are satisfied. For example, a single Plan I Participant who has met his or her Hospital Deductible and Copays is responsible for 10% of the first $17,500 of covered in-network Hospital expenses during the year, or $1,750 as Coinsurance.

When you have paid your Deductible and the maximum Coinsurance amount, the Plan will reimburse 100% of Covered Expenses for the remainder of the year, with the exception of Hospital Copays. Your total in-network out-of-pocket expenses are also limited by the comprehensive out-of-pocket maximum described on the previous page.

If your eligibility changes from Plan I to Plan II during a calendar year, any charges that applied toward your Coinsurance out-of-pocket limit under Plan I will apply toward your Plan II out-of-pocket limit. If your eligibility changes from Plan II to Plan I during a calendar year, the reverse is also true.

Emergency Care Under the Hospital Benefit

An emergency is the sudden and unexpected onset of an injury or illness that is acute and that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, permanent impairment to bodily functions or permanent dysfuntion of a body part in the absence of immediate medical attention. Examples of emergencies include but are not limited to, uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones.

Emergency treatment at in-network and out-of-network Hospitals is covered within 72 hours after an accident or within 24 hours of a sudden and serious illness.

The Hospital Copay applies when you visit the emergency room. Only one Copay will apply if you are hospitalized immediately for the same accident or illness.

If you are admitted to an out-of-network Hospital due to an emergency, you or the Hospital should call the applicable network listed below within 48 hours to report the emergency admission and request authorization for coverage.

- For an emergency admission to a Hospital for medical care, call Anthem Blue Cross at (800) 274-7767.
- For an emergency admission to a Hospital for mental health or substance abuse treatment, call Beacon Health Options at (866) 277-5383.

Covered Hospital Benefits

The Plan's Hospital benefits cover facility charges for medical and surgical treatment as well as mental health and substance abuse treatment. Like medical and surgical treatment, mental health and substance abuse treatment is covered for a vast number of conditions. Among them are anxiety, stress, eating disorders, depression, bipolar disorders, psychosis, schizophrenia and substance abuse (alcohol and/or other drugs). If you have a question about a particular condition and whether coverage is provided:

- For medical or surgical treatment, contact the Plan at (800) 777-4013 or **www.sagaftraplans.org/health**.
- For mental health or substance abuse treatment, contact Beacon Health Options at (866) 277-5383 or **www.achievesolutions.net/sag-aftra**.

The Plan's Hospital benefits include coverage for the services listed below.

- Emergency treatment for services which are billed by the Hospital and listed on its statement of charges. Any services that are not included on the Hospital bill and are billed separately, such as Physicians' or surgeons' charges, may be covered under the medical benefits. Urgent care center charges may also be covered under the medical benefits.
- In-network alternative levels of mental health and substance abuse care:
  - Residential treatment center – Treatment that is provided in a 24-hour non-medical facility.
  - Partial Hospital program – Treatment that is provided for 6 – 8 hours per day.
  - Intensive outpatient program – Treatment that is provided for 2 – 3 hours per day.
- In-network birthing centers. Charges for out-of-network birthing centers may be covered under the medical benefits.
- In-network outpatient Hospital treatment for diagnostic services and therapy such as x-rays, imaging tests, physical therapy and chemotherapy.
- Inpatient hospice care provided by an in-network Medicare-certified hospice program, when an individual is terminally ill with a life expectancy of less than 12 months. Hospice benefits are not subject to the Deductible. Outpatient hospice care may be covered under the medical benefits.
- Outpatient surgery in an in-network Hospital, surgical suite or ambulatory surgical center, including charges for services connected with surgeries that are billed by the facility. Services not billed by the facility and charges at an out-of-network surgical suite or at a surgical center may be covered under the medical benefits.

- Semi-private room, board, Hospital services and supplies for acute care for a covered diagnosis at in-network Hospitals. For stays in a private room, the Plan pays the in-network Hospital's most common semi-private room rate. You are responsible for the difference between the private and the semi-private room rates.

In-network Hospital services and supplies considered for coverage include the following:

- Administration of blood or blood plasma (the actual charge for blood is covered under the medical benefits).
- Anesthesia.
- Cardiac testing.
- Drugs and medicines.
- Intensive care.
- Medical supplies and devices, splints, casts and dressings.
- Operating, delivery, treatment and recovery rooms.
- Oxygen.
- Physiotherapy and hydrotherapy.
- Special diets.
- Staff nursing care.
- X-rays, imaging tests, laboratory exams and pathology exams.

Hospital Stays for Delivery of a Child and Maternity Care

A Hospital stay related to childbirth, miscarriage, ectopic pregnancy or premature termination of pregnancy is only covered if the patient is a Participant or the spouse of a Participant. A newborn's ordinary nursing care in the Hospital is also covered, but only if the newborn is the Participant's dependent. For pregnant Dependent children, only Hospital charges for treatment in connection with complications of pregnancy are covered. Complications of pregnancy do not include the elective termination of a pregnancy.

For any Hospital stay in connection with childbirth, in accordance with federal law, the Plan does not restrict inpatient stay benefits to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or the newborn's attending Physician from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable) if the mother and newborn are healthy, and after consulting with the mother.

In any case, the Plan does not require that a Provider obtain authorization from the Plan for prescribing a length of stay that does not exceed 48 hours (or 96 hours, for a Cesarean section).

Non-Covered Hospital Expenses

The following are not covered under the Plan's Hospital benefits:

- All expenses for out-of-network Hospital services, except for emergency treatment as described on the previous page.
- A stay in a facility or Hospital that is not registered as a general Hospital by the American Hospital Association and does not meet accreditation standards of the Joint Commission on Accreditation of Hospitals, except for facilities that provide alternative levels of care for the treatment of mental health and substance abuse as outlined on the previous page.
- A stay primarily for diagnostic tests, pulmonary tuberculosis, convalescent care, rest or Custodial Care.
- A stay primarily for physical or rehabilitative therapy. If a patient is transferred to a Hospital's rehabilitation wing (either from the same acute care Hospital or from another acute care Hospital), and the care is still considered acute care, the Plan may consider benefits.
- Care that is covered under other Plan benefits, such as ambulance, blood and blood plasma, x-ray or radiation therapy, special braces, appliances or equipment, or outpatient care.
- Christian Science homes or sanitariums.
- Convalescent facilities.
- Charges in connection with Cosmetic Surgery, except under the limited circumstances described on page 56.

- Out-of-network birthing centers (limited coverage is provided under the medical benefits).
- Outpatient hospice care (covered under the medical benefits).
- Personal comfort items, such as a television or telephone.
- Physician's surgical suite or an out-of-network surgery center (limited coverage is provided under the medical benefits).
- Private duty nursing for care that would normally be provided by the Hospital's nursing staff.
- Services provided by Physicians, surgeons or anesthesiologists not employed by the Hospital (covered under the medical benefits).
- Services of technicians and other vendors not employed by the Hospital.
- Skilled nursing facilities. If a patient is transferred to a skilled nursing facility from an acute care Hospital and the care is still considered acute, the Plan may consider benefits.
- Urgent care centers (covered under the medical benefits).

For other non-covered services, refer to the general exclusions listed on pages 89-91.

Medical Benefits (Including Mental Health and Substance Abuse)

MEDICAL BENEFITS AT-A-GLANCE	PLAN I		PLAN II	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Deductible	TIHN – No Deductible BlueCard PPO/ Beacon Health Options – $250 per person; $500 per family	$500 per person; $1,000 per family	TIHN – No Deductible BlueCard PPO/ Beacon Health Options – $500 per person; $1,000 per family	$1,000 per person; $2,000 per family
Office Visit Copay	$25	None	$25	None
Plan Pays	Preventive and wellness – Deductible and Copays waived; 100% of Contract Rate Office visits – Deductible waived; 100% of Contract Rate Other services – 90% of Contract Rate	70% of Plan's Allowance	Preventive and wellness – Deductible and Copays waived; 100% of Contract Rate Office visits – Deductible waived; 100% of Contract Rate Other services – 80% of Contract Rate	60% of Plan's Allowance
Your Coinsurance	Preventive, wellness and office visits – None Other services – 10% of Contract Rate	30% of Plan's Allowance[6]	Preventive, wellness and office visits – None Other services – 20% of Contract Rate	40% of Plan's Allowance[6]
Coinsurance Out-of-pocket Limit	$1,000 per person; $2,000 per family	$2,500 per person; $5,000 per family	$1,200 per person; $2,400 per family	$3,000 per person; $6,000 per family

[6] Additionally, Out-of-network Providers may charge you the difference between their charges and the Plan's Allowance (balance billing). This amount does not apply toward your Coinsurance limit.

The Plan uses the BlueCard PPO network and The Industry Health Network (TIHN) for all in-network medical benefits, except for mental health and substance abuse care. The Plan uses Beacon Health Options In-network Providers for mental health and substance abuse care. Out-of-network services are also covered under these benefits.

Annual Medical Deductible

Services covered under the medical benefits are subject to an annual Deductible based on the calendar year. The medical Deductible is separate from the Deductibles for other benefits provided by the Plan, such as the Hospital, prescription drug and dental Deductibles.

As outlined in the table on the previous page, the amount of the medical Deductible varies depending on whether or not you use In-network Providers, and whether you are covered under Plan I or Plan II.

The family Deductible is satisfied when two or more family members have combined to pay the amount of the family Deductible in Covered Expenses in a calendar year. However, the Plan will not apply more than the individual Deductible amount to any one family member. Refer to the example on page 51.

The Plan applies Covered Expenses toward your Deductible as it processes Claims, rather than according to the date of service. Providers submit their Claims in accordance with their own billing schedules, and Claims are frequently received out-of-order with regard to the date of service, particularly when multiple Providers are used.

If your eligibility changes from Plan I to Plan II during a calendar year, any charges that applied toward your Deductible under Plan I will apply toward your Plan II Deductible. If your eligibility changes from Plan II to Plan I during a calendar year, the reverse is also true.

Copays, Coinsurance and Out-of-pocket Limits

Once you have satisfied the annual Deductible, the Plan will provide reimbursement of Covered Expenses as shown in the table on the previous page. You are responsible for the applicable Copays and Coinsurance.

The Coinsurance out-of-pocket limit is the maximum amount you will have to pay for Covered Expenses during the calendar year after your Deductible and Copays are satisfied. For example, a Plan II Participant who is single and who has satisfied his or her Deductible and applicable Copays is responsible for 20% of the first $6,000 of covered in-network medical expenses, or $1,200 as Coinsurance.

When you have paid your Deductible, applicable Copays and the maximum Coinsurance amount, the Plan will pay 100% of Covered Expenses, with the exception of in-network office visit Copays. Your total in-network out-of-pocket expenses are also limited by the Comprehensive Out-of-pocket Maximum described on page 50.

If your eligibility changes from Plan I to Plan II during a calendar year, any charges that applied toward your Coinsurance out-of-pocket limit under Plan I will apply toward your Plan II out-of-pocket limit. If your eligibility changes from Plan II to Plan I during a calendar year, the reverse is also true.

Medical Benefits

The Plan's medical benefits provide coverage for medical and surgical treatment as well as mental health and substance abuse treatment. Like medical and surgical treatment, mental health and substance abuse treatment is covered for a vast number of conditions. Among them are anxiety, stress, eating disorders, depression, bipolar disorders, psychosis, schizophrenia and substance abuse (alcohol and/or other drugs). If you have a question about a particular condition and whether coverage is provided:

- For medical or surgical treatment, contact the Plan at (800) 777-4013 or **www.sagaftraplans.org/health**.
- For mental health or substance abuse treatment, contact Beacon Health Options at (866) 277-5383 or **www.achievesolutions.net/sag-aftra**.

The Plan's medical benefits include coverage for the following:

- Ambulance services for **emergency transportation** to or from the **nearest** Hospital that has the facilities to treat your medical problem. Services provided to relocate a patient for family or personal convenience are not covered.

- Anesthesia services, including administration of anesthesia. See page 60 for anesthesia limits for colonoscopies and upper gastrointestinal endoscopies.
- Artificial limbs and eyes, crutches, splints, casts and braces, surgical dressings, and medical supplies when prescribed by a Physician, including:
  - Prosthetic appliances, such as artificial limbs or eyes needed for the initial replacement of natural limbs or eyes, and subsequent replacements that are functionally necessary (does not include dental appliances);
  - An initial pair of orthopedic or corrective shoes following surgery; and
  - Orthopedic or corrective shoes for children under 12 (two pairs covered each calendar year).
- Birth control for women, including Norplant, intrauterine devices (IUDs) and Depo-Provera. Birth control received from an In-network Provider is not subject to the Deductible or Coinsurance. (Birth control pills, diaphragms, vaginal rings and patches are covered by the Plan's prescription drug benefits through Express Scripts.)
- Blood and plasma, except protein rich plasma.
- Breast implant removal when Medically Necessary due to pain from contracture or rupture of an implant. The Plan will consider the cost to remove the implant, but not the cost of a replacement implant or reconstruction. Benefits are payable for a maximum of one surgery per breast per lifetime. This limit does not apply to breast surgeries resulting from cancer treatment. Please see pages 62-63 for surgery pre-authorization requirements.
- Breast pumps, when rented or purchased from an In-network Provider. Total rental payments are limited to the Plan's Allowance for purchases. Breast pumps are not subject to the Deductible or Coinsurance and are limited to one pump per birth.
- Cardiac and cerebrovascular rehabilitative therapy. Benefits are payable for a maximum of three months if such therapy commences within six months of a clinical cardiac or CVA (cerebrovascular accident) episode.
- Certified nurse practitioner services, when the nurse is acting within the scope of his or her license. Office visits to an in-network certified nurse practitioner are not subject to the Deductible or Coinsurance; they are subject to the office visit Copay.
- Cervical traction units, except those prescribed by an acupuncturist, chiropractor or naturopath.
- Chemotherapy.
- Christian Science practitioner. If you are receiving services from a Christian Science practitioner in connection with a medical condition, the Plan does not pay for any other medical treatment for that same condition. The Plan also does not pay for Christian Science homes or sanitariums.
- Cosmetic Surgery, only if necessary for one of the following:
  - For the prompt repair of accidental injury;
  - To repair birth defects (congenital anomalies) as certified by a Physician; or
  - For certain reconstructive surgeries following a mastectomy, including reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas (as required by the Women's Health and Cancer Rights Act of 1998).
- Dentist's charges as a result of accidental injury to natural sound teeth when repair work is

completed within 24 months of an accident. A natural sound tooth is one which has not been restored or has been restored with an amalgam or composite filling. A natural sound tooth does not include a missing tooth. The Plan may consider charges for the repair of a tooth that was previously crowned provided the accidental injury is due to external causes and resulted in either hospitalization or surgery to the injured tooth. If approved under the medical benefits, no coverage is available under the dental benefits.

- Dentist's charges for the removal of cysts and tumors.
- Dialysis treatment.
- Drugs and medications that are injectable or infusible and administered by the Physician's office, including allergy shots. (Specialty medications are covered under the Express Scripts prescription drug benefits and must be obtained through Accredo Specialty Pharmacy.)
- Drugs and medications requiring a Physician's or a Dentist's prescription and dispensed by a registered pharmacist for Participants and Dependents who are not covered by the Express Scripts prescription drug benefits (see page 74). Benefits are payable at the out-of-network level subject to the medical Deductible.
- Drugs that do not require a prescription if you are under the care of a Physician for a current illness. The Physician must state in writing to the Plan the necessity for the use of such medication for the treatment of your illness. The non-prescription drugs must be generally accepted treatment for a given condition or illness. Not included are non-drug items dispensed in the Physician's office, food and/or nutritional supplements and homeopathic remedies or vitamins taken orally, by injection or by infusion.
- Durable Medical Equipment (DME), when rented or purchased from a qualified DME supplier, prescribed by a Physician and determined to be Medically Necessary by the Plan. Total rental payments are limited to the Plan's Allowance for the purchase of the equipment. If equipment is to be used for an extended period of time, purchase may be preferred. **Not all DME is covered, so call the Plan at (800) 777-4013 before renting or purchasing DME.** DME that does not require a Physician's prescription is not covered. Neither is DME that is prescribed by an acupuncturist or chiropractor, or DME purchased from a non-qualified supplier such as Amazon or eBay. Note: In order for the Plan to consider charges for DME, the equipment must meet all the following criteria:

  1. Must be prescribed by a Physician;
  2. Provided by a qualified DME supplier;
  3. Used by the covered individual for whom a Claim has been made;
  4. Cannot be used where sickness or injury is not present;
  5. Can withstand repeated use; and
  6. Is not a general use item that can be used by other family members.

- Eyeglasses (initial pair only), or contact or scleral lenses when required following a covered eye surgery.
- Food allergy testing, when performed as part of the normal work-up of an allergy patient. The tests must be Medically Necessary.
- Foot orthotics when prescribed by a Physician, subject to the following replacement guidelines:

  - Age 16 or younger – One pair every 12 months.
  - Age 17 or older – One pair every 24 months.

  The Plan does not cover additional pairs of orthotics purchased for different styles of shoes.
- Gender dysphoria – Medically Necessary services for treatment of gender dysphoria, including but not limited to diagnosis, psychotherapy, continuous hormone therapy (payable under the Express Scripts prescription drug benefits),

laboratory testing (to monitor the safety of continuous hormone therapy) and gender reassignment surgery **(pre-authorization required)**. Voice modification surgery and voice therapy are not covered. See page 61 for additional details and limitations regarding gender reassignment surgery.

- Genetic/genomic tests. Only tests which are appropriate for the clinical diagnosis as determined by the Plan's medical consultants will be considered. All tests are subject to medical review. Tests that are Experimental or Investigative Procedures are not covered.
- Hearing aids, up to a maximum payment of $1,500 per device under Plan I or $1,000 per device under Plan II. Devices are limited to one per ear every three years. Repairs and battery replacement are not covered. Cochlear implants are not subject to these limits.
- Home health care (may include nursing, Durable Medical Equipment, and other medical supplies, such as IV medications). Please see page 69 for limitations on nursing and the previous page for limitations on Durable Medical Equipment.
- Hospice care provided on an outpatient basis by a Medicare-certified program, when an individual is terminally ill with a life expectancy of less than 12 months. Hospice benefits are not subject to the Deductible. Inpatient hospice care may be covered under the Hospital benefits.
- Lab and diagnostic tests to diagnose an illness or injury. Only tests which are appropriate for the clinical diagnosis as determined by medical consultants for the Plan will be considered. All tests are subject to medical review. Lab tests that are part of a panel will not be paid as separate tests.
- Lactation support and counseling services, which are not subject to the Deductible, Copay or Coinsurance. Benefits for out-of-network lactation consultants require that the consultant be an International Board Certified Lactation Consultant and are subject to a lifetime maximum of three visits.
- Mammography services.
- Neuro-psychological testing **when pre-authorized.**
- Nutritional counseling by a Registered Dietitian (RD) for Participants or Dependents with chronic illnesses such as diabetes (including gestational diabetes), coronary artery disease, ulcerative colitis, Crohn's Disease, malabsorption syndrome, cystic fibrosis, HIV/AIDS or cancer. Nutritional counseling is not subject to the Deductible or the in-network office visit Copay and is limited to one initial and two follow-up visits per person per lifetime.
- Obstetrical care and delivery for Participants or their spouses, when provided by a Physician, a certified nurse midwife or state-licensed midwife, including pre and post-natal care and delivery. The Plan will only consider charges up to the global maternity allowance for obstetrical care, even if you change obstetricians and/or midwives during your pregnancy. The global maternity allowance encompasses the obstetrical care provided by all your obstetricians and/or midwives. Other charges for diagnostic tests such as lab work, ultrasound or amniocentesis are considered separately, if Medically Necessary. Prenatal care from an In-network Provider is not subject to the Deductible, Copays or Coinsurance.
- Obstetrical prenatal care for Dependent children when provided by an In-network Provider (a Physician, a certified nurse midwife or state-licensed midwife). This care is not subject to the Deductible, Copays or Coinsurance. Treatments for complications during pregnancy are covered whether provided by In-network or Out-of-network Providers, and coverage is subject to the medical Deductible, Copays and Coinsurance. Delivery and post-natal services are not covered, nor are prenatal charges from Out-of-network Providers.
- Oxygen, including its administration.
- Pap tests.

- Pediatrician charges for attendance at birth by Cesarean section (Participants or their spouses only).
- Physician services, that is, fees of a legally qualified licensed Physician or surgeon for professional medical or surgical services in or out of the Hospital or at an urgent care center. Charges from in-network Physicians for office visits or visits to an urgent care center are not subject to the Deductible or Coinsurance; they are subject to the office visit Copay.
- Preventive or wellness services, such as physical exams and certain diagnostic tests, including services required by the ACA. Preventive or wellness services from an In-network Provider are not subject to the Deductible, Copays or Coinsurance.
- Private duty outpatient nursing (from a registered nurse, licensed vocational nurse, licensed practical nurse or a nurse with an equivalent state license) other than a relative or resident in your home **when pre-authorized**. For additional information, see pages 69-70.
- Professional fees for disorders listed in the "mental disorders" section of the current edition of the International Classification of Diseases publication. Charges for office visits to In-network Providers are not subject to the Deductible or Coinsurance; they are subject to the office visit Copay. Not all diagnoses are covered. Please contact Beacon Health Options for additional information.
- Psychiatrist or psychopharmacologist services for prescription drug management. Charges for office visits to In-network Providers are not subject to the Deductible or Coinsurance; they are subject to the office visit Copay.
- Psychotherapy. Charges from In-network Providers are not subject to the Deductible or Coinsurance; they are subject to the office visit Copay.
- Pulmonary rehabilitation.
- Radiation therapy.
- Radium and radioactive isotope therapy.
- Radioallergosorbent (RAST) testing. The Plan will consider charges for the minimum number of tests that are medically required in order to make a diagnosis.
- Sleep studies (polysomnography) **when pre-authorized**. The Plan will review the referring Physician's clinical exam notes and completed sleep study questionnaire, which includes the Epworth Sleepiness Scale. Home studies and separate sleep studies to determine C-PAP titration are not covered unless Medically Necessary. The Plan covers treatment of sleep apnea when documented by medical records. Sleep studies performed for primary snoring are not covered.
- Temporomandibular joint syndrome (TMJ) treatment, only when osseous changes (bony abnormalities) exist and can be determined by x-ray or other appropriate imaging techniques, or in situations in which soft tissue degeneration in the temporomandibular joint can be documented. Dental expenses in connection with orthodontia are not included.
- Therapy benefits, subject to specific limitations. Refer to pages 63-65.
- Therapy exams, that is, one initial medical exam per type of therapy for the Physician or covered therapist who is providing covered therapy treatment. For physical therapy and physical medicine, the Plan will also consider charges for an additional exam. Charges from In-network Providers are not subject to the Deductible or Coinsurance; they are subject to the office visit Copay.
- Urgent care centers.
- Visiting nurse services **when pre-authorized** (limited to reasonable and customary both by amount and frequency of visits). Each visit

counts as one hour toward the 672-hour limit as described on page 69.

- Wigs, limited to one per lifetime following cancer treatment.
- X-rays, CT scans or MRIs to diagnose an illness or injury. Only tests which are appropriate for the clinical diagnosis as determined by medical consultants for the Plan will be considered.

Special Rules for Radiology, Anesthesiology and Pathology (RAP) Providers

If an in-network Physician refers you to an out-of-network radiology, anesthesiology or pathology (RAP) Provider, the Plan will pay the In-network Level of Benefits for the RAP Claims. Payment will be based on the Plan's Allowance and you will be responsible for charges over this amount. When the Plan receives a RAP Claim, it is not always clear that you were referred by an in-network Physician. You must let the Plan know about the referral so that RAP benefits can be paid at the in-network level.

You will also receive the In-network Level of Benefits (based on the Plan's Allowance) if you receive RAP services as an inpatient or outpatient at an in-network Hospital or facility, regardless of whether or not you were referred by an in-network Physician.

Surgical Benefits

Contact the Plan before undergoing any surgical procedure to determine if the procedure is covered under the Plan, if pre-authorization is required, or to learn of any Plan limitations.

Obtaining a Second Opinion

The Plan encourages you to obtain a second opinion when surgery is recommended. A second opinion can help you determine whether surgery is truly required, or whether some alternative treatment may also be appropriate. The Plan will pay 100% of the Allowance for a second (or third) opinion for you or your Dependent when obtained prior to undergoing a covered surgery. The Deductible and Copay/Coinsurance amount will not apply to the second (or third) opinion.

Important Note About Anesthesia Services

When an In-network Provider performs a colonoscopy that is covered under the Plan's preventive benefits, anesthesia provided by a separate anesthesiologist will be covered when determined to be medically appropriate by the attending Provider. Under current guidelines, preventive colonoscopies are covered only for adults age 50 or older once every 10 years.

For diagnostic or therapeutic colonoscopies and upper gastrointestinal endoscopies, a separate anesthesiologist's charges will not be covered unless the Plan's medical consultants determine that it is Medically Necessary. For example, conditions such as pregnancy, extremes of age, or patients with anatomical difficulties that might interfere with airway support would qualify as Medically Necessary for the presence of a separate anesthesiologist. This rule also applies when an Out-of-network Provider performs a preventive colonoscopy.

You should check with your surgeon before the procedure to determine if he or she intends to use a separate anesthesiologist, as this may increase your out-of-pocket costs.

When anesthesia is provided by your surgeon, the fee for this service is part of the surgical package and is not covered by the Plan if charged separately.

Transplants

With the exception of corneal transplants, expenses incurred in connection with organ transplants will not be covered by the Plan unless a written pre-authorization is obtained.

The Plan reserves the right to deny coverage for a transplant if it is not performed in a Blue Distinction Center or Center of Excellence. Anthem Blue Cross maintains the list of these authorized in-network facilities. To obtain pre-authorization for a transplant, follow the instructions under "Pre-Authorization for Surgery" on the following page.

If your transplant surgery is approved by the Plan, donor expenses are considered for payment, provided that the donor does not have such coverage under his or her own medical insurance plan. Written documentation from the donor's insurance plan is required.

If you are donating an organ to another person, the Plan does not consider your donor expenses for coverage, because it is not considered Medically Necessary for you.

If you or your Dependents are covered under more than one health plan, including benefits provided by other entertainment industry plans, you should obtain pre-authorization from all plans that provide coverage.

Bariatric Surgery

Charges incurred in connection with bariatric surgery will be considered for payment if you obtain pre-authorization and you have:

- a Body Mass Index (BMI) of at least 40; or
- a BMI of at least 35 with other weight-related health conditions, such as diabetes or hypertension.

Please contact the Plan for specific and detailed guidelines regarding benefits for bariatric surgery. To obtain pre-authorization for a bariatric surgery, follow the instructions under "Pre-Authorization for Surgery" on the following page.

Gender Reassignment Surgery

Charges incurred in connection with gender reassignment surgery will be considered for payment if you receive pre-authorization and you meet the criteria adopted by the Plan for such surgeries. Not all charges are eligible. For example, services that are considered cosmetic, such as those listed on the following page, are generally not covered.

Additional examples of non-covered charges include, but are not limited to:

- Breast augmentation;
- Brow lift;
- Calf implants;
- Chondroplasty (thyroid cartilage reduction);
- Facial bone reconstruction or facial implants;
- Gluteal augmentation;
- Jaw reduction;
- Lip reduction/enhancement; and
- Pectoral implants.

To obtain pre-authorization for a gender reassignment surgery, follow the instructions under "Pre-Authorization for Surgery" on the following page. Please contact the Plan for specific and detailed current guidelines regarding benefits for treatment of gender dysphoria.

Cosmetic Surgery and Other Cosmetic Procedures

The Plan does not cover Cosmetic Surgeries or procedures except under specific limited conditions. Eyelid, nasal and breast surgeries have a mandatory pre-authorization requirement. The Plan will cover Cosmetic Surgery necessary for the prompt repair of accidental injury, or to repair birth defects, or for certain reconstructive surgery after a mastectomy.

If your Physician advises you that surgery is required for functional reasons, it is strongly recommended that you obtain pre-authorization before having the surgery. That way you will know whether the surgery is covered.

The final amount payable will not be determined until the operative report is reviewed with your Claim. In all cases, your Physician will be asked to furnish certain information to the Plan.

The following is a list of some of the Cosmetic Surgeries and procedures that are NOT covered by the Plan.

- Abdominoplasty.
- Alopecia senilis, or male pattern baldness treatment.
- Blepharoplasty (eyelid surgery) – Elective surgery to the upper eyelids is generally not covered. However, under certain circumstances, the Plan's medical consultants may review your case to determine if it meets the criteria for coverage. Have your Physician follow the surgery pre-authorization procedures outlined on this page and provide an ophthalmologist's report, which includes an automated visual field test and preoperative frontal and lateral gaze photos.
- Botox injections, except for the treatment of certain medical conditions as approved by the Food and Drug Administration (FDA).
- Breast reduction – Elective breast reduction is generally not covered. However, under certain circumstances, it may be reviewed by the Plan's medical consultants to determine if it meets the criteria for coverage. Have your Physician follow the surgery pre-authorization procedures outlined on this page. The Physician should be certain to include the patient's height, weight and the number of grams of tissue to be removed from each breast.
- Chemical peels, except for severe acne when accepted treatment has failed.
- Collagen injections, except when used for the restoration, repair and correction of abnormalities or defects caused by an accident or covered surgery.
- Dermabrasion.
- Dermatology procedures for skin conditions that do not require treatment, such as the removal of freckles, age spots, wrinkles, skin tags, etc.
- Genioplasty (chin implants).
- Gynecomastia surgery for enlarged male mammary glands, except for documented hormone imbalances, or the presence of tumors or an endocrine producing tumor in the breast.
- Hair transplants.
- Laser hair removal.
- Laser resurfacing.
- Lipectomy.
- Liposuction.
- Otoplasty (ear procedure).
- Panniculectomy.
- Repair of diastasis recti when done at the same time as abdominoplasty, panniculectomy or lipectomy.
- Revision of scar tissue from previous Cosmetic Surgery. See page 56 for information on breast implant removal.
- Rhinoplasty (nose procedure) .
- Rhytidectomy (face lift).
- Telangiectasia (spider veins) treatment.

Pre-Authorization for Surgery

Transplants, bariatric surgery, gender reassignment surgery and eyelid, nasal and certain breast surgeries have mandatory pre-authorization requirements. Breast surgeries for which coverage is required by the Women's Health and Cancer Rights Act of 1998 do not require pre-authorization. See page 56 for information on these surgeries.

To obtain pre-authorization for a surgery that requires it, the following steps must be taken.

1. You must advise your Physician of the Plan's pre-authorization requirement. Your Physician is required to contact the Plan and provide all of the necessary information.
2. Your surgeon must submit a letter stating the surgical procedures to be performed, the Medical

Necessity for the surgery and the anticipated fee. The Physician's request for pre-authorization must be sent to the Plan and include the patient's history and physical report, along with diagnostic quality preoperative photographs for eyelid, nasal and breast surgeries.

The Plan's medical consultants will review the information, and the Plan will advise you in writing as to whether the surgery will be covered. The final amount payable will not be determined until the actual operative and pathology reports are received with the Claims and reviewed.

If your surgeon performs different or additional procedures other than those that were pre-authorized, and these procedures are not covered under the Plan, the charges will not be considered for payment.

Surgeon Services

The Plan provides coverage for the surgeon's fee for covered surgeries. A copy of the operative and pathology reports is required for most surgeries. Please have your surgeon include the reports when the surgeon's charges are submitted. Surgical benefits are payable whether surgery takes place in or out of the Hospital.

Assistant Surgeon Services

If an assistant surgeon is necessary for the procedure, the Plan's Allowance for the assistant surgeon will be limited to 20% of the Allowed Amount for the surgeon. If a surgical assistant, such as a registered nurse first assistant or Physician assistant, is necessary for the procedure, the Plan's Allowance for the surgical assistant will be limited to 10% of the Allowed Amount for the surgeon.

Anesthesiologist Services

The Plan will consider an Allowance that takes into account the type of surgery, time in attendance and area of the country in which the surgery is performed. Please see:

- Page 60 for special rules on when in-network benefits are paid for anesthesiology and other RAP services; and
- Page 60 for important information regarding anesthesia coverage for colonoscopies and upper gastrointestinal endoscopies.

Benefits for Multiple Surgeries

If multiple surgical procedures are performed at the same time, whether through the same or separate incisions, the Plan will pay benefits based on the following:

- For the primary procedure, 100% of the Plan's Allowance.
- For the second procedure, 50% of the Plan's Allowance.
- For each remaining procedure, 25% of the Plan's Allowance.

Procedures that are considered global to or incidental to another covered procedure are not allowable.

Use of an Out-of-Network Surgical Suite, Ambulatory Surgical Center or Birthing Center

A surgical suite or an ambulatory surgical center is a site, either in a Physician's office or an independent facility, where outpatient surgery is performed. If the surgery takes place in an out-of-network surgical suite or ambulatory surgical center, the Plan's Allowance is limited to $1,000 for use of the facility's operating and recovery rooms and all central supplies when Medically Necessary for the procedure performed. The Plan's Allowance is also limited to $1,000 for the use of an out-of-network birthing center. Coverage for in-network surgical suites and surgical centers and for in-network birthing centers is provided under the Hospital benefits.

Therapy Benefits

Contact the Plan before undergoing any type of therapy to determine if the therapy and related Provider charges are covered, or if there are any limitations or exclusions. All therapy visits must be Medically Necessary for the diagnosis or treatment of an accidental injury, sickness, pregnancy or other medical condition. For a complete definition of Medical Necessity, see page 132.

Medically Necessary therapy for mental health and substance abuse treatment is covered, but it is not subject to the out-of-network allowances or visit limits outlined in this section.

Covered Therapies and Providers

Therapy visits are not considered office visits, so they are subject to the Deductible and Coinsurance. The Plan will consider charges for the following therapies subject to the limitations noted.

- Acupuncture when performed by a licensed certified acupuncturist. No benefits will be paid for any diagnostic tests performed or ordered by a certified acupuncturist or for equipment or supplies prescribed by a certified acupuncturist, even if the Provider is duly licensed by a state agency and authorized to provide such services within the scope of his or her license.
- Biofeedback, if biofeedback is recommended and/or prescribed by a Physician for migraine headaches, hypertension, chronic pain, organic muscle abnormalities, chronic anorectal dysfunction associated with incontinence and constipation, or chronic pelvic muscular dysfunction associated with urinary incontinence.
- Chiropractic care, when performed by a Doctor of Chiropractic (DC) and limited to traditional chiropractic services which include the initial physical examination, subsequent chiropractic manipulations and x-rays of the spine, when Medically Necessary. No benefits will be paid for any other diagnostic tests performed or ordered by a chiropractor or for cervical traction units and other supplies or equipment prescribed by a chiropractor even if he or she is duly licensed by a state agency and authorized to provide such services within the scope of his or her license.
- Occupational therapy, when performed by a registered occupational therapist (OTR).
- Osteopathic manipulative therapy when performed by a Doctor of Osteopathy (DO).
- Physical therapy and physical medicine when performed by a registered physical therapist (RPT), or a Physician.
- Speech/voice therapy when performed by a speech/language pathologist, provided that the services are not part of an educational program.
- Vision therapy, when performed by a Doctor of Optometry (OD), including developmental vision therapy.

The Plan does not cover fees for health clubs, masseurs, masseuses, fitness instructors, dance therapists, colon hydrotherapists or similar practitioners, even when recommended or prescribed by a Physician. The Plan also does not cover fees of medical assistant therapists, aides or other Providers not specifically licensed by the state to render physical therapy, physical medicine or rehabilitative therapy, even though they are operating under the supervision of a covered Provider. The Plan does not cover the fees for Rolfing, Alexander Technique, feldenkrais, bioenergetics, posture realignment, Pilates therapy or yoga.

Plan's Allowance and Maximums for Therapy Benefits

The Plan has a maximum Allowance it will consider for therapy benefits. The Allowance depends on the type of therapy and whether you are receiving the therapy from an In-network or Out-of-network Provider. Additionally, the Plan has a maximum number of visits for certain types of therapy. The table on the next page outlines these Allowances and maximums. The Plan will also consider one initial medical exam per type of therapy for the Physician or therapist who is providing treatment. For physical therapy and physical medicine, the Plan will cover a second medical exam. Additional exams for all types of therapies will only be covered if there is a significant change to the patient's condition that warrants a re-examination. This determination will be based on a review of medical records by the Plan's medical consultants.

Medical exams are considered office visits. This means that exams from In-network Providers are not subject to the Deductible and Coinsurance – but they are subject to the office visit Copay.

THERAPY	IN-NETWORK ALLOWANCE	OUT-OF-NETWORK ALLOWANCE	MAXIMUM VISITS PER CALENDAR QUARTER
Acupuncture	Contract Rate	$55 per visit	8 visits[7]
Biofeedback	Contract Rate	$55 per visit	9 visits
Chiropractic	$45 per visit	$45 per visit	12 visits[7]
Physical, Occupational and Osteopathic	Contract Rate	$65 per visit	None
Speech and Vision	Contract Rate	$55 per visit	None

[7] The Plan will not cover more than 12 outpatient sessions every Calendar Quarter for any combination of acupuncture and chiropractic treatment. In addition, visits for occupational, osteopathic, physical, speech and vision therapy will count toward the 12-visit quarterly maximum. For example, if you use five physical therapy visits during a Calendar Quarter and then want to visit a chiropractor, you would have seven visits available for the remainder of that quarter. As another example, if you used 10 chiropractic visits and then wanted to visit an acupuncturist, no acupuncture visits would be covered since you have already had more than eight therapy visits in the Calendar Quarter.

Preventive and Wellness Benefits

The Plan provides two levels of benefits for routine care: preventive benefits and wellness benefits.

Preventive benefits are services identified by the Affordable Care Act (ACA) that must be covered without cost sharing (Deductible, Copays or Coinsurance) when rendered by an In-network Provider. For the most part, the Plan also covers these services at Out-of-network Providers however they are subject to the Deductible and Coinsurance.

Wellness benefits apply to routine care services that are not identified as preventive services by the ACA. Wellness services received from In-network Providers are also covered without cost sharing. Wellness services received from Out-of-network Providers are subject to the Deductible and Coinsurance.

Preventive Benefits

The Plan will cover preventive services whether they are performed separately or in the course of an annual physical. However, to avoid cost sharing at In-network Providers, the primary purpose of your office visit must be for preventive care.

Cost sharing is permitted for an office visit involving a preventive service if the office visit is billed separately or the primary purpose of the office visit is not the preventive service. For example, if you go to an In-network Provider for a sore throat, and while there, the Physician recommends you have your cholesterol checked, the visit is subject to the office visit Copay, and the cholesterol test is paid at 100%. Conversely, if you have been diagnosed with a condition such as high cholesterol, and your Physician subsequently performs a cholesterol test, then that test is subject to cost sharing, as it is in connection with a medical condition.

The list of covered preventive services as of January 1, 2017 appears in the table on the following pages. This list may be updated by the federal government from time to time; for the most current information, visit **www.healthcare.gov/coverage/preventive-care-benefits**. Many of these services are provided during routine physicals and well-child, well-woman or well-man exams. Routine physicals and well-woman and well-man exams are limited to one per calendar year. Well-child exams are also limited to one per calendar year after age four, although more frequent exams may be covered before that age.

Covered Preventive Care Services as Required by the Affordable Care Act

NEWBORNS	• Gonorrhea preventive medication for eyes	• Screening for: - Hearing loss - Hemoglobinopathies or sickle cell disease - Hypothyroidism - Phenylketonuria (PKU)
CHILDHOOD/ ADOLESCENT IMMUNIZATIONS	• Diphtheria, Tetanus, Pertussis • Haemophilus Influenzae Type B • Hepatitis A and B • Human Papillomavirus (HPV) • Inactive Poliovirus • Influenza (flu)	• Measles, Mumps, Rubella • Meningococcal • Pneumococcal (pneumonia) • Rotavirus • Varicella (chickenpox)
CHILDHOOD	• Autism screening for children at 18 and 24 months • Behavioral assessment for children of all ages • Blood pressure screening • Developmental screening for children throughout childhood • Dyslipidemia screening for children at higher risk of lipid disorder • Fluoride supplements for children without fluoride in their water. Fluoride supplements require a Physician's prescription and are covered under the Express Scripts prescription drug benefits. • Height, weight and BMI measurements • Hematocrit or hemoglobin screening	• Iron supplements for children six to 12 months at risk for anemia. Iron supplements are covered under the medical benefits and require a Physician's prescription to be considered for coverage. • Lead screening for children at risk of exposure • Medical history for all children throughout development • Obesity screening and counseling • Oral health risk assessment for young children • Tuberculin testing for children at higher risk of tuberculosis • Vision screening when performed during the course of a routine pediatric visit
ADDITIONAL SCREENINGS FOR ADOLESCENTS	• Alcohol and drug use assessment • Cervical dysplasia screening for sexually active young women • Depression screening • Domestic and interpersonal violence screening and counseling for young women • Hepatitis B screening for adolescents at higher risk	• HIV screening for adolescents at higher risk • Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk • Well-woman visits

ADULTS	• Alcohol misuse screening and counseling • Aspirin use to prevent cardiovascular disease and colorectal cancer. Aspirin is covered under the Express Scripts prescription drug benefits provided you have a Physician's prescription and you meet the age and risk criteria. • Blood pressure screening • Cholesterol screening for men age 35 or older, women age 45 or older, and younger adults at higher risk • Colorectal cancer screenings, including fecal occult blood testing, sigmoidoscopy or colonoscopy for adults age 50 or older • Depression screening • Diabetes screening for type 2 diabetes for adults with high blood pressure • Diet counseling for adults at higher risk for chronic disease	• Hepatitis B screening for adults at higher risk • Hepatitis C screening for adults at higher risk and one time for everyone born 1945 through 1965 • HIV screening for everyone ages 15 through 65 and other ages at higher risk • Lung cancer screening for adults at higher risk • Obesity screening and counseling • Sexually transmitted infection (STI) prevention counseling for adults at higher risk • Statin use to prevent cardiovascular disease. Statins are covered under the Express Scripts prescription drug benefits provided you meet the age and risk criteria. • Syphilis screening for adults at higher risk • Tobacco use screening for all adults and cessation interventions for tobacco users. Cessation interventions are covered under the Optum Quit for Life® Program (see page 72).
ADULT IMMUNIZATIONS	• Diphtheria, Tetanus, Pertussis • Hepatitis A and B • Herpes Zoster (shingles) • Human Papillomavirus (HPV) • Influenza (flu)	• Measles, Mumps, Rubella • Meningococcal • Pneumococcal (pneumonia) • Varicella (chickenpox)
ADDITIONAL SCREENINGS FOR MEN	• Abdominal aortic aneurysm one-time screening for men age 65 to 75 who have smoked	

ADDITIONAL SERVICES AND SCREENINGS FOR WOMEN	• BRCA counseling about genetic testing for women at higher risk • Breast cancer chemoprevention counseling for women at higher risk • Breast cancer mammography every one to two years for women age 40 or older • Cervical cancer screening • Chlamydia infection screening for younger women and women at higher risk • Contraception for women with reproductive capacity – FDA-approved contraception methods, sterilization and contraceptive coverage. Contraceptives that are administered in the Physician's office such as Norplant, intrauterine devices (IUDs) and Depo-Provera are covered under the medical benefits. Or, you may obtain these medications or devices under the Express Scripts prescription drug benefits and submit any associated professional fees for reimbursement under the medical benefits. Birth control pills, diaphragms, vaginal rings, patches and over-the-counter contraceptives are covered under the Express Scripts prescription drug benefits. Over-the-counter items require a Physician's prescription. Condoms are not covered. • Domestic and interpersonal violence screening and counseling • Gonorrhea screening for women at higher risk • Human Papillomavirus (HPV) DNA testing every three years for women age 30 or older • Osteoporosis screening for women age 60 or older, depending on risk factors • Well-woman visits	
SPECIFICALLY FOR PREGNANT WOMEN	• Anemia screening • Aspirin use to prevent preeclampsia for women at higher risk. Aspirin is covered under the Express Scripts prescription drug benefits and requires a Physician's prescription. • Breastfeeding support, supplies and counseling • Folic acid supplements for women who may become pregnant. Folic acid supplements are covered under the Express Scripts prescription drug benefits and require a Physician's prescription.	• Gestational diabetes screening • Hepatitis B screening during the first prenatal visit • Prenatal visits • Rh incompatibility blood type screening, including follow-up testing for women at higher risk • Urinary tract or other infection screening

The Plan will not deny coverage for sex-specific benefits for which an individual is otherwise eligible because his or her gender does not align with other aspects of their sex or with the sex assigned to them at birth.

Wellness Benefits

Not all routine services are included in the ACA's preventive services list. The Plan considers these procedures for coverage under the wellness benefits. The Plan will cover wellness services whether they are performed separately or in the course of an annual physical.

Wellness services received from In-network Providers are not subject to the medical Deductible, Copays or Coinsurance. However, to avoid cost sharing, the primary purpose of your office visit must be for wellness or preventive care. Wellness services provided by Out-of-network Providers are subject to the Deductible and Coinsurance.

The Plan will consider generally accepted standards of medical practice for routine procedures such as the following:

- Bone density tests for women under age 60 and for men – One per calendar year. Bone density tests for women age 60 or older are covered under preventive benefits.
- Chest x-ray.
- Complete blood count.
- EKG.
- Mammograms for women under age 40 – One per calendar year. Mammograms for women age 40 or older are covered under preventive benefits.
- Travel immunizations.
- Urinalysis.

Outpatient Nursing Benefits

For private duty outpatient nursing services, the Plan's benefit is limited to 672 hours per person per calendar year. For example, this is equivalent to 28 days of nursing at 24 hours per day, or 56 days at 12 hours per day. The number of days of nursing allowable depends on the number of hours of nursing required per day. The allowance does not need to be used all at one time. In addition, as outlined on pages 59-60 for visiting nurse services, each visit counts as one hour toward the 672 limit.

For example: If you use 150 hours of nursing at the beginning of the year, the balance of 522 hours is available for the remainder of the calendar year. Private duty nursing in excess of the 672 hours may be considered by Case Management (see the following page). Because the nursing benefit contains several restrictions, as described below, you must obtain approval before services are rendered. The amount allowed per visit will be determined by the Plan's Allowable Charge guidelines.

Obtaining Approval for Private Duty Outpatient Nursing Care

The Plan does not cover inpatient private duty nursing services under any circumstances. Private duty nursing care at home may be covered if you obtain advance approval as follows:

- The nursing services must be prescribed by your Physician as Medically Necessary for treatment of an illness or injury that is covered by the Plan.
- The level of nursing care must require a registered nurse (RN), licensed vocational nurse (LVN), licensed practical nurse (LPN) or equivalent state license who is not a relative or resident of your home.
- The nursing must not be for Custodial Care or long-term care (see Glossary on page 130).
- The Physician must submit a written diagnosis and treatment report within 14 days of the start of nursing services.
- Nursing notes must be submitted for review as Claims are filed.

Medical consultants for the Plan will review your Physician's report and the nursing notes. If the nursing care is approved, the Plan will specify the number of days that it will cover and the amount per visit that it will allow.

If your Physician prescribes private duty nursing care, please contact the Plan as soon as possible. Also note that services by Christian Science practitioners are not recognized as nursing services by the Plan.

Case Management

One of the Plan's most important tools in providing benefits for individuals with a serious illness or injury is the Case Management program. Case Management offers a personal approach, by which a coordinator works with the patient, the family and the attending Physician to develop an appropriate treatment plan and to identify and suggest alternatives to traditional inpatient Hospital care.

Some services that are not normally covered under the medical benefits may be considered under the Case Management program. These include, but are not limited to, home nursing services, home physical and/or occupational therapy and Durable Medical Equipment. Long-term Custodial Care is not covered under the Hospital benefits, the medical benefits or the Case Management program. All services and equipment must be pre-authorized by the Case Management team.

The Plan's Case Management team uses Case Management nurses to assist in approving and arranging necessary services and equipment and with locating appropriate Providers and negotiating rates with Out-of-network Providers when no In-network Providers are available.

Case Management can help with a wide variety of serious illnesses and injuries, including burns, spinal cord injuries, multiple trauma injuries, cancer, cardiovascular disease, stroke, joint replacement post-surgical care, HIV/AIDS, cerebral palsy and multiple sclerosis. The Case Management team can also assist in arranging hospice care for patients with terminal conditions. If you feel that Case Management is appropriate for your care, contact the Plan as soon as possible.

Case Management services are completely voluntary and are meant to benefit the patient. Accordingly, if the patient and the Physician do not agree that the alternative plan is to the patient's benefit, the patient is not required to participate in the Case Management program.

The Case Management program is also provided as part of the Plan's regular health coverage, so there is no additional cost to covered Participants or Dependents.

Non-Covered Medical Expenses

(all practitioners)

The following medical expenses are not covered by the Plan.

- Acupuncture – Diagnostic services ordered or performed by a certified acupuncturist, or supplies and equipment prescribed by a certified acupuncturist, even if the Provider is duly licensed by a state agency and authorized to provide such services within the scope of his or her license.
- Applied behavior analysis (ABA).
- Charitable Hospital care – Treatment received in charitable Hospitals.
- Chiropractic care – Diagnostic services ordered or performed by a chiropractor (except spinal x-rays) or supplies and equipment prescribed by a chiropractor even if he or she is duly licensed by a state agency and authorized to provide such services within the scope of his or her license.
- Condoms.
- Cord blood harvesting and storage charges.
- Cosmetic Surgery and procedures, except where otherwise noted (see page 56 under "Medical Benefits" and pages 61-62 under "Cosmetic Surgery and Other Cosmetic Procedures").
- Custodial Care – Treatment received in custodial, convalescent, educational, rehabilitative care or rest facilities.
- Custodial nursing services.
- Cytotoxic testing.

- Dental services or appliances (dental services are covered under the dental benefit, see pages 81-84).
- Durable Medical Equipment, if it is a second or duplicate piece of approved Durable Medical Equipment for travel or convenience purposes.
- Electrolysis.
- Environmental equipment, such as air filters, humidifiers and non-allergic bedding.
- Equipment and procedures not approved by the FDA.
- Exercise equipment, whirlpools, sunlamps, heating pads and other similar general use items, whether or not prescribed by your Physician.
- Eyeglasses, contact lenses or eye refractions (except following covered eye surgery as described on page 57 or as provided through VSP as described on pages 85-86).
- Food supplements, herbs, minerals, vitamins and other nutritional supplements.
- Foot care – Arch supports, heel pads and heel cups. Routine foot care (removal of corns and calluses or cutting of nails) is not covered, except when prescribed by a Physician who is treating you for a metabolic, neurologic or peripheral vascular disease such as diabetes or arteriosclerosis.
- Gestational surrogate, that is, charges for services rendered to a gestational surrogate or to a fetus implanted into a gestational surrogate.
- Growth hormones (except when pre-approved by Express Scripts under the prescription drug benefit as outlined on page 78).
- Health clubs, Rolfing, Alexander Technique, feldenkrais, bioenergetics, posture realignment, Pilates therapy or yoga.
- Homeopathic remedies.
- Hypnosis or hypnotherapy.
- Infertility treatment, including: infertility services after voluntary sterilization; artificial insemination; assisted reproductive technology (ART) procedures; services, prescription drugs and supplies related to ART procedures; infertility-related non-surgical and surgical procedures; the diagnostic testing performed after the start of infertility treatment; the cost of donor sperm and associated fees; and the cost of donor eggs and associated fees.
- Inpatient private duty nursing.
- Intraoperative neurophysiologic monitoring, except in limited cases where the Plan's consultant determines that it is Medically Necessary.
- Learning disabilities support or care, specifically, charges in connection with learning disabilities and academic accommodations.
- Masseur or masseuse services, including services provided by massage therapists (MT), oriental medical doctors (OMD or DOM, one who practices oriental medicine), fitness instructors, dance therapists or colon hydrotherapists.
- Medical assistant therapists, aides or other Providers not specifically licensed by the state to render physical or rehabilitative therapy, even though they are operating under the supervision of a covered Provider.
- Medically unnecessary services or supplies, that is, services or supplies which are not recognized as generally accepted medical practice or necessary for diagnosis or treatment.
- Modifications to a home or automobile to accommodate illness or injury.
- Multifocal intraocular lens (IOL) implanted during cataract surgery that corrects refractive errors. The Plan covers cataract surgery and a standard (monofocal) IOL.
- Naturopathic services, even if the Provider is duly licensed in any state and authorized to

provide medical services, including diagnostic tests performed or ordered by a naturopath. Naturopathic services include conventional diagnosis, therapeutic nutrition, botanical medicine, homeopathy, naturopathic childbirth attendance, classical Chinese medicine, hydrotherapy, manipulation, pharmacology and minor surgery.

- Oral and topical medications dispensed in a Physician's office.
- Over-the-counter pregnancy tests.
- Personal comfort items while hospitalized, such as TV or telephone.
- Pregnancy of Dependent children including delivery, post-natal care or elective termination of pregnancy (prenatal care from an In-network Provider and treatment of complications of pregnancy are covered).
- Psychological testing.
- Reversal of vasectomy or tubal ligation.
- Specialty beds such as Sleep Number beds.
- Surgical correction of a bite defect.
- Surgical procedures to correct a refractive error such as LASIK, photorefractive keratectomy (PRK), radial keratotomy or radial thermocoagulation (RTK).
- Weight control or weight loss programs, regardless of any underlying medical condition for which they may be prescribed.

For additional information, refer to the general exclusions, which are listed beginning on page 89.

Optum's Quit for Life® Program

All covered Participants and Dependents who are at least 18 years old have access to the Quit for Life® Program, brought to you by the American Cancer Society® and Optum. Quit for Life® is the leading tobacco cessation program in the United States and is available at no cost to you and your Dependents age 18 and older.

The program integrates free medication, web-based learning and confidential phone-based support from expert Quit Coaches®. The Quit for Life® Program includes:

- Up to five outbound coaching calls.
- Unlimited toll-free access to Quit Coaches®.
- Access to Web Coach®, a private online community of e-learning tools and social support.
- A printed workbook that you can reference in any situation to help you stick with your quitting plan.
- Advice on quitting aids such as nicotine replacement therapy and prescription medication.
- Up to eight weeks of nicotine replacement therapy, such as the nicotine patch or gum, sent directly to your home. An additional four weeks of therapy may be provided if necessary.
- Up to eight weeks of prescription medication, such as buproprion or Chantix, through the Express Scripts prescription drug benefits. An additional four weeks of therapy may be provided if necessary. Optum will coordinate with Express Scripts so that these medications are provided at no cost to you.
- A survey upon program completion.

To enroll in the Quit for Life® Program, call (866) QUIT-4-LIFE ((866) 784-8454) or visit **www.quitnow.net/sag-aftra**.

Prescription Drug Benefits

PRESCRIPTION DRUG BENEFITS AT-A-GLANCE	PLAN I AND PLAN II	
	Retail	Home Delivery (includes Specialty)
Deductible	Plan I – $75 per person; $150 per family Plan II – $175 per person; $350 per family	
Supply	Up to a 30-day supply	Up to a 90-day supply
Copay	You pay the greater of the two Copays shown: Generic – $10 or 10% of the total prescription cost Preferred brand – $25 or 25% of the total prescription cost Non-preferred brand – $40 or 40% of the total prescription cost In addition, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication.	You pay the greater of the two Copays shown: Generic – $20 or 10% of the total prescription cost; maximum $50 per prescription Preferred brand – $50 or 25% of the total prescription cost; maximum $125 per prescription Non-preferred brand - $100 or 40% of the total prescription cost; maximum $300 per prescription In addition to the maximum Copays listed above, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication.
Preventive Services Prescriptions	Generic prescription medications that appear on the list of Affordable Care Act preventive services are not subject to the Deductible or Copay. See pages 66-68.	
Long-term Medications (taken for 90 days or more)	Must be obtained through home delivery after the second 30-day fill.	
Specialty Medications	Must be obtained through Express Scripts' specialty pharmacy, Accredo. Covered as other medications outlined above.	

The Plan's prescription drug benefits are administered by Express Scripts. All Participants eligible for these benefits will receive an Express Scripts ID card, which should be presented at retail pharmacies when filling prescriptions. For Participants who are not eligible for the Express Scripts benefits (see the following page), prescription drug coverage is provided under the medical benefits at the out-of-network level.

Eligibility

You and your covered Dependents are eligible for prescription drug benefits provided through Express Scripts if the Plan provides your primary coverage, or if your primary plan does not include prescription drug coverage. If Medicare is your primary plan and this Plan provides secondary coverage, you and your covered Dependents are eligible for the Express Scripts benefits, provided you and your spouse do not enroll in a Medicare Part D Prescription Drug Program. **If you enroll in Medicare Part D, you will not be eligible for any prescription drug coverage under the Plan.**

If this Plan is not your primary plan, or if you owe the Plan money due to audit findings by the Contribution Compliance or Participant Eligibility Departments, your prescription drug benefits will be covered under medical benefits at the out-of-network level.

Annual Pharmacy Deductible

The calendar year Deductible for Express Scripts prescription drug coverage is outlined in the table on the previous page. The Deductible applies to both retail pharmacy purchases and home delivery purchases, including specialty medications received through Accredo. The family Deductible is satisfied when at least two or more family members have combined Covered Expenses that exceed the amount of the family Deductible in a calendar year. However, the Plan will not apply more than the individual Deductible to any one family member.

If your eligibility changes from Plan I to Plan II during a calendar year, any charges that were applied toward your Plan I Deductible will apply toward your Plan II Deductible. If your eligibility changes from Plan II to Plan I, the reverse is also true.

The pharmacies where you fill prescriptions will collect charges that apply to your Deductible. However, any price differences between brand name drugs and their generic equivalents (where applicable) do not apply toward your Deductible.

Copays

Your pharmacy Copays are outlined in the table on the previous page. Copays vary depending on whether the prescription is a generic, preferred brand or non-preferred brand drug. If your prescription is for a preferred or non-preferred brand name drug that has a generic alternative, you will be responsible for the generic Copay plus the difference in price between the generic and brand name prescription. You will be responsible for the brand/generic difference even if your doctor indicates "DAW" (dispense as written) or "no substitution" on the prescription. The price differential does not apply toward your Deductible.

Preferred Prescriptions Formulary

The Plan uses Express Scripts' National Preferred Formulary, which is a list of covered brand name and generic medications. These medications are selected because they can safely and effectively treat most medical conditions while helping to contain costs. A list of the current National Preferred Formulary exclusions is available online at **www.express-scripts.com**. Medications that are not on the Formulary are not covered.

Retail Pharmacy Benefits

You should use a participating retail pharmacy for short-term prescriptions, such as antibiotics to treat infections. Show your Express Scripts ID card to the pharmacist and pay your retail Copay each time you fill a new prescription.

To find a participating retail pharmacy near you:

- Ask at your retail pharmacy whether it participates in the Express Scripts network;
- Visit **www.express-scripts.com**, log in to the secure website and click "Locate a pharmacy." If you have not registered on Express Scripts' website, you will need to do so; or
- Call Express Scripts at (800) 903-4728.

If you use an out-of-network pharmacy, you must pay the entire cost of the prescription, and then submit a Claim form to Express Scripts as described on page 104. You will be reimbursed the amount that would have been charged by a participating retail pharmacy, minus the required Copay. The discounted cost will count toward your prescription drug Deductible.

If you are eligible for the Plan's regular prescription drug coverage through Express Scripts, your prescriptions will not be considered under the Plan's medical benefits except for certain over-the-counter prescriptions under the ACA's list of approved preventive services. For details, please refer to pages 66-68.

Home Delivery Pharmacy Benefits

You must use the home delivery pharmacy for medications that you take on a long-term basis (90 days or more, such as those used to treat high blood pressure or high cholesterol). Each prescription for a long-term medication may be filled no more than twice at a retail pharmacy, for a maximum of a 30-day supply with each fill. All subsequent prescriptions for each long-term medication must be filled through the home delivery pharmacy. If you continue to purchase a long-term medication at a retail pharmacy after the first two 30-day fills, you will pay the entire cost of the medication.

Ordering Prescriptions

The first time you are prescribed a new maintenance medication, ask your Physician for two prescriptions: the first for up to a 30-day supply to be filled at a retail pharmacy, and the second for up to a 90-day supply to be filled through the home delivery pharmacy.

You and/or your Physician may submit prescriptions as follows.

- *By fax from your Physician* – Give your ID number to your doctor and have your doctor call (888) EASYRX1 ((888) 327-9791) to obtain fax instructions.
- *Online* – Visit **www.express-scripts.com** and follow the instructions to register for Express Scripts Pharmacy's home delivery services. Once you have registered, click "Manage prescriptions" and follow the instructions. Express Scripts will contact your Physician to transfer your current prescriptions to the home delivery pharmacy.
- *By mail* – Request an order form from the Plan by calling (800) 777-4013 or from Express Scripts by calling (800) 903-4728. Mail your prescription and the required Copay along with the completed order form in the envelope.

Express Scripts Home Delivery Service
P.O. Box 747000
Cincinnati, OH 45274-7000

Delivery of Your Medication

Prescription orders are processed promptly and are usually delivered to you within eight days. If you are currently taking a medication, be sure to have at least a 14-day supply on hand when ordering.

Paying for Your Medication

You may pay by check, money order, Visa, MasterCard, Discover/NOVUS, American Express or Diners Club.

Accredo Specialty Pharmacy Benefits

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis.

These medications must be obtained through Accredo, which is a dedicated specialty pharmacy within the Express Scripts family of pharmacies, rather than at

Please Note:
The pharmacist's judgment and dispensing restrictions, such as quantities allowable, govern certain controlled substances and other prescribed drugs. Federal law prohibits the return of dispensed controlled substances.

your local retail pharmacy or through your Physician's office. If you choose to use a pharmacy other than Accredo, you will be responsible for the entire cost of the prescription.

Accredo includes access to nurses who are trained in specialty medications, pharmacist availability 24/7 and coordination of home care and other health care services. They can also arrange for prescriptions to be delivered to a Physician's office for administration. For more information please call Accredo at (800) 903-4728.

Other Pharmacy Benefit Features

No-Cost Immunizations

The following vaccines are covered at no cost to you if received from an Express Scripts participating pharmacy:

- Diptheria, Tetanus, Pertussis;
- Hepatitis A and B;
- Herpes Zoster (shingles);
- Human Papillomavirus;
- Inactive Poliovirus;
- Influenza (flu);
- Measles, Mumps, Rubella;
- Meningococcal;
- Pneumococcal (pneumonia);
- Rabies;
- Travel immunizations;
- Varicella (chickenpox); and
- Any immunizations required in the event of bioterrorism.

To use this benefit, call your pharmacy first to make sure the vaccine you need is in stock and that the pharmacy provides vaccine administration. Once you have verified that the pharmacy has the vaccine and can administer it, simply visit your pharmacy, present your Express Scripts ID card and the pharmacy will take care of the rest.

Express Scripts' Personalized Medicine Program

Personalized medicine takes advantage of advances in science to help your Physician make more precise and effective prescription and dosage choices through genetic tests that reveal how your body will metabolize certain drugs.

These tests, called pharmacogenomics tests, offer several advantages, including better outcomes, fewer side effects and less waste.

If you are using a medication covered by Express Scripts' Personalized Medicine Program such as warfarin for a heart condition, a pharmacist will contact your doctor to see if it is appropriate for you to participate in the program. If your Physician agrees, you will be contacted by a pharmacist to let you know that the testing is available. If you agree to participate, you will receive a cheek swab test that you can administer on your own. The results will be sent to your Physician and to a specially trained Express Scripts pharmacist who will work with your Physician to interpret the results. Of course, your Physician decides which drug and dose is right for you.

The Personalized Medicine Program is available to you at no additional cost and requires no action on your part. It is completely voluntary, and any decisions to change treatments or dosages are up to you and your Physician. All information gathered during testing is treated confidentially, and no tests are conducted other than the tests which you specifically authorize. All aspects of the program comply with privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA) and the Genetic Information Non-Discrimination Act of 2008 (GINA), as well as applicable state laws.

Prior Authorization

Most of your prescriptions can be filled without prior authorization at a retail pharmacy. However, some drugs are only covered for certain uses or in certain quantities. Lamisil and Wellbutrin SR are examples of medications that require prior authorization by Express Scripts before they can be covered. If you present a prescription requiring prior authorization, your Physician may need to provide additional information before the prescription is covered.

When you take a prescription that needs prior authorization to the retail pharmacy, the system will automatically review your file (age, sex and history of prior drug therapies) to determine if the medication can be dispensed. The pharmacy will advise you if additional information is required. Either you or the pharmacy can ask your Physician to call Express Scripts at (800) 753-2851 to initiate the prior authorization process. This call will start a review that typically takes two to five business days, unless additional information is required, in which case, the review may take longer. Both you and your Physician will be notified in writing of the decision.

If the prescription is approved, the letter will tell you the length of your coverage approval. If the prescription is denied, the letter will include the reason for coverage denial and instructions on how to submit an appeal, if you choose to do so.

If you want the prescription immediately without waiting for the prior authorization, you will have to pay the full retail price at the pharmacy. If the prescription is approved, your Claim should be sent to Express Scripts for reimbursement at 100% minus the prescription drug Copay and Deductible.

Step Therapy Requirements

For certain prescription drugs to be covered, the Plan requires covered individuals with certain conditions – including high blood pressure, nasal allergies or acid reflux – to try effective and more affordable prescription drugs first before "stepping up" to more expensive drugs.

- *Step 1 drugs* – These front-line drugs are generic and sometimes lower-cost brand name drugs that have generally proven to be safe, effective and affordable. In most cases you should try these drugs first because they usually provide the same health benefit as a more expensive drug, at a lower cost to you and the Plan.
- *Step 2 and Step 3 drugs* – Second-line drugs are brand name alternative drugs that generally are necessary for only a small number of patients for whom front-line drugs have failed. Third-line drugs are the most expensive option and have not shown greater clinical efficacy than lower-cost drugs.

The Plan's step therapy requirements have been developed and are updated regularly under the guidance and direction of licensed Physicians, pharmacists and other medical experts. Together with Express Scripts, they review the most current research on thousands of drugs tested and approved by the FDA for safety and effectiveness.

Only some medications are subject to the step therapy requirements, and the prescription drugs that are may change from time to time. Your pharmacist can tell you if your prescription requires step therapy. Or, at any time you can find out yourself by logging in to **www.express-scripts.com** and clicking "Price a Medication."

With step therapy, more expensive brand-name drugs are usually covered as second-line alternative drugs if any of the following applies:

- You have already tried the generic drugs covered in the step therapy program and they were unsuccessful.
- You cannot take a specific generic drug (for example, because of a documented allergy).
- Your Physician demonstrates, for medical reasons, that you need a brand-name drug.

If one of these situations applies to you, your Physician may request an override from Express Scripts, allowing you to take a second-line prescription drug. If the override is approved, you will pay the appropriate Copay for the drug.

If your Physician's request for an override is denied, you may follow the appeals process as described on pages 108-112. If you choose not to appeal or your appeal is denied, you can talk to your Physician again about prescribing one of the front-line drugs covered by the step therapy program. Or you can choose to pay the full price for the drug.

Compound Medications

Compound medications are custom-made or mixed by a pharmacy based on a Physician's prescription. Compound medications usually include more than one ingredient. At a participating retail pharmacy, you will pay your retail Copay for compound medications if the

Important Note About Coverage of Compound Medications

Coverage limits apply to compound medications. The Plan will only reimburse the cost of the active main ingredient, minus the Copay. In addition, if one ingredient is a non-covered item, the compound claim will be denied.

pharmacist submits a Claim electronically. In other cases, you must submit a Claim for reimbursement to Express Scripts, which must be accompanied by an itemized list of the ingredients with their full 11-digit National Drug Code (NDC) number(s) for the Claim to be processed.

Growth Hormones

Growth hormones are considered specialty medications and are covered only when purchased through Accredo. They also require prior authorization from Express Scripts before filling your first prescription. Growth hormones are not covered for familial short stature, constitutional growth delay or for non-FDA-approved uses such as anti-aging programs or athletic enhancement.

Male Erectile Dysfunction Drugs

Prescriptions for male erectile dysfunction drugs, including but not limited to, Cialis, Levitra and Viagra, are covered only when there is an underlying medical condition, such as diabetes or a prior prostate surgery, that necessitates treatment with these medications. Prescriptions are limited to six pills of any combination of these drugs in a 30-day period. These medications require pre-authorization from the Plan, and you may contact the Plan for a list of the information needed to complete this process.

Alternatively, you may fill your first prescription at a participating pharmacy with your Express Scripts prescription drug card and pay 100% of the discounted price for the prescription. Send your original pharmacy receipt to the Plan, along with a letter from your Physician confirming your underlying medical condition to be treated and your medical records, for review. If the prescription is determined to be Medically Necessary, the Plan will forward the Claim to Express Scripts for reimbursement at 100% minus the prescription drug Copay, subject to the prescription drug Deductible.

If you use a non-participating pharmacy, your first Claim should be filed with the Plan as outlined above. If the prescription is determined to be Medically Necessary, you will be reimbursed the amount that would have been paid if you had used a participating pharmacy. You are responsible for the remainder of the bill.

After Medical Necessity is determined, subsequent prescriptions may be filled in the usual way by paying the prescription drug Copay at participating pharmacies. For non-participating pharmacies, Claims should be submitted to Express Scripts as described on page 104.

Infertility Drugs Prescribed for Non-Infertility Conditions

Certain medications commonly used to treat infertility may also be prescribed for conditions unrelated to infertility. In these cases, you should follow the procedures for pre-authorization and filing a Claim as outlined under “Male Erectile Dysfunction Drugs.”

Sleep Aids

Prescriptions for sleep-aid therapy, such as Ambien or Lunesta, are limited to quantities sufficient to treat 15 days per month. If you require medication in excess of this amount, you must obtain a preauthorization from the Plan. Contact the Plan for a list of the information needed to complete the pre-authorization.

Smoking Deterrents

Medications used to help you stop smoking, such as buproprion and Chantix, are not covered unless you are enrolled in the Quit for Life® Program (see page 72). If you are enrolled in the program, up to eight weeks of medication will be provided at no cost to you. An additional four weeks of therapy may be provided if necessary. Optum, which administers the Quit for Life® Program, will coordinate with Express Scripts so that you may receive these medications.

Generic Drugs

Minimize your out-of-pocket costs by choosing generic equivalent drugs whenever possible. If you are prescribed a drug for which a generic equivalent is available, you will generally pay much less out-of-pocket if you purchase the generic equivalent instead of the brand name drug. The FDA requires that generic equivalent medications have the same active ingredients with the same quality, safety and effectiveness as their brand name counterparts.

Prescription Drug Coverage Through Your Medical Benefits

Prescription drug coverage is provided under the medical benefits in the following circumstances:

- This Plan is not your primary plan, and your primary plan includes prescription drug coverage.
- You have a prescription for an over-the-counter medication that appears on the list of ACA preventive services (see below):
  - Aspirin to prevent cardiovascular disease (men: age 45 – 79; women: age 55 – 79);
  - FDA-approved contraceptives for women;
  - Folic acid supplements for women who may become pregnant; or
  - Iron supplements for children 6 to 12 months at risk for anemia.

Prescriptions for over-the-counter medications on the list of preventive services are not subject to the medical Deductible or Coinsurance and will be paid at 100% of the Plan's Allowance. Other prescriptions and supplies that are processed under the medical benefits will be paid at the out-of-network level of benefits, subject to the out-of-network medical Deductible and Coinsurance.

Express Scripts does not process secondary prescription drug Claims or Claims for over-the-counter medications. To receive reimbursement for these Claims, submit a copy of the drug bill to the Plan. If you have primary prescription drug coverage under another plan, you must also submit that plan's Explanation of Benefits (EOB) form.

The drug bill must include the prescription number, name of the patient, name of the Physician, quantity filled and strength of medication. Credit card vouchers, cash receipts or canceled checks may not be substituted for bills to process drug Claims. The Plan reserves the right to request original receipts for drug purchases.

Offset of Future Benefit Reimbursements Due to Audits

If you owe the Plan money due to any audit findings by the Contribution Compliance or Participant Eligibility departments, you or your Dependents are not eligible to use the Express Scripts retail or home delivery programs until the balance due is paid in full. You will need to submit prescription charges as outlined previously under "Prescription Drug Coverage Through Your Medical Benefits." You will be notified as soon as the Plan has recovered the entire amount that you owe, irrespective of the source of recovery, at which point you may resume regular prescription drug coverage through Express Scripts (both retail and home delivery).

Questions

If you need help or have any questions about your prescription drug program, you can call the Plan or contact Express Scripts by visiting **www.express-scripts.com** or calling (800) 903-4728.

Non-Covered Prescription Drug Expenses

The Plan's prescription drug benefits are designed to cover those prescriptions and medicines that, under state or federal law, require a Physician's prescription. However, the Plan reserves the right to restrict prescription drug coverage to one retail network pharmacy or to deny coverage for individual drugs. If a restriction is imposed, home delivery is not available as an option. The following items are not covered:

- Anti-obesity preparations.
- Any prescription refilled in excess of the number of refills specified by the Physician or any refill dispensed after one year from the Physician's original order.
- Charges for the administration or injection of any drug.
- Condoms.
- Contraceptive jellies, creams, foams, implants, IUDs or injections. (These are covered under the medical benefits if FDA-approved and prescribed by your Physician.)
- Dehydroepiandrosterone (DHEA).
- Drugs whose sole purpose is to promote or stimulate hair growth (i.e., Rogaine, Propecia) or drugs for cosmetic purposes (i.e., Renova).
- Drugs not approved by the FDA for the treatment rendered.
- Fluoride products (except for children whose water source does not contain fluoride).
- Glucowatch products (covered under the medical benefits).
- Homeopathic medications, both over-the-counter and Federal Legend (i.e. drugs that, under Federal law, may only be dispensed with a Physician's prescription).
- Infertility drugs, except when approved by the Plan for the treatment of non-infertility conditions.
- Insulin pumps (covered under the medical benefits).
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Mifeprex.
- Non-Federal Legend drugs.
- Non-Formulary drugs.
- Non-sedating antihistamines (NSAs) such as Allegra, Clarinex, Xyzal and Zyrtec, except for coverage for generic Zyrtec 5 mg chewable tablets and generic Zyrtec syrup to patients age six or younger.
- Relenza for children age six or younger.
- Sleep aids such as Ambien and Lunesta in excess of a quantity sufficient to treat 15 days per month. Medication in excess of this amount requires prior authorization for possible approval of extended benefits.
- Smoking deterrents, unless enrolled in the Quit for Life® Program (see page 72).
- Therapeutic devices or appliances.
- Yohimbine.
- Federal Legend vitamins.

For additional information, refer to the general exclusions which are listed beginning on page 89.

Dental Benefits

DENTAL BENEFITS AT-A-GLANCE	PLAN I			PLAN II		
	Delta Dental PPO	Delta Premier	Out-of-network	Delta Dental PPO	Delta Premier	Out-of-network
Deductible	$75 per person; $200 per family			$100 per person; no family maximum		
Diagnostic and Preventive Benefits	No Deductible; 100% of Contract Rate	75% of Contract Rate	75% of Plan's Allowance	No Deductible; 100% of Contract Rate	60% of Contract Rate	60% of Plan's Allowance
Basic Benefits	75% of Contract Rate		75% of Plan's Allowance	60% of Contract Rate		60% of Plan's Allowance
Major Benefits	50% of Contract Rate		50% of Plan's Allowance	50% of Contract Rate		50% of Plan's Allowance
Calendar Year Maximum (not applicable to individuals under age 19)	$2,500			$1,000		

The Plan's dental benefits are designed to help pay a portion of your dental expenses. Delta Dental, the nation's largest and most experienced dental benefits carrier, provides the PPO network for the Plan.

Selecting a Dentist

There are two types of Dentists in the Delta Dental network:

- Delta Dental PPO Dentists
- Delta Premier Dentists

When you use a Delta Dental PPO Dentist, your diagnostic and preventive services are covered at 100% and are not subject to the Deductible. Payment is based on a pre-approved fee, and your Dentist will file your Claims for you.

When you use a Delta Premier Dentist, payment is based on a preapproved fee. These Dentists will file your Claim forms for you, but diagnostic and preventive services are subject to the Deductible and paid at less than 100%.

To find a Delta Dental PPO or Delta Premier Dentist:

- Visit **www.deltadentalins.com/sag-aftra**.
- Call your Dentist and ask if he or she is a Delta Dental PPO Dentist or Delta Premier Dentist.

Using an Out-of-network Dentist

When you use a Dentist outside of Delta Dental's network, or if you reside outside the United States, payment is based on the Plan's Allowance or the fee the Dentist actually charges, if less. If your Dentist's fees exceed the Plan's Allowance, you are responsible for the difference between the Plan's payment and the Dentist's actual charges. In addition, you will be responsible for your regular Coinsurance and any Deductible that may apply. Finally, your out-of-network Dentist may collect payment up front and may not be willing to file a Claim form for you.

Important Note:
There is no Deductible for diagnostic and preventive services when you use a Delta Dental PPO in-network Dentist.

Deductible

Dental benefits are payable after you meet the annual Deductible. This dental Deductible is a separate Deductible from the Hospital, medical and prescription drug Deductibles. The amount of the dental Deductible differs for Plan I and Plan II, as noted below:

- Plan I - $75 per person/$200 per family. [8]
- Plan II - $100 per person/no family maximum.

If your eligibility changes from Plan I to Plan II during a calendar year, any charges that were applied toward your Plan I Deductible will apply toward your Plan II Deductible. If your eligibility changes from Plan II to Plan I, the reverse is also true.

Dental Benefits

Covered dental charges are charges from a Dentist or Physician for the services and supplies required for dental care and treatment of a disease, defect or accidental injury – or for preventive dental care.

Covered dental charges do not include any amounts above the customary charges for similar services or supplies by Dentists or Physicians in the same area. Where alternative services or supplies are customarily available for such treatment, covered dental charges will only include the least expensive professionally acceptable treatment plan.

Charges must be incurred and the services and/or supplies furnished while you or your Dependent are covered by the Plan. Charges are incurred on the date the service is rendered or the supply is furnished, with the following three exceptions:

1. With respect to fixed bridgework, crowns, inlays, onlays or gold restorations, the charge is incurred on the first date of preparation of the affected tooth or teeth.
2. With respect to full or partial dentures, the charge is incurred on the date the impression is taken.
3. With respect to endodontics, the charge is incurred on the date the tooth is opened for root canal therapy.

As shown in the table on the previous page, the Plan pays a different percentage based on the type of dental services you receive.

Diagnostic and Preventive Services

Diagnostic and preventive services under the dental benefits include the following:

- Oral examination – Once every six months (an additional oral exam is available for women while they are pregnant).
- Cleanings – Two per calendar year (an additional cleaning/scaling is available for women while they are pregnant). [9]
- X-rays:
  - Bitewing – Once every six months;
  - Full mouth – Once every three years;
  - Panoramic – Once every three years.
- Fluoride treatment – Individuals under age 19, once per calendar year.
- Biopsy/tissue examination.
- Emergency palliative treatment.

[8] If two or more members of your family are injured in the same accident, only one Deductible will be applied against all the covered dental charges incurred during any one year as a result of such accident.

[9] Individuals receiving post-periodontal surgery maintenance from an in-network or out-of-network Dentist are entitled to cleanings and scalings up to four times per year.

- Consultation by a covered specialist.
- Space maintainers.
- Study models.
- Sealants – Individuals under age 14, once every three years.

Basic Services

Basic services under the dental benefits include the following:

- Restorative – Amalgam, silicate or composite fillings. Charges for fillings are payable when they are necessary to restore the structure of the tooth broken down by decay or non-accidental injury.
- Oral surgery – Extractions, including surgical removal of teeth.
- Endodontics – Root canal therapy.
- Periodontics – Treatment of gums and bones supporting teeth.
- General anesthetics or IV sedation for oral surgery and certain endodontic and periodontal procedures.
- Injectable antibiotics.
- Addition of teeth to existing denture.
- Repair and rebasing of existing dentures.

Major Services

Major services under the dental benefits include the following:

- Restorative services – Gold fillings, inlays and crowns.
- Crown replacement – If crown is over three years old.
- Gold filling replacement – If filling is over five years old.
- Fixed bridges/partial or full dentures/implants – If required to replace lost natural teeth or an existing prosthesis or implant which is over five years old and cannot be made serviceable.

Major services are also subject to these additional limitations:

1. Covered charges for both temporary and permanent prostheses are limited to the charge for a permanent prosthesis.
2. Covered charges for a crown or gold filling will be limited to the charge for an amalgam filling, unless the tooth cannot be restored with amalgam.
3. Covered charges for porcelain or plastic veneer crowns (tooth colored crowns) may be limited to the charge for a metal crown on certain teeth in the back of the mouth. You may want to obtain a pre-treatment estimate so you will know how much the Plan will pay.
4. Charges for gold fillings, inlays and crowns are payable when they are necessary to restore the structure of the tooth broken down by decay or non-accidental injury.
5. Implants (an artificial tooth root that a periodontist places into your jaw to hold a replacement tooth or bridge) are covered under the major services portion of the Plan's dental benefits. Additional surgical procedures, such as bone grafting or tissue regeneration, or special imaging techniques such as CT scans, that are performed in connection with the placement of the implant are not covered under the dental or medical benefits. You may want to obtain a pre-treatment estimate (see the following page) so you will know how much the Plan will pay.

Maximum Dental Benefit

The maximum amounts that the Plan will pay for all covered dental charges in a calendar year are listed below:

- Plan I - $2,500 per person.
- Plan II - $1,000 per person.

There is no calendar year maximum for covered individuals under age 19.

If your eligibility changes from Plan I to Plan II during a calendar year, any charges that were applied toward your Plan I annual maximum will apply toward your Plan II annual maximum. If the Plan has already paid more

than $1,000 under your Plan I eligibility, no additional dental benefits will be paid under your Plan II eligibility for the rest of the calendar year.

If your eligibility changes from Plan II to Plan I in a calendar year, any charges that were applied toward your Plan II annual maximum will apply toward your Plan I annual maximum.

Pre-treatment Estimates

The Plan's dental benefits include an optional provision that allows you to learn in advance how much the Plan will pay for extensive dental work – before services are performed. The Plan strongly suggests that you ask your Dentist to request a free pre-treatment estimate from Delta Dental before undergoing any major services, or even basic services (see the previous page). This will ensure that you know up front what the Plan will pay and the amount for which you will be responsible. For information on how to request a pre-treatment estimate, please refer to the section on filing a Claim on page 104.

Questions

If your need help or have any questions, you can call the Plan or contact Delta Dental by visiting **www.deltadentalins.com/sag-aftra** or calling (800) 846-7418.

Non-covered Dental Expenses

- Accidental injury to natural sound teeth. (This coverage is provided under the medical benefits. See pages 56-57.)
- Adjustments to prosthesis within six months from installation.
- Anesthesia, other than anesthesia or IV sedation administered by a licensed Dentist in connection with covered oral surgery and select endodontic and periodontal procedures.
- Extra-oral grafts (grafting tissues from outside the mouth to oral tissue).
- Hospital costs and any additional fee charged by the Dentist for Hospital treatment.
- Occlusal guards and complete occlusal adjustment.
- Orthodontic treatment other than for related extractions or space maintainers.
- Procedures, restorations and appliances to increase vertical dimension or to restore occlusion.
- Replacement of existing restorations for any purposes other than active tooth decay.
- Services with respect to congenital or developmental malformations, or services and supplies cosmetic in nature, including but not limited to cleft palate, upper or lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (discoloration of the teeth) and anodontia (congenitally missing teeth).
- Services and supplies not recognized as generally accepted dental practice.
- Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth, including but not limited to equilibration and periodontal splinting.
- Specialized techniques involving precision attachments, personalization or characterization.
- Surgery or special imaging performed in connection with the placement of a dental implant.
- Training in or supplies used for dietary counseling, oral hygiene or plaque control.
- Temporomandibular joint syndrome (TMJ) treatment. (In certain circumstances, this coverage may be provided under the medical benefits. See page 59.)
- Treatment by someone other than a Dentist or Physician, except when performed by a duly qualified technician under the direction of a Dentist or Physician.

For additional information, refer to the general exclusions, which are listed beginning on page 89.

Vision Benefits

VISION BENEFITS AT-A-GLANCE	PLAN I		PLAN II
	In-network	Out-of-network	
Eye Exams	100% after $10 Copay (one exam per calendar year)	80% up to a maximum payment of $50[10] (one exam per calendar year)	No vision benefits available
Glasses	20% discount	No benefit	
Professional Services for Contact Lenses	15% discount	No benefit	

The Plan provides vision benefits through Vision Service Plan (VSP). This benefit is intended for routine vision care. The diagnosis and treatment of eye disease or injury is covered under the medical benefits.

Eligibility for Vision Benefits

All covered Plan I Participants and Dependents are eligible for VSP's Exam Plus Plan. Vision benefits are not available to Plan II Participants or Dependents.

Finding In-network Providers

You may search for Providers that participate in VSP's Exam Plus Plan, as described below:

- Call (800) 877-7195 and ask for a list of VSP participating doctors to be mailed to you. Or, you may simply enter a specific doctor's office telephone number to verify the doctor's participation in the VSP Exam Plus network.
- Visit the VSP website at **www.vsp.com** to locate an In-network Provider near you.
- Contact VSP by mail at:

Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100

Using the Vision Benefit

To use the Plan's vision benefit, follow the steps below:

1. Locate a VSP Exam Plus provider.
2. Call the doctor to make an appointment.
3. Identify yourself as a VSP Exam Plus Participant in the SAG-AFTRA Health Plan.
4. Provide the doctor with your health care ID number. If the patient is a Dependent child, you must also provide the patient's date of birth.

Eye Exams and Discounts on Corrective Lenses

The Plan's vision benefit includes one eye exam every calendar year for covered Plan I Participants

[10] If the eye exam is received through a non-VSP Provider, pay the full amount of the bill and submit a Claim for reimbursement as described on page 105.

and Dependents. Under the Plan's vision benefit, eye exams include an analysis of the patient's visual functioning and a prescription for corrective lenses when necessary. The exam includes additional services and follow-up eye care for Participants and Dependents with type 1 diabetes.

The Plan also offers discounts on complete pairs of glasses as well as professional services associated with prescription contact lenses. These discounts are applied to the doctor's usual and customary charge and are only guaranteed when you purchase them within 12 months of the last covered eye exam from any VSP In-network Provider. For glasses, you must purchase both lenses and frames. Contact lenses are available at the VSP doctor's normal retail price.

Laser Vision Correction Surgery

The VSP Exam Plus Plan network provides a discount on three commonly performed laser vision correction procedures – laser-assisted in-situ keratomileusis (LASIK), custom LASIK[11] and photorefractive keratectomy (PRK). Although the Plan does not pay the cost of the surgery, you have access to the procedures at reduced fees through VSP's network of doctors and laser centers. You will pay the Provider's discounted rate, which will not exceed the following:

- $1,500 per eye for PRK;
- $1,800 per eye for LASIK; or
- $2,300 per eye for Custom LASIK.

These fees include both pre- and post-operative care through your VSP doctor.

To schedule a complimentary screening and consultation about the benefits and risks of laser vision correction surgery, contact an in-network doctor. You may locate in-network VSP Providers at **www.vsp.com** or by calling (800) 877-7195.

Life Insurance Benefits

The life insurance benefit is insured through a policy with Metropolitan Life Insurance Company (MetLife).

Eligibility

To qualify for the life insurance benefit, you must be a Plan I Participant with Earned Eligibility or Senior Performers coverage at the time of your death. The life insurance benefit is not available if you are covered under COBRA or under Plan II Earned Eligibility, nor is it available to Dependents.

Your life insurance coverage begins when your Plan I Earned Eligibility or Senior Performers coverage begins, provided that you pay the required premium for health coverage. However, if a Participant with Earned Eligibility dies during the period between the Base Earnings Period and the Benefit Period, the life insurance benefit will be payable (but not accidental death and dismemberment benefits).

Life Insurance Benefit

The life insurance benefit amount depends on the type of coverage you have:

- Plan I Earned Eligibility – $10,000.
- Senior Performers – $5,000.

Your life insurance benefit is payable to the beneficiary or beneficiaries that you named on the most recent Beneficiary Designation Form on file with the Plan.

Please call the Plan to request a new Participant Information Form and Beneficiary Designation Form for any changes that may affect your personal profile, or to make a change in your beneficiary designation.

Funeral Expenses

Up to $500 of the life insurance benefit may be reimbursed to an individual who has incurred the

[11] Custom LASIK, or custom wavefront LASIK, is a laser vision correction procedure that allows the doctor to further customize the correction applied to each individual eye.

cost for funeral expenses on behalf of an eligible Participant. However, a Claim must be submitted prior to the payment of the life insurance.

The amount of life insurance benefit payable will be reduced by the amount paid for funeral expenses. In order to receive reimbursement of funeral expenses, you must submit a copy of the itemized charges, a certified copy of the death certificate and proof of payment.

Accelerated Life Insurance Benefit

In order to provide some financial assistance to terminally ill Participants, the Plan includes a provision for an accelerated life insurance benefit, which allows terminally ill covered Participants to receive 80% of their life insurance benefit while still living. For the purpose of this benefit, the Plan defines an individual as terminally ill if, due to injury or sickness he or she is expected to die within 24 months. The Plan will require a completed accelerated benefit claim form and a signed Physician's certification statement stating that you are terminally ill. Contact the Plan for additional information and forms.

Loss of Eligibility

When you lose Earned Eligibility under Plan I, your life insurance (but not the accidental death and dismemberment benefits) will remain in effect for 31 days following the date you lose Earned Eligibility.

You can convert your life insurance (but not accidental death and dismemberment benefits) to an individual policy during that 31-day period without undergoing a medical examination. You may convert $5,000 if you are losing Plan I Earned Eligibility and gaining Senior Performers eligibility. If you are not gaining Senior Performers eligibility, you may convert $10,000. However, if you have received an accelerated life insurance payment, the amount you may convert will be reduced by the amount of the accelerated benefit you have already received.

If you are totally disabled at the time you lose Earned Eligibility, and you are under age 65, your life insurance can remain in effect on a nonpayment of premium basis. For the purpose of this benefit, totally disabled means that due to an accidental bodily injury or sickness:

- You are unable to perform the material and substantial duties of your regular occupation; and
- You are unable to perform any occupation for which you are fit by education, training or experience.

Benefits will be payable upon your death if you were totally disabled for at least nine months. You must apply for a waiver of premium with MetLife within 12 months from the date your Earned Eligibility ends. You will be required to provide proof of continued disability each year. Contact the Plan for information and forms.

The continuation of life insurance under the waiver of premium provision will end on the earliest of:

- The date you die;
- The date your total disability ends;
- The date you do not provide proof of total disability, as required; or
- The date you refuse to be examined by MetLife's physician, as required.

Accidental Death and Dismemberment (AD&D) Benefits

The accidental death and dismemberment (AD&D) benefits are insured through a policy with Metropolitan Life Insurance Company (MetLife).

Eligibility

To qualify for AD&D benefits, you must be a Plan I or Plan II Participant with Earned Eligibility at the time of your loss. Your AD&D coverage ends when you lose Earned Eligibility. AD&D benefits are not available if you have COBRA or Senior Performers coverage, nor are these benefits available to Dependents.

AD&D Benefits

Benefits are payable if you are involved in an accident and you suffer any of the losses indicated below as a result of the accident. Generally, the loss must occur within 90 days of the accidental injury. Exceptions are for coma and brain damage, which must occur or manifest within 30 days of the accidental injury. The maximum benefit that will be paid for all losses resulting from one accident is $10,000.

If you die in the accident, the benefit will be paid to your beneficiary. Otherwise, the benefit will be paid to you, the Participant.

ACCIDENT RESULTING IN:	THE BENEFIT PAID IS:
Loss of life	$10,000
Loss of one arm at or above elbow	$7,500
Loss of one leg at or above knee	$7,500
Loss of one hand	$5,000
Loss of one foot	$5,000
Loss of thumb and index finger on same hand	$2,500
Loss of sight of one eye	$5,000
Loss of hearing in both ears (must continue for six consecutive months)	$5,000
Loss of speech (must continue for six consecutive months)	$10,000
Paralysis of one arm	$2,500
Paralysis of one leg	$2,500
Coma – Benefit becomes payable on the 7th day of a coma	$100/month for up to a maximum of 60 months
Brain damage – Requires a five-day hospitalization and brain damage that has persisted for 12 consecutive months	$10,000
More than one of the above resulting from one accident	$10,000 or the sum of the benefits payable for each loss (whichever is less)

Paralysis means loss of use of a non-severed limb. A Physician must determine the paralysis to be permanent, complete and irreversible.

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused.

Brain damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life.

Seat Belt and Air Bag Benefits

Additional benefits may be available if you die in a car accident and you were wearing a seat belt and sitting in a seat protected by an air bag. These benefits are available whether you were driving or riding as a passenger in a passenger car. Passenger car means any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes or any vehicle used for recreational or professional racing.

If you were wearing a seat belt that was properly fastened at the time of the accident, an additional $1,000 benefit will be paid. Seat belt also includes any child restraint device that meets the requirements of state law.

If you were wearing a seat belt and sitting in a seat protected by an airbag, an additional $500 benefit will be paid. This benefit is in addition to the seat belt benefit.

A police officer investigating the accident must certify that the seat belt was properly fastened. If applicable, the police officer must also certify that the passenger car in which you were traveling was equipped with airbags. A copy of such certification must be submitted with the Claim for benefits.

Exclusions

AD&D benefits are not payable for losses due to:

- Diagnosis of or treatment for physical or mental illness or infirmity.
- Committing or trying to commit a felony.
- Infection, unless it occurs in an external accidental wound.
- Intentional or reckless self-inflicted injury.
- Intoxication, if you were the operator of a vehicle or other device involved in the accident.
- Service in the armed forces of any country or international authority, except the United States National Guard.
- Suicide or attempted suicide.
- Voluntary use of:
  - Any drug, medication or sedative unless it is:
    - » Taken or used as prescribed by a Physician; or
    - » An over-the-counter drug, medication or sedative taken as directed.
  - Alcohol in combination with any drug, medication or sedative.
  - Poison, gas or fumes.
- War, whether declared or undeclared; or act of war, insurrection, rebellion or riot.

General Exclusions

The following exclusions apply to all of the Plan benefits:

- Hospitalization, treatment, services, prescription drugs or supplies provided while you are not covered by the Plan.
- Charges for any injury or sickness resulting from or occurring during the commission of, or attempt to commit a felony.
- Charges for completing Claim forms, reports or copying of medical records.
- Charges for Experimental or Investigative Procedures (see Glossary on pages 131-132).
- Charges for military-related injury or illness. However, the Veterans' Administration or a governmental military Hospital or other governmental agency has the right to be reimbursed in accordance with the provisions of the Plan for any charges for services rendered to a covered person for services or supplies which are not related to military service. For individuals with Senior Performers coverage who are eligible for

Medicare, the Hospital and medical benefits paid by the Plan will depend on the amount you would have received if the service had been performed in a non-governmental facility, with Medicare as the primary payor.

- Charges for services provided or paid for by the U.S. government or any other government, except as otherwise provided herein. In addition, benefits will be payable if there is a legal obligation to pay for charges without regard to the existence of any insurance or employee benefit plan.
- Charges for on-the-job injuries or illnesses. These charges are excluded whether or not your employer obtained a Workers' Compensation policy. Occupational injuries or illnesses are normally covered by Workers' Compensation Insurance. **If you work through a loan-out company, you should make sure that your employer covers you under its Workers' Compensation policy.** The Plan will consider charges for injuries or illnesses that are specifically excluded from Workers' Compensation laws.
- Charges for services or supplies not recommended by a Physician.
- Charges for services or supplies that are provided by any Government or governmental political subdivision in conjunction with the operation of their correctional or mental health programs.
- Charges for services rendered by providers who are not licensed by the appropriate state or federal authority.
- Charges for service rendered by a Provider that are not within the Provider's licensure.
- Charges for services rendered to you by yourself or by a Provider who is an "immediate relative" or by any person who normally lives in the covered person's home. An "immediate relative" includes husband and wife, biological or adoptive parent, child and sibling, stepparent, stepchild, stepbrother and stepsister, father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law and daughter-in-law, grandparent and grandchild, spouse of grandparent and grandchild. This exclusion does not apply to benefits provided under the Express Scripts prescription drug program.
- Charges for state-mandated benefits not otherwise covered by the Plan. The Plan is self-funded and therefore is not subject to state-mandated insurance laws because of an exemption provided under ERISA.
- Charges for telephone, email or internet consultations.
- Charges in excess of the Contract Rate (see Glossary on page 130). In-network Providers cannot bill you for covered charges in excess of the Contract Rate.
- Charges in excess of the Plan's Allowance (see Glossary on page 129).
- Charges in excess of the reasonable charge.
- Charges incurred for a service or supply that is not Medically Necessary (see Glossary on page 132). This exclusion also applies to any hospitalization (or any part of a Hospital stay) that is related to a procedure that is not Medically Necessary or that is not recommended or approved by a Provider.
- Charges incurred on account of declared or undeclared war, and illness or injuries resulting from war, whether declared or undeclared, or any act of war.
- Charges submitted for which you are not financially responsible.
- Charges submitted more than 15 months after the date services are incurred (18 months for Hospital charges).
- Charges that are not considered appropriate for the treatment of an illness or accident.

- Charges incurred as a result of an injury or illness that is caused by the act or omission of another person (except as provided under the subrogation and reimbursement provision on pages 120-121).
- Charges for services or supplies that are ordered from internet retailers such as Amazon, Overstock and eBay.

IX. Understanding Medicare

Terms to know for Section IX:

Please refer to the Glossary on pages 129-133 for definitions of these and other capitalized key terms.

Coordination of Benefits (COB)

Earned Active Eligibility

Earned Eligibility

Earned Inactive Eligibility

Senior Performer

Important Note:

The Plan has specific rules for Coordination of Benefits (COB) with Medicare, which are described on pages 99-101. The table in that section explains terms used specifically for Medicare COB such as "Earned Active Eligibility" and "Earned Inactive Eligibility."

There are four different types of Medicare coverage.

- Medicare Part A covers Hospital charges and requires no premium.
- Medicare Part B covers doctors' bills and other medical care, but is optional coverage that requires a monthly premium.
- Medicare Part C (sometimes called Medicare Advantage) refers to plans offered by private insurers that you may choose in lieu of traditional Medicare benefits. Most Part C plans require a premium, and if you enroll in Part C, you waive your rights to benefits from Medicare Parts A and B.
- Medicare Part D refers to coverage for prescription drugs offered by private insurers. Part D plans work in conjunction with your traditional Medicare benefits (Parts A and B) and typically require a monthly premium.

Medicare Part A – Inpatient Hospital Coverage

Enrollment in Part A is no longer automatic because eligibility for Medicare occurs at age 65, while the Social Security retirement age is no longer 65. If you and/or your spouse are not enrolled in Medicare Part A when Medicare is primary, under its COB rules the Plan will pay benefits as if you had received benefits from Medicare. You and your spouse are strongly encouraged to enroll for Medicare Part A when each of you reach age 65, even if you are still working and have Earned Active Eligibility under the Plan.

We suggest that you contact Medicare at least three months before your 65th birthday to begin the enrollment process. This will eliminate the possibility that you could be subject to benefit reductions for Hospital charges after your Earned Active Eligibility ends and you become eligible for Senior Performers, COBRA or Earned Inactive Eligibility. Remember, there is no premium for Part A.

Medicare Part B – Outpatient Medical Coverage

Enrollment in Part B is not automatic. You must apply and pay a monthly premium, and you may only enroll during a defined enrollment period. Because Part B requires a premium, you may choose not to enroll until Medicare becomes your primary plan, which is when your Earned Active Eligibility ends and you become eligible for Senior Performers, COBRA or

Earned Inactive Eligibility. However, if you wait too long, there will be a gap before Medicare begins. If this happens, the Plan will pay benefits under its COB rules as if you had received benefits from Medicare. To avoid a coverage reduction, contact both the Plan and Medicare to make sure that you enroll as soon as your Earned Active Eligibility ends. We suggest that you contact Medicare at least three months before your 65th birthday.

Medicare Part C – Alternative Private Coverage

Medicare Part C, also called Medicare Advantage, is an option that Medicare beneficiaries can choose as an alternative to traditional Medicare benefits (Parts A and B) and sometimes Part D coverage. There are many different Medicare Advantage plans available nationwide, and some plans require monthly premiums while others do not. However, all Medicare Part C plans are administered through private insurers and require enrollees to waive their traditional Medicare benefits.

Medicare Part D – Private Prescription Drug Coverage

Prescription drug coverage is available through Medicare Part D plans offered by private insurers, and most Part D plans require a premium. You may enroll in a Part D plan when you become eligible for Medicare, or during the annual open enrollment period from October 15 through December 7. Visit **www.medicare.gov** for dates and other information about Medicare's annual open enrollment period.

Unlike Parts A and B, you may decide *not* to enroll in a Medicare Part D plan. If you choose to enroll in a Part D plan, you will not be eligible for the prescription drug benefits included with the Plan's Senior Performers, COBRA, Earned Inactive Eligibility or Surviving Dependent coverage.

The prescription drug benefits offered under the Plan are considered "creditable coverage." This means they are comparable to the standard Medicare drug benefits, except under very limited circumstances.

There are three possible situations in which you may be better off enrolling in a Medicare Part D plan.

- *People with limited resources* – Medicare includes special provisions for those with limited income and resources. The special provisions may allow you to receive Medicare prescription drug benefits with no premium and low or no Deductibles and Copays. If you think you may qualify, contact the Social Security Administration or complete their worksheet found on their website (**www.ssa.gov**).

- *COBRA Participants* – If you are currently enrolled in COBRA Continuation Coverage and are also Medicare-eligible, it is possible that, with the monthly premiums and prescription drug Deductible and Copays, you may pay more for the Plan's coverage than through a Medicare Part D plan plus Medicare's Hospital and medical benefits. Keep in mind that if you decide to enroll in a Medicare Part D plan and stop paying your COBRA premiums, you will have no coverage – Hospital, medical, prescription drug or dental – under the Plan. You cannot drop just the prescription drug benefits and retain the other Plan coverage. Also, if you terminate your COBRA Continuation Coverage, you will not be able to regain coverage unless you requalify for Earned Eligibility.

- *Medicare HMO Participants* – If you are enrolled in a Medicare HMO, that plan may have automatically enrolled you in their Medicare Part D plan. The HMO may not allow you to drop just the prescription drug coverage without dropping the Hospital and medical coverage as well.

When making your decision to enroll, you should compare the Plan's coverage, including what medications are covered, with the coverage and cost of the Medicare Part D plans available in your area.

If you enroll in a Medicare Part D plan and you later drop that coverage, you can receive prescription drug coverage from the Plan again, provided you are still eligible for coverage. In such a case, your prescription drug coverage under the Plan will be effective the first of the month after your Medicare Part D coverage ends.

If you are eligible for Medicare, the Plan will annually mail you a Notice of Creditable Coverage. This notice is also available upon request by calling the Plan or by visiting **www.sagaftraplans.org/health**. The notice will advise you that the Plan's prescription drug coverage is, on average, comparable to the standard Medicare prescription drug coverage. Keep this notice, as you will need a copy of it if you lose coverage under the Plan and you want to enroll in a Part D plan without paying a higher premium.

X. Coordination of Benefits

Coordination of Benefits (COB) refers to the set of rules that determines responsibility for payment among all health plans that cover an individual. You must keep the Plan informed about all other health coverage that you have or are eligible to receive, so that the plans can properly coordinate your benefits.

The Plan coordinates benefits with all other group and private health plans, as well as Medicare. The Plan also coordinates benefits for married couples who are both eligible for coverage as Participants in the Plan and for the Dependent children of two eligible married Participants. If a parent and a child are both Participants, the Plan will coordinate benefits with respect to the child's coverage. However, since under Plan rules the parent cannot be a Dependent of the child, the parent will only be treated as a Participant and will only have his or her own coverage.

If you qualify for coverage with the Plan and another health plan, it is important that you understand the impact of choosing whether or not to pay the premium for either the Plan or the other plan(s).

COB rules can be difficult to understand. Therefore, we strongly recommend you contact the Plan to discuss your individual situation when deciding whether or not to pay a premium for coverage. You should also contact your other plan(s), as plans have different rules for coordinating benefits.

Determination of Primary Plan and General Rules for COB

Whichever plan is designated as the primary plan pays first on your Claims. If a balance is still due after the primary plan's payment, the Claim should be sent to the secondary plan for consideration (and, if applicable, a third plan and so on).

In determining which of the plans is primary or secondary (or third), the Plan will apply the rules outlined below. The first rule that applies to your specific situation will be followed.

1. The plan without a COB provision is always primary.
2. The plan that covers a person as a participant is primary to any plan covering the person as a dependent.
3. The plan that covers a person with Earned Eligibility or as an active employee is primary to any plan covering the person as a retiree or any

Terms to know for Section X:

Please refer to the Glossary on pages 129-133 for definitions of these and other capitalized key terms.

Allowed Amount/Allowance

Claim

Contract Rate

Coordination of Benefits (COB)

Earned Active Eligibility

Earned Eligibility

Earned Inactive Eligibility

Entertainment Industry Coordination of Benefits (EICOB)

Explanation of Benefits (EOB)

In-network Provider

Out-of-network Provider

Provider

Important Note:

When coordinating benefits with Medicare, the Plan also uses active and inactive coverage rules. Please see pages 99-101 for a description of Medicare COB.

plan providing self-paid coverage, such as COBRA Continuation Coverage.

4. If a person has the same type of eligibility (for example, Earned Eligibility) with more than one plan, the plan covering the person for the longest continuous period is primary to any plan(s) that has covered the person for a shorter period. If you have the same coverage effective date under more than one plan, please contact the Plan for help determining how your benefits should be coordinated.

Determination of Dependent Child's Primary Plan

In the case of a dependent child where the parents are not divorced, the Plan uses the "birthday rule." This means the plan of the parent whose birthday occurs earlier in the calendar year is primary. If both parents have the same birthday, the plan that has covered the child the longest is primary. If the other plan does not have the birthday rule, then the other plan's rules will determine who is primary.

In the case of a dependent child where the parents are divorced, the rules are:

- If the parent with custody has not remarried, the plan of the parent with custody is primary to the plan of the non-custodial parent.
- If the parent with custody has remarried, the plan of the custodial parent is primary, the plan of the custodial parent's spouse is secondary and the plan of the non-custodial parent is third.
- If a court order provides a different order of benefit determination, the court order will be followed. A copy of the court order will be required.

Coordination of Benefits With Other Entertainment Industry Health Plans

If you are entitled to primary coverage with another entertainment industry plan but fail to pay the premium in that plan, the SAG-AFTRA Health Plan will maintain its secondary position. The Plan refers to this as the Entertainment Industry Coordination of Benefits (EICOB) rule. This rule was incorporated to maintain the correct primary and secondary positions of the health plans based on your longest continuous coverage.

Other entertainment industry plans subject to the EICOB rule include the Directors Guild of America-Producer Health Plan, the Equity-League Health Plan, the Motion Picture Industry Health Plan and the Writers' Guild-Industry Health Fund. These rules apply to Participants and Dependents in both Plan I and Plan II, regardless of whether you have Earned Eligibility or you are eligible for Senior Performers or Surviving Dependent coverage.

If you do not enroll in your primary coverage, the Plan will maintain its secondary position by only paying up to 20% of the Allowed Amount for your Hospital and medical Claims, including mental health and substance abuse Claims, subject to the Deductibles. For prescription drug benefits, you will not receive an Express Scripts ID card. You must pay for your prescriptions at the pharmacy and submit a Claim to the Plan for reimbursement of up to 20% of the Allowed Amount, subject to the out-of-network medical Deductible. Dental and vision benefits will continue to be administered through Delta Dental and Vision Service Plan as if the Plan is primary.

Important Note:
While we have done our best to provide an explanation, the Plan's Entertainment Industry Coordination of Benefits (EICOB) rules can be difficult to understand. We strongly suggest you contact the Plan to discuss your individual situation.

Exceptions to EICOB Rule

The following exceptions to the EICOB rule apply in the situations described below:

- *Same longest continuous coverage date* – When the longest continuous coverage date, as described on the previous page, is the same under the Plan and your other plan, you are referred to as a "pro rata" Participant. This means that you will be able to choose the plan you wish to be primary. Only Participants in this situation are given a choice of which plan they wish to be primary. If you think you may be a pro rata Participant, please contact the Plan.

- *Primary plan offers only individual coverage* – If your primary plan only offers individual coverage and excludes coverage for your Dependents, the Plan will continue to pay primary for your Dependents. For example, the Equity-League Health Plan provides individual coverage and requires Participants to pay the full cost of coverage for their Dependents. If your primary coverage is Equity-League, your Dependents would continue to be covered as primary in the SAG-AFTRA Health Plan, regardless of whether you continued the other coverage. However, if the other plan does provide Dependent coverage, you will be required to keep your Dependent coverage in the other plan to avoid a reduction in your benefits from the Plan.

- *Deferral of Equity-League Health Plan eligibility* – The Equity-League Health Plan has a rule that gives its participants the choice to defer their health coverage in order to gain a longer period of eligibility for coverage. If your other primary plan is the Equity-League Health Plan and you choose to defer your Equity-League eligibility in accordance with that plan's rules, the Plan will not apply its special EICOB rule. This means the Plan will pay as primary for those participants during the deferral period. However, if you drop your Equity-League coverage for any reason other than the special deferral rule (such as for non-payment of premiums), the Plan will reduce its benefits accordingly.

- *The Plan's original position is third or lower* – If the Plan's original position is third or lower, the reduction does not apply, provided you pay for your primary or secondary coverage. For example, if you have DGA coverage as primary, Equity-League coverage as secondary and Plan coverage as third – but you fail to pay your Equity-League premium – the Plan will pay as if it were in second position. Your benefits will not be reduced because of your failure to pay the Equity-League premium. However, if you fail to pay both your DGA and Equity-League premiums, the Plan will reduce its benefits.

  If Medicare is your primary plan, this exception changes so that the reduction does not apply if the Plan's original position is fourth or lower. For example, if Medicare is primary, Equity-League is second and the Plan is third – and you fail to pay the Equity-League premium – the Plan will only pay what it would have paid in the third position.

- *Married Participants both eligible for Plan coverage* – A special rule applies to married Participants who are both eligible for Plan coverage and who also have coverage in another entertainment industry plan. If the Plan is primary for one or both of the Participants, the Plan will not reduce benefits if the Participant and/or the spouse of the Participant does not elect to enroll in the other entertainment plan coverage. You may choose to pay for only one SAG-AFTRA Health Plan coverage, which will cover you and your Dependents as primary coverage. If you pay the premiums for both SAG-AFTRA Health Plan coverages, the Plan will coordinate benefits between both coverages.

- *Parent and Dependent child both eligible for Plan coverage* – The special rule just described also applies to families where a parent and Dependent child are both eligible for the Plan.

Coordination of Benefits With HMOs

If you or your Dependents have primary coverage with an HMO (including a Medicare HMO), you must

use Providers in the HMO's Provider network. When you do, the Plan will pay secondary for any Copays or Deductibles you may incur. If you do not use HMO network Providers, the Plan will reduce its benefits by 80%. In other words, the maximum the Plan will pay is 20% of the Allowed Amount for the Claim.

It is extremely important that you use your HMO network Providers when the HMO is your primary plan. If you do not, your benefits under this Plan will be reduced and you will have much larger out-of-pocket expenses.

In cases where your HMO excludes specific services that this Plan covers, such as chiropractic care, regular Plan benefits will be paid.

How Benefits Are Calculated

Once a determination has been made about which plan is primary, the benefits are processed as follows.

When the Plan Is Primary

If this Plan is primary, bills should be submitted as outlined under "How to File a Claim" (pages 102-105). This Plan will pay benefits based on its rules as if there were no other coverage.

When the Plan Is Secondary

If this Plan is secondary, copies of the original bills and a copy of the other plan's EOBs should be submitted as outlined under "How to File a Claim" (pages 102-105). However, if this Plan is secondary because Medicare is your primary coverage, you do not need to send your bills and EOBs to the Plan. Medicare will submit this information on your behalf.

The Plan will determine how much it would have paid had there been no other coverage. It will then subtract what was paid by the primary plan from the total COB allowable expenses. The COB allowable expenses are based on whether or not the Provider is an In-network Provider.

The difference between the COB allowable expenses and what the primary plan paid will be paid by the Plan, provided it does not exceed the amount the Plan would have paid if it was primary. When a BlueCard PPO or Beacon Health In-network Provider is used, if the primary plan has already reimbursed more than the network Contract Rate, the Plan will not make any payment, and the remaining charges become a network write-off. You are not responsible for the balance.

PROVIDER STATUS		COB ALLOWABLE EXPENSES
This Plan	The Primary Plan	
In-network	In-network	The lower of this Plan's network Contract Rate or the primary plan's network contract rate
In-network	Out-of-network	This Plan's network Contract Rate
Out-of-network	In-network	The primary plan's network contract rate
Out-of-network	Out-of-network	The higher of this Plan's Allowance or the primary plan's allowance

To better understand how this works, refer to the examples outlined below. Both examples assume that the Participant is enrolled with Plan I coverage, is using an Out-of-network Provider and that the Deductibles have been met.

IF THIS PLAN IS PRIMARY		IF THIS PLAN IS SECONDARY	
$600	COB allowable expenses	$600	COB allowable expenses
x 70%	Plan's benefit	$420	Primary plan's payment
$420	Plan pays	$180	Plan pays

Coordination of Benefits With Medicare

If you are age 65 or older and you have COBRA, Senior Performers or Surviving Dependent coverage, Medicare provides primary coverage and the Plan provides secondary coverage. With regard to Earned Eligibility, federal law requires that this Plan be primary to Medicare for active Participants who are age 65 or older. The rules in the table below should be applied to determine whether or not you have Earned Active Eligibility or Earned Inactive Eligibility.

IF YOUR EARNED ELIGIBILITY IS BASED ON	YOU ARE	YOUR PRIMARY PLAN IS	YOUR SECONDARY PLAN IS
All sessional Covered Earnings	Active	SAG-AFTRA Health Plan	Medicare
All residual Covered Earnings[12]	Inactive	Medicare	SAG-AFTRA Health Plan
A combination of residual and sessional Covered Earnings	Active	SAG-AFTRA Health Plan	Medicare
Alternative Days	Active	SAG-AFTRA Health Plan	Medicare
Covered Roster Artist status	Active	SAG-AFTRA Health Plan	Medicare
Network/Station Staff status	Active	SAG-AFTRA Health Plan	Medicare

It is possible for your status to change from year to year. For example, if you have Senior Performers coverage and satisfy the minimum Covered Earnings requirement through a combination of residual and sessional earnings, you regain Earned Active Eligibility and the Plan becomes your primary plan. In the next year, if you only have residual earnings, you change back to Senior Performers coverage and Medicare would become your primary plan. Senior Performers and Surviving Dependents cannot gain Earned Inactive Eligibility. If the minimum Covered Earnings requirement is satisfied solely through residuals, these individuals keep their Senior Performers or Surviving Dependent eligibility.

The Plan will notify you of any change in your eligibility and can tell you which plan is primary at any time.

[12] The AFTRA Health Fund considered a Participant who satisfied the earnings requirement entirely through residual earnings to have active eligibility. If you had AFTRA active eligibility based on residuals as of December 31, 2016, your active eligibility will continue in the SAG-AFTRA Health Plan through the end of your Benefit Period. Thereafter, the Plan will evaluate your active and inactive status based on the rules outlined in the table.

Important Notes

The following special rules apply to any Participant or Dependent who is eligible for Medicare, including Participants or Dependents age 65 or older and Participants or Dependents who are eligible for Medicare due to a disability.

- The distinction between sessional and residual earnings is made only for purposes of COB with Medicare. If you satisfy the minimum earnings requirement through residuals only, you will have inactive coverage and Medicare will be primary.
- Medicare is primary for Medicare-disabled Dependents of Participants younger than age 65 whose Earned Eligibility is based on residuals only.
- Special rules apply to individuals with End Stage Renal Disease. Contact the Plan for details or refer to the Medicare & You handbook available at **www.medicare.gov**.

If you or your Dependents qualify for other health coverage in addition to the Plan and Medicare, please contact the Plan to determine the order of Claims payment. The Plan's Entertainment Industry Coordination of Benefits (EICOB) rules will apply in this situation and can be difficult to understand (see pages 96-97).

How Benefits Are Calculated When Coordinating With Medicare

The Medicare COB method described in this section applies to all Participants and Dependents with Medicare except those that received Senior Performers or Surviving Dependent benefits under the Screen Actors Guild–Producers Health Plan prior to January 1, 2017. For those Medicare COB rules, see the following page.

Medicare pays its benefit allowances first for Hospital or medical services that you receive and the Plan pays its benefits second based on the Plan's in-network reimbursement provisions. Before the Plan begins to pay a benefit, you must satisfy the annual in-network Hospital and medical Deductibles.

Upon receipt of your Claim, the Plan will subtract what Medicare paid from the Medicare allowance and then deduct any outstanding annual Deductible amounts you may owe (based on your annual in-network Hospital Deductible and your annual in-network medical Deductible). After your outstanding Deductible amounts have been subtracted, the Plan will apply the in-network Copays and Coinsurance amounts as applicable.

The total benefit paid by Medicare and the Plan will generally cover less than 100% of the Medicare allowance. Participants usually will have an out-of-pocket expense, regardless of whether or not they have satisfied the Plan's in-network Deductibles.

To better understand how this works, refer to the examples outlined below.

Example 1:

In this example a Plan I Participant receives medical services and has not had any expenses applied toward the Plan's in-network medical Deductible of $250. The following additional assumptions are used:

Medicare

• Medicare covered allowance	$2,500
• Medicare pays 80%	$2,000

SAG-AFTRA Health Plan

• Annual in-network medical Deductible	$250
• Plan pays	90%
• Participant Coinsurance	10%

1. Medicare covered allowance	$2,500
2. Medicare pays	$2,000
3. Balance after the Medicare payment (line 1 – line 2)	$500
4. Remainder of annual in-network medical Deductible	$250
5. Balance less the Deductible (line 3 – line 4)	$250
6. Plan pays 90% of the amount from line 5	$225
7. Participant pays 10% of the amount from line 5	$25
8. Participant balance due to Provider equals line 3 – line 6	$275

Example 2:

In this example the Participant has satisfied the Plan I annual in-network medical Deductible of $250. All of the other assumptions are the same used in the previous example.

1.	Medicare covered allowance	$2,500
2.	Medicare pays	$2,000
3.	Balance after the Medicare payment (line 1 – line 2)	$500
4.	Remainder of annual in-network medical Deductible	$0
5.	Balance less the Deductible (line 3 - line 4)	$500
6.	Plan pays 90% of amount from line 5	$450
7.	Participant pays 10% of the amount from line 5	$50
8.	Participant balance due to Provider equals line 3 - line 6	$50

The Plan will calculate its benefits as if you had received benefits from Medicare even in the following situations.

1. *You fail to enroll in Medicare Parts A and B when the Plan is secondary to Medicare.* You should contact Medicare at least three months before you turn age 65 to enroll in Medicare.

2. *You use a doctor who has opted out of Medicare.* Medicare allows doctors the opportunity to opt out of the Medicare system and contract directly with patients to provide treatment that will not be covered by Medicare. A doctor who has opted out of Medicare must inform the patient that Medicare will not cover his or her services. Additionally, the doctor and patient must sign a written contract in which the patient agrees that the doctor's charges will not be paid by Medicare. If you or your spouse use the services of a doctor who has opted out of Medicare when Medicare is your primary coverage, the Plan will pay only what it would have paid if you had chosen a Provider who does accept Medicare.

3. *You fail to use a Medicare HMO Provider when Medicare is primary.* Medicare beneficiaries have a choice between traditional Medicare (Parts A and B) or a Medicare HMO (Part C). If you or your spouse are enrolled in a Medicare HMO as your primary plan, but you do not use HMO network Providers, the Plan will pay only what it would have paid if you had used the HMO network Providers.

Individuals Who Received Senior Performers or Surviving Dependent Benefits Under the SAG-Producers Health Plan Prior to January 1, 2017

If you received Senior Performers or Surviving Dependent benefits under the Screen Actors Guild–Producers Health Plan prior to January 1, 2017, the SAG-AFTRA Health Plan will coordinate benefits with Medicare using the method described under "When the SAG-AFTRA Health Plan Is Secondary" on pages 98-99. However, the Plan will reduce benefits by 80% for Medicare beneficiaries under the three situations described above. This is because the Plan will pay Claims only on a secondary basis, as if you received primary reimbursement from Medicare.

XI. Claims and Appeals

Terms to know for Section XI:

Please refer to the Glossary on pages 129-133 for definitions of these and other capitalized key terms.

Claim

Concurrent Care Claim

Disability Claim

Experimental or Investigative Procedure

Explanation of Benefits (EOB)

Medical Necessity

Post-service Claim

Pre-service Claim

Urgent Care Claim

A Claim for benefits is a request for benefits made in accordance with the Plan's Claims procedures outlined in this section. Simple inquiries about the Plan's provisions unrelated to a specific Claim are not treated as Claims for benefits, nor are requests for prior approval of benefits that do not require such approval.

In addition, when you present a prescription to a pharmacy to be filled under the terms of the Plan, that request is not a Claim under these procedures. However, if your prescription request is denied in whole or in part, you may file an appeal of the denial by using the procedures outlined under "Health, Disability and Retroactive Removal of Coverage Appeals" on pages 108-112.

Authorized Representatives

If you wish to designate an authorized representative to act on your behalf with respect to your Claim for benefits, you must complete the Plan's Authorization for Release of Health Information Form. Please contact the Plan to request this form or download the current version from the forms section of **www.sagaftraplans.org/health**. If you designate an individual to act as your authorized representative, he or she may complete the Claim form for you if you are unable to complete the form yourself.

Please be advised that no rights under the Plan, including but not limited to the right to receive any benefit or any right to pursue a Claim or cause of action, are assignable. Any payment by the Plan directly to a Provider pursuant to a written election or purported assignments submitted by a Participant or a Dependent is provided at the discretion of the Board of Trustees as a convenience to the Participant or Dependent and does not imply an enforceable assignment of any benefits or the right to pursue a Claim or cause of action.

How to File a Claim

Claims for Hospital and Medical Benefits

When you use In-network Providers, the Provider will file the Claim for you. For out-of-network Claims, the Provider may file the Claim for you. If the Provider files the claim, all Claims from California Providers and facilities should be sent to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Claims from Providers and facilities in states outside California should be sent to the local Blue Cross and Blue Shield plan for the area where the Provider is located. The local plan claim submission addresses can be obtained by calling (800) 810-BLUE.

If you file the Claim, you must complete a Claim form and submit it to the Plan:

SAG-AFTRA Health Plan
P.O. Box 7830
Burbank, CA 91510-7830

Claim forms may be obtained from the Plan or downloaded from the forms section of **www.sagaftraplans.org/health**.

The Plan will accept Hospital expenses for up to 18 months after the date of service, and medical expenses for up to 15 months after the date of service. Any requests for payment of Hospital expenses submitted more than 18 months after the date of service or for payment of medical expenses submitted more than 15 months after the date of service will be considered time barred and will not be considered for payment.

If you receive treatment outside of the United States, submit a detailed bill (along with an English translation, if applicable) to the Plan. The bill should include the date that services were provided, a description of each service, the charge for each service and the reason treatment was provided. Be sure to also include the type of currency that was used when you paid for these services.

Before submitting a Claim form, be sure it is filled out properly. To avoid delay in the processing of your Claims, follow these steps:

1. Be sure to complete Part 1 of the Plan's Claim form in full. Attach your Physician's itemized bill to the completed Claim form.
2. You and the Physician should complete a separate form for each family member and for each illness, as applicable.
3. If you are seeing a Physician(s) for more than one illness or injury, you must submit a form for each illness or injury, as applicable.
4. Please answer all questions completely.
5. Make sure you or your authorized representative answer all questions about other insurance. Provide the name(s) of the other insurance, the address, identifying codes, and the name of the policyholder. Failure to provide information about other insurance and to answer questions honestly and completely may constitute fraud.
6. When you are covered by more than one plan, each plan will require a copy of all itemized bills with the diagnosis and corresponding EOBs. A copy of the operative and pathology reports is required for most surgical procedures. Please submit copies of the reports when you submit the surgeon's bill.
7. Be sure to complete Part 3 of the Claim form if you wish the Plan to make payment directly to the Provider of services. An updated assignment of benefits is required every 12 months. Only the Participant can assign payment of benefits. This cannot be done by any other person, including your eligible Dependent(s). The Plan accepts "Signature on File" as a valid assignment of benefits, though we reserve the right to request the actual assignment.
8. If reimbursement for medical expenses and correspondence are to be handled by your business manager or accountant, please let us know in writing at the time you submit your first Claim form. We cannot give information to a third party without your written permission. An Authorization for Release of Health Information is available from the Plan or from the forms section of **www.sagaftraplans.org/health**.
9. Do not forget to sign the form. Your business manager or legal representative cannot sign for you unless he or she has power of attorney. If that is the case, please send a copy of the authorizing document.

10. If you have questions, contact the Plan at (800) 777-4013 or log in to your Benefits Manager at **www.sagaftraplans.org/health** and use the Plan's secure message center.

Claims for Mental Health and Substance Abuse Benefits

When you use In-network Providers for inpatient care, alternative levels of care or outpatient therapy, the Provider will file the Claim for you. When you use an Out-of-network Provider for outpatient therapy, you or your Provider should submit Claims directly to Beacon Health Options. **Do not send Claim forms to the Plan.**

Beacon Health Options
Latham Claims
P.O. Box 1290
Latham, NY 12110

You may download Claim forms at **www.sagaftraplans.org/health** or request a form by calling the Plan.

Follow the instructions on the Claim form carefully and answer all questions completely. This will expedite the processing of the Claim. If you would like benefits to be paid directly to the Provider, be sure to sign the form in the space provided.

Claims for Prescription Drug Benefits

If you use a non-participating retail pharmacy for your prescription drugs, you must file a Claim with Express Scripts. Claim forms may be requested by calling the Plan or they may be downloaded from the forms section of **www.sagaftraplans.org/health**. Alternatively, you may call Express Scripts at (800) 903-4728.

Non-participating retail pharmacy Claims should be submitted to:

Express Scripts, Inc.
Attention: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

You will be reimbursed the amount that would have been charged by a participating pharmacy less the required Copay.

If your prescription drug coverage is provided under the medical benefits as outlined on page 79, submit your Claims to the Plan. A prescription drug Claim should include a medical Claim form, a copy of the prescription and the original receipt.

Claims for Dental Benefits

When you use an in-network Dentist, the Dentist will file the Claim for you. When you use an out-of-network Dentist, you or your Dentist should submit Claims directly to Delta Dental. **Do not send Claim forms to the Plan.**

Delta Dental of California
Claims Department
P.O. Box 997330
Sacramento, CA 95899-7330

Claim forms may be downloaded from the forms section of **www.sagaftraplans.org/health** or from Delta Dental's website, **www.deltadentalins.com/sag-aftra**. Forms may also be requested by calling the Plan. Follow the instructions on the Claim form carefully and answer all questions completely. This will expedite the processing of the Claim. If you would like for benefits to be paid directly to the Dentist, be sure to sign the form in the space provided.

If your estimated charges are less than $300, the Claim form serves as a statement of actual charges. You must complete the employee section while your Dentist completes the Dentist's section. Send the completed form to Delta Dental after services are performed.

If your estimated charges are $300 or more, the form may serve as a pre-treatment estimate of charges. You must complete the employee section while your Dentist completes the Dentist's section before treatment begins. The form should then be sent to Delta Dental. After review, a statement indicating the benefits payable under the Plan will be returned to you and your Dentist. When the work is completed, your Dentist should indicate on the statement the specific services performed, the date performed and the actual charges.

Claims for Vision Benefits

If an Exam Plus eye exam is received through a VSP Provider, the Provider will file the Claim for you. If you use a non-VSP Provider, you should request a copy of the bill showing the amount of the eye examination.

Send the bill to:

VSP Vision
Attention: Non-Member Doctor Claims
P.O. Box 385018
Birmingham, AL 35238-5018

Be sure to include the Participant's name, mailing address and ID number, as well as the patient's name, relationship to Participant and date of birth.

Claims for Life Insurance or AD&D Benefits

In the event of your death, your Dependent or beneficiary should provide a certified copy of your death certificate, and, if appropriate, evidence of the accidental nature of death to the Plan. In the event of any other loss that may be covered under the AD&D benefit, you should notify the Plan promptly. You should also contact the Plan if you are applying for an accelerated life insurance payment. A Claim form will be sent to you.

General Information About Claims

Types of Claims

A **Pre-service Claim** is a Claim for a benefit for which the Plan requires approval before medical care is obtained. For Hospital and medical benefits, prior approval is required for the following:

- Bariatric surgery;
- Eyelid, nasal and certain breast surgeries;
- Gender reassignment surgery;
- Neuro-psychological testing;
- Organ transplants;
- Outpatient private duty nursing; and
- Sleep studies.

Certain prescription drugs also require prior approval. The pharmacy will tell you if a drug requires prior approval, or you may search Express Scripts' website for the name of a drug to learn if approval is required.

An **Urgent Care Claim** is any Claim for medical care or treatment where the application of the time period for making a Pre-service Claim determination meets one of the criteria below:

- Could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or
- In the opinion of a Physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

The Plan generally determines whether your Claim is an Urgent Care Claim. Alternatively, any Claim that a Physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above shall be treated as an Urgent Care Claim.

A **Concurrent Care Claim** is a Claim that involves an approved, ongoing course of treatment for a specific period of time or a specific number of treatments. If the Claim involves urgent care, it will be treated as an Urgent Care Claim. Otherwise, it will be subject to the time periods for Pre-service Claims as outlined on the following page.

A **Post-service Claim** is a Claim submitted for payment after health treatment has been obtained.

Disability Claims are Claims that require a finding of total disability as a condition of eligibility. Under the Plan, this would be a Claim for the waiver of life insurance premium or coverage under the total disability extension. With regard to the waiver of life insurance provision, MetLife reserves the right to have a Physician examine you while you are totally disabled.

Initial Determination

When you submit a Claim, the Plan has a certain amount of time to make a determination regarding payment of the Claim. The time to make a determination may be extended if necessary due to matters beyond the Plan's control. For example, an extension may be available if the Plan needs additional information from you or your Physician to make its determination.

You will be notified of the circumstances requiring the extension. Refer to the table below which outlines these time periods and any available extensions.

Notice of Determination

For all Claims, you will receive written notice of the Plan's determination, which will notify you of your rights under ERISA and include the following:

	HEALTH CLAIMS			DISABILITY CLAIMS
Claims Procedures	Pre-service	Urgent Care	Post-service	
How long does the Plan have to make a determination when you file a Claim?	15 days.	72 hours.	30 days.	45 days.
Are there any extensions available?	Yes, one 15-day extension.	No.	Yes, one 15-day extension.	Yes, two 30-day extensions. You will be notified of the first extension within 45 days. You will be notified of any second extension within the first 30-day extension.
What happens if the Plan needs additional information?	The Plan will tell you what information is needed within five days of receipt of the Claim. You have 45 days to respond.	The Plan will tell you what information is needed within 24 hours of receipt of the Claim. You have 48 hours to respond.	The Plan will tell you what information is needed within 30 days of receipt of the Claim. You have 45 days to respond.	The Plan will tell you what information is needed within the time periods outlined above. You have 90 days to respond.
If additional information is requested, when must the Plan make its determination?	Within 15 days of the earlier of: • the day you respond; or • the end of the 45-day response period.	Within 48 hours of the earlier of: • the day you respond; or • the end of the 48-hour response period.	Within 15 days of the earlier of: • the day you respond; or • the end of the 45-day response period.	Within 30 days of the earlier of: • the day you respond; or • the end of the 90-day response period.

1. The specific reason(s) for the determination and reference to any specific Plan provision(s) on which the determination is based.
2. A description of any additional material or information necessary to perfect the Claim and an explanation of why the material or information is necessary.
3. A description of the appeal procedures and applicable time limits.
4. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
5. If an internal rule, guideline or protocol was relied upon in making the determination, a statement that a copy of the rule is available upon request at no charge.
6. If the determination was based on the absence of Medical Necessity, or because the treatment was an Experimental or Investigational Procedure, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.
7. For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. Urgent care determinations may be provided orally and followed with written notification.

Appeals

Eligibility, Life Insurance and AD&D Appeals

If your Claim for a life insurance benefit or AD&D benefits is denied in whole or in part, you will be notified, in writing, within 90 days of receipt of your Claim. In addition, decisions that involve eligibility for coverage and application of certain administrative rules that do not involve a specific Claim for benefits, will be made within 90 days of receipt of your request. In some instances, an additional 90 days may be required. If additional time or information is needed, you will be notified in writing of the reasons. In no case will the extension exceed 180 days from the date your Claim was received.

The notice of determination will contain specific reasons for the determination and a specific reference to the provisions of the Plan or policy on which the determination is based. If you disagree with the determination you may appeal within 180 days of the date of the decision. In addition, if you have not been notified of action taken on your Claim within 180 days from the date it was received by the Plan, you may treat the Claim as having been denied and may make an appeal in the following ways:

- **Administrative review of a determination to deny.** If you received an adverse determination on your Claim or your eligibility/administrative issue and you have additional medical or other information to provide in support of your Claim or request, you may request an administrative review by the Plan. Your request must be submitted in writing to the chief executive officer of the Plan within 60 days of notice of the denial of the Claim or other adverse determination and accompanied by the additional medical or other information upon which you rely. While you are not required to go through the step of an administrative review, if you have additional information to support your Claim or request, we encourage you to first attempt to resolve the issue through this process.
- **Appeal of a determination to deny.** If you have no additional medical or other information or you feel the Claim or other eligibility/administrative request has been incorrectly denied, initially or after administrative review as outlined above, you may appeal to the Appeals Committee of the Board of Trustees. An appeal to the Appeals Committee must be submitted in writing to the chief executive officer within 180 days of the initial denial of the Claim or 180 days of the administrative review denial, whichever is later, and accompanied by a statement giving the reasons the denial is believed to be incorrect.

A determination by the Plan on an administrative review, or by the Appeals Committee on an appeal, shall be made within 60 days after the receipt of the request. An additional 60 days may be required for

special study. However, the determination will be made no later than 120 days after your request is received. The notice of the determination will contain specific reasons for the determination and a specific reference to the provisions of the Plan on which the determination is based.

If you have not been notified of action taken on your appeal within the 120-day period, you may treat the appeal as having been denied and may initiate a lawsuit as described under the heading "Your Rights Under ERISA" on pages 123-124.

Health, Disability and Retroactive Removal of Coverage Appeals

If your health Claim or Disability Claim is denied in whole or in part, you may ask for a review. You may also request a review if the Plan has retroactively removed your health coverage. In accordance with federal law, the Plan provides both an internal and external appeals process; however, the external appeals process is only available in certain circumstances. See page 110 for additional information.

Under the internal process, your Claim determination notice will tell you where to send an appeal. If your denied Claim is for Hospital or medical benefits, or for coverage under the total disability extension, you may appeal one time to the Appeals Committee of the Board of Trustees. You may also appeal to the Appeals Committee if your health coverage was retroactively removed.

If your denied Claim is for another type of benefit, there are two levels of internal appeal. The first is to the appropriate benefit partner organization, as listed below. If your Claim is denied after the first review, you may file a second appeal with the Appeals Committee.

BENEFIT	COMPANY
Dental	Delta Dental
Hospital/Medical Utilization Management Review	Anthem Blue Cross
Life Insurance Premium Waiver	MetLife
Mental Health and Substance Abuse	Beacon Health Options
Prescription Drug	Express Scripts
Vision	VSP

Your initial request for review must be made in writing within 180 days after you receive notice of the denial. Specific information on how to file an appeal with these organizations is contained in their Claim denial notices.

Appeals involving Urgent Care Claims may be made verbally by calling one of the numbers outlined in the table below.

URGENT CARE APPEALS		
Benefit	Company	Phone Number
Hospital	Anthem Blue Cross	(800) 274-7767
Mental Health and Substance Abuse	Beacon Health Options	(866) 277-5383
Prescription Drug – Clinical Appeals	Express Scripts	(800) 864-1135
All Other Benefits	Plan	(800) 777-4013

If your appeal is for a Concurrent Care Claim, the Plan will provide continued coverage for the course of treatment during the appeal process.

Internal Appeal Process

You have the right to review documents relevant to your Claim. You will be provided with any new material considered during the appeal.

Someone other than the person who originally denied the Claim will review your appeal. The determination will be made on the basis of the record, including any additional documents and comments submitted by you. If your Claim was denied on the basis of a medical judgment, such as lack of Medical Necessity, a health care professional with appropriate training and experience in a relevant field of medicine will be consulted. Any such health care professional shall not be an individual who was consulted in connection with the Claim denial, nor a subordinate of any such individual.

Notice of Determination on Internal Appeal

The table below outlines the timing for the internal appeal determination.

The Plan may waive the internal appeal process and proceed to the expedited external review procedures if your attending Provider determines that your appeal is urgent because it involves a medical condition for which the time period for completion of the appeal would seriously jeopardize your life or health, or your ability to regain maximum function.

	HEALTH CLAIMS			DISABILITY CLAIMS
Appeals Procedures for Denied Claims	Pre-service	Urgent Care	Post-service (including retroactive removal of coverage)	
How much time do I have to appeal?	180 days.	180 days.	180 days.	180 days.
How may I make the appeal?	**Anthem Blue Cross and Beacon Health Options** Verbally or in writing. **All others** In writing.	Verbally or in writing.	**Beacon Health Options** Verbally or in writing. **All others** In writing.	In writing.
How long does the Plan have to make a determination on my appeal?	**One level** 30 days. **Two levels** 15 days for each level.	**One level only** 72 hours.	**One level** Usually appeals will be decided at the next Appeals Committee meeting. [13] You will be notified within five days of the determination. **Two levels** 30 days for each level. [13]	**One level** Usually appeals will be decided at the next Appeals Committee meeting. [13] You will be notified within five days of the determination. **Two levels** 30 days for each level. [13]

[13] If your first or second level internal appeal is received within 30 days of the next regularly scheduled Appeals Committee meeting, it will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances a delay until the third regularly scheduled meeting following receipt of your internal appeal may be necessary.

Important Note:
External review is not available for every Claim denial or internal appeal denial.

If you submit an appeal or other request for review and we need additional information to evaluate your request, we will contact you to advise what additional information is needed and the timeframe within which the information must be provided. If you do not provide the information within that timeframe, the appeal/request for review will be decided based upon the information provided.

The determination on any review of your Claim will be provided to you in writing. If the internal appeal is denied, the notice will explain the reason for the determination as described in items 1, 4, 5 and 6 under "Notice of Determination" on pages 106-107. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your Claim.

External Review Process

If your internal appeal is denied, you may file a request for external review with the Plan under the circumstances outlined below.

- The initial Claim denial or internal appeal denial involved medical judgment. Examples include determinations of Medical Necessity, appropriateness, health care setting, level of care and experimental or investigational status.
- Your health coverage was retroactively removed, unless this occurred because you did not meet the Plan's eligibility requirements. Retroactive removal of coverage due to eligibility reasons is not eligible for external review.

The Plan will accept requests for external review in accordance with federal law.

Preliminary Review

The Plan will complete a preliminary review of the request. In addition, to the requirements outlined above, all of the following additional requirements must be met:

1. For Pre-service and Urgent Care Claims, you were covered under the Plan at the time the health care service or other benefit was requested. For Post-service Claims, you were covered under the Plan at the time the health care service or other benefit was provided.
2. The initial Claim denial or the internal appeal denial do not relate to the failure to meet the Plan's eligibility requirements.
3. You have exhausted the Plan's internal appeal process, unless you are not required to do so under federal law or in accordance with a request for an expedited external review.
4. You have submitted a completed External Appeals Form.

Notice of Preliminary Review

The Plan will issue a written notice after completion of the preliminary review. If your internal appeal denial is not eligible for external review, the notice will include the reasons for this as well as contact information for the U.S. Department of Labor's Employee Benefits Security Administration. If your request for external review is not complete, the notice will describe the information or materials needed to make it complete.

The table below outlines the timing for the preliminary external review steps.

EXTERNAL REVIEW STEP	RESPONSIBLE PARTY	TIME TO COMPLETE
Request external review	Patient (or authorized representative)	Four months after receipt of internal appeal denial.
Preliminary review	Plan	Five business days after receipt of request.
Notice of preliminary review decision	Plan	One business day after making decision.
Provide additional information for external review	Patient (or authorized representative)	The later of: • The end of the four-month filing period; or • 48 hours following receipt of notice of preliminary review decision.

Assignment to an Independent Review Organization (IRO)

In accordance with federal law, the Plan will assign an accredited independent review organization (IRO) to conduct the external review. The IRO will notify you, in writing, when the organization receives the external review request.

This notice will include a statement that you may submit additional information in writing for the IRO to consider. The information should be submitted within 10 business days of receiving the notice. The IRO may accept and consider additional information submitted after 10 business days, though it is not required to do so.

The Plan will provide the IRO with any documents and information used in denying the Claim or denying the internal appeal within five business days after the external review is assigned to the IRO. If the Plan fails to do so, the IRO may terminate the external review and make a decision to reverse the denial. Within one business day after making such decision, the IRO must notify you and the Plan.

Upon receipt of any information submitted by you in connection to the external review, the IRO will forward it to the Plan within one business day. Upon receipt, the Plan may reconsider its Claim denial or internal appeal denial. The Plan will provide written notice to you and the IRO if it reverses its previous decision within one business day of such reversal. Thereafter, the IRO will terminate the external review proceedings.

External Review Decision

The IRO will review all information and documents received within the required time frames and will use experts where appropriate to make coverage determinations under the Plan. The IRO is not bound by any decisions or conclusions reached during the initial benefit denial or the internal appeal. In addition to the documents and information provided, the IRO will consider the following, as it determines appropriate, when making its decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan, you or your treating Provider(s);
- The terms of the Plan (unless contrary to applicable law);
- Appropriate medical practice guidelines, including evidence-based standards;
- Any applicable clinical review criteria developed and used by the Plan (unless contrary to the Plan or applicable law); and
- The opinion of the IRO's clinical reviewer.

The IRO will provide written notice of the final external review decision to you and the Plan within 45 days after the IRO receives the external review request. Such notice will include: (i) an explanation of the primary reason(s) for the IRO's decision; (ii) references to the evidence or documentation considered in reaching the decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision; (iii) the binding effect of the decision with a statement that judicial review may be available to you; and (iv) current contact information for any applicable office of health insurance consumer assistance or ombudsman.

Expedited External Review

Expedited external review is available for the following cases:

- You or your Dependent have a medical condition for which the time period for completion of the standard external review would seriously jeopardize your or your Dependent's life, health or ability to regain maximum function, as determined by your attending Physician; or
- The internal appeal denial concerns an admission, availability of care, continued stay, or health care item, service, or other benefit for which you or your Dependent received emergency services, but have not been discharged from a Provider's facility.

You must file a request for expedited external review. The request should be filed with the following benefit partner organizations:

EXPEDITED EXTERNAL REVIEW		
Benefit	Company	Phone Number
Hospital	Anthem Blue Cross	(800) 274-7767
Mental Health and Substance Abuse	Beacon Health Options	(866) 277-5383
Prescription Drug – Clinical Appeals	Express Scripts	(800) 864-1135
All Other Benefits	Plan	(800) 777-4013

Upon receipt of the request, the preliminary review will be performed as soon as possible without regard to the five business days allowed for the non-expedited process. A notice of determination will be sent as soon as the preliminary review is completed.

If the request is eligible for expedited external review, the Plan or its designee shall assign an IRO in accordance with the external review procedures and transmit or provide all required documents and information by secure email, by telephone, by fax or by any other available method.

The IRO must provide its final external review decision in accordance with the external review standards described previously and provide notice of such decision as expeditiously as you or your Dependent's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request.

Reversal of Denial

In the event the Claim denial or the internal appeal denial is reversed by the Plan, its designee or the IRO, the Plan will provide coverage or payment for the Claim in accordance with applicable law and regulations, but it reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law and regulations.

90-Day Limitation on When a Lawsuit May Be Filed

You may file a lawsuit to obtain benefits only after you have exhausted the Claims and appeals process set forth above with the exception of the external review process, which is voluntary. However, if you have requested an external review, you may not file a lawsuit until the external review process is concluded. You may also file a lawsuit if the Plan or IRO does not reach a decision, or notify you that an extension is necessary within the appropriate time periods described previously.

A lawsuit may not be filed more than 90 days after the earlier of: (i) the date you receive the Plan's or IRO's written decision on your appeal; or (ii) the end of the appeals and extension time periods previously described.

Discretionary Authority

The Board of Trustees (or the chief executive officer or any committee, if authorized by the Board) has 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.

Without limiting the generality of the foregoing, the Board (or its designee) 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 Plan to Participants or their beneficiaries;
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan or other Plan documents in accordance with their terms and to interpret and apply the provisions of the Collective Bargaining Agreements;
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan or other Plan documents;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other Plan documents;
- Process, and approve or deny, benefit Claims and rule on any benefit exclusions; and
- Decide questions as to whether services rendered are services covered under the Plan.

All determinations made by the Board (or its designee) with respect to any matter arising under the Plan and any other Plan documents shall be final and binding.

XII. Other Important Information

Terms to know for Section XII:

Please refer to the Glossary on pages 129-133 for definitions of these and other capitalized key terms.

COBRA Continuation Coverage

Collective Bargaining Agreement (CBA)

Covered Earnings

Dependent

ERISA

Participant

Please refer to the following pages in this section for other important information for Plan Participants.

Notice of Privacy Practices

The SAG-AFTRA Health 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 pays for such care and services that are covered under the terms of the Plan. The Plan may share your health information with doctors and other health care Providers for treatment purposes or for the coordination or management of your care. For example, if you are in the Hospital due to an accident or illness, the Plan may share your health information with all your health care Providers involved in your care and treatment.

- *Payment:* The Plan may use or disclose your health information for purposes of processing medical Claims, verifying your eligibility, determining Medical Necessity, utilization review and authorizing services. For example, your health information will be used in making a Claim determination.

  In some circumstances it may be necessary for the Plan to disclose your health information, including your eligibility for health benefits and specific Claim information to other covered entities such as other health plans (in order for the Plan to coordinate benefits between this Plan and another plan under which you may have coverage).

  The Plan may also disclose your health information and your Dependents' health information, on Explanation of Benefit (EOB) forms and other payment-related correspondence, such as pre-certifications which are sent to you.

- *Health care operations:* The Plan may use or disclose your health information for purposes of Case Management, underwriting/premium rating, quality improvement and overall Plan operations. For example, the Plan periodically obtains proposals from health care companies in an effort to select appropriate Provider networks 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. For example, the Plan may use your child's date of birth to remind you that your Dependent, who would otherwise lose coverage under the Plan, may enroll in COBRA Continuation Coverage.

- *Business associates:* The Plan may disclose your health information to business associates. Business associates are entities retained or contracted by the Plan, such as Anthem Blue Cross, Beacon Health Options, Delta Dental, Express Scripts, UCLA Health and VSP 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 his or her 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 EOBs and other 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 EOBs and other 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:

1. *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.

2. *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.

3. *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.

4. *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 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.

5. *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.

6. *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.

7. *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, 2017. 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**.

Name:	Privacy Officer SAG-AFTRA Health Plan
Address:	**Mailing Address:** P.O. Box 7830 Burbank, CA 91510-7830 **Street Address:** 3601 West Olive Avenue Burbank, CA 91505
Telephone:	(800) 777-4013
Email:	privacyofficer@sagaftraplans.org

Subrogation and Reimbursement

When benefits are paid by the Plan for the treatment of an illness or injury that is the result of an act or omission of a third party, certain special rules apply, as described in this section. Under such circumstances, if the Participant or Dependent pursues or has the right to pursue a recovery for such act or omission, the Plan will pay benefits for Covered Expenses related to such illness or injury only to the extent that the benefits for Covered Expenses are not paid by the third party and only after an appropriate written subrogation and reimbursement agreement is executed with the Plan.

The following are some examples of situations in which this provision may apply:

- You or your Dependent are injured in an automobile accident that you claim was caused by the act or omission of another person or other third party.
- You or your Dependent slip and fall or are otherwise injured under circumstances that you claim resulted from the act or omission of another person or third party.
- You or your Dependent suffer an illness or injury as a result of medical malpractice.

By accepting benefits related to such illness or injury, you – and, if applicable, your Dependent(s) – agree:

- To notify the Plan in writing whenever a claim against a third party is made for damages as a result of an injury, sickness or condition;
- That the Plan has established a lien on any recovery received by you or your Dependent(s), legal representative or agent;
- To notify any third party responsible for the illness or injury of the Plan's right to reimbursement for any Claims paid by the Plan related to the illness or injury;
- To hold any reimbursement or recovery received by you or your Dependent(s), legal representative or agent in trust (and not commingled with other assets) on behalf of the Plan to cover all benefits paid by the Plan with respect to such illness or injury and to reimburse the Plan promptly for the benefits paid, even if you or your Dependent(s) are not fully compensated ("made whole") for the loss;
- That the Plan has the right of first reimbursement (i.e. from the first dollar payable) against any recovery or other proceeds of any claim against the other person (whether or not the Participant or Dependent is made whole) and that the Plan's claim has first priority over all other claims and rights (including, without limitation, attorneys' fees);
- To reimburse the Plan in full up to the total amount of all benefits paid by the Plan in connection with the illness or injury from any recovery received from a third party, regardless of:
  - Whether or not the recovery is specifically identified as a reimbursement of medical expenses;
  - Any purported allocation or itemization of recovery to specific types of injuries; and
  - The form of recovery (e.g. settlement, court judgment, arbitration award or otherwise).

  All recoveries from a third party, whether by lawsuit, settlement, insurance or otherwise, must be turned over to the Plan as reimbursement up to the full amount of the benefits paid by the Plan;
- That the Plan's claim is not subject to reduction for attorney's fees or costs under the Common Fund Doctrine[14] or otherwise;
- That, in the event that you or your Dependent(s), legal representative or agent elect not to pursue any claim(s) against a third party, the Plan shall be

[14] The Common Fund Doctrine states generally that a litigant who creates, discovers, increases or preserves a fund to which others also have a claim is entitled to recover litigation costs and attorney's fees from that fund.

equitably subrogated to your right of recovery and may pursue claims on your behalf. (This means that the Plan may begin legal action against the third party seeking payment of damages related to the illness or injury);

- To assign, upon the Plan's request, any right or cause of action to the Plan;
- Not to take or omit to take any action to prejudice the Plan's ability to recover the benefits paid and to cooperate in doing what is reasonably necessary to assist the Plan in obtaining reimbursement;
- To cooperate in doing what is necessary to assist the Plan in recovering the benefits paid or in pursuing any recovery;
- To notify the Plan within 10 days of disbursement of any recovery by the third party and to forward such recovery to the Plan within that 10-day period; and
- To consent to the Plan's entry of a judgment against you and, if applicable, your Dependent(s), in any court for the amount of benefits paid on your or your Dependent's(s') behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the Plan's attorneys' fees and costs.

No benefits will be payable for charges and expenses which are excluded from coverage under any provision of the Plan. The Plan may enforce its right to reimbursement by filing a lawsuit, recouping the amount owed from a Participant's or a covered Dependent's future benefit payments, or any other remedy available to the Plan. The Plan may recoup from a Participant's or a covered Dependent's future benefit payments regardless of whether benefits have purportedly been assigned to the Physician, Hospital or other Provider since no rights under the Plan are assignable (see "Authorized Representatives" on page 102).

The Plan may permit you or your Dependent(s) to reimburse less than the full amount of benefits paid and recovered as it determines in its sole discretion. Any reduction of the Plan's claim is subject to prior written approval by the Plan.

Contribution and Dependent Verification Audits

Contribution Verification Audits

Periodically the Plan discovers that reported earnings are intentionally misrepresented in order to obtain Plan eligibility. In essence, signatory companies are fraudulently contributing on behalf of individuals who do not perform services covered by a SAG-AFTRA Collective Bargaining Agreement or misrepresenting the amount of compensation the individual received for covered services and the basis for the compensation reported. As an example, some companies are "buying" health coverage for individuals by contributing the minimum necessary to qualify for Earned Eligibility or otherwise misrepresenting the status of their company or their employees in order to participate in the Plan.

Companies and individuals who engage in this conduct are liable to the Plan for any overpaid benefits and administrative fees mistakenly or improperly paid by the Plan. The verification of contributions to the Plan is an important aspect of the Plan's integrity, because fraudulently obtained benefits deplete the Plan's assets and affect the benefits available to the rest of the Participants, and because the Plan is obligated to pay benefits only on behalf of the eligible Participants and beneficiaries of this Plan.

You should maintain and be prepared to supply, upon the Plan's request, copies of employment contracts, proof of service, proof of payments, including payroll stubs, W-2 forms, income tax returns and bank records. You bear the burden of demonstrating that you provided services of the type covered by the Collective Bargaining Agreement, and the failure to provide access to such documents may be deemed by the Plan as the basis to disallow any contributions reported for your services.

Dependent Verification Audits

You may be selected for an audit to verify the eligibility of your Dependents under the Health Plan. Failure to comply with an audit request can lead to a loss of benefits for your Dependents.

By participating in the Plan, you agree to cooperate with the Plan's reasonable efforts to audit the status of any Dependent. Providing information or documents within the established time periods is a condition of your Dependent's eligibility for benefits; therefore, if the information or documents are not provided, the Plan, in its sole discretion, may determine that your Dependent does not qualify as a Dependent or loses continued eligibility as a Dependent. You may be held responsible for any overpayments made as a result of the failure to provide such information or documentation.

When you become eligible for benefits under the Plan, you must submit a completed Participant Information Form to the Plan. The Participant must sign this confidential legal document. If the Participant is under the age of 18, the parent or legal guardian must sign for the child.

In order to verify Dependent eligibility, the Plan performs routine audits. These audits are for your protection to assure that Plan benefits are reserved for eligible Participants and their eligible Dependents.

If you are selected for an audit, the Plan will send you an initial inquiry specifying the documents needed for Dependent verification. For example, the Plan may request a copy of a recorded marriage certificate to verify your spouse or a recorded birth certificate for a child. If you cannot locate a requested document, contact the Plan for assistance contacting the issuing agency. If the Plan does not receive a response to its initial request, a follow-up notice will be sent. The failure to respond will be deemed an admission of fraudulent conduct. If there is no response to our second request you will receive a Notice of Termination of Benefits for the unverified Dependents. Additionally, you will be responsible for paying back any health care expense paid by the Plan on behalf of non-qualified Dependents.

If you need to update the Plan's records with respect to your Dependents, contact the Plan or visit **www.sagaftraplans.org/health** to obtain the proper form.

Overpayments

The Plan has the right to recover any mistaken payment, overpayment or payment made to any individual who was not eligible for that payment. Together, these overpayments are referred to in this SPD simply as an overpayment. You will receive written notification if a reimbursement to the Plan is required.

You can be held individually liable for reimbursing the Plan for the amount of the overpayment if your eligibility was established because of fraud or intentional misrepresentation of material fact. In addition, the Plan has the right to collect the overpayment from you, your eligible Dependents (or any individual you have claimed to be your eligible Dependent), or your employer, or to pursue each or all of you for reimbursement. The Board of Trustees can take all actions as it determines appropriate, in its sole discretion, to recover the overpayment. Such actions may include:

- Reducing the amount owed to the Plan by applying the amount of contributions made by your employer on your behalf during the relevant period;
- Entering into written agreements for the repayment of overpaid benefits, with interest if applicable; and
- Requiring that the amount of overpayment be deducted from all future benefit payments for you and your eligible Dependents until the full amount is paid.

In addition, the Board of Trustees may in their discretion, seek payment of such amounts through filing a lawsuit or taking any other measure they deem necessary and appropriate. You, your eligible Dependent(s) (or any individual you have claimed to be your eligible Dependent), and your employer are also

responsible for paying the Plan all expenses incurred collecting the overpayment, audit fees, attorneys' fees and interest calculated from the date of the initial overpayment.

False or Fraudulent Claims

Anyone who submits any false or fraudulent Claim or information to the Plan may be subject to criminal penalties – including a fine, imprisonment or both – as well as damages in a civil action under applicable state or federal law. Furthermore, the Board of Trustees reserves the right to impose such restrictions upon the payment of further benefits to any such Participant or Dependent as may be necessary to protect the Plan, including the deduction from such future benefits of amounts owed to the Plan because of the payment of any false or fraudulent Claim. The Participant, Dependent or any individual you have claimed to be your eligible Dependent must pay the Plan for all its legal and collection costs as well as benefit payments made (with interest).

If it is determined that an individual became eligible for Plan benefits as a result of earnings which are determined to be non-Covered Earnings, the individual's coverage could be cancelled 30 days after the Plan provides the individual with notice of cancellation. If the coverage is cancelled as a result of fraud or intentional misrepresentation, the individual's coverage may be rescinded retroactively. Also, to the extent permitted by law, the individual may be obligated to refund all benefits received in excess of contributions by the individual's employer to the Plan on the individual's behalf.

Termination of eligibility as a result of a contribution or Dependent verification audit does not constitute a qualifying event for COBRA Continuation Coverage.

If the Trustees believe that fraud has been perpetrated against the Plan, the Trustees may require a Participant to provide certain documentation or information to determine if benefits were properly paid. If such documentation (or an explanation as to why the documents or information cannot be provided) is not received by the Plan, then the Trustees reserve the right to terminate any future benefits for the Participant and his or her covered Dependents.

Your Rights Under ERISA

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as outlined in this section.

Rights to Receive Information About Your Plan and Benefits

You have the right to examine, at the Plan offices and free of charge, all Plan documents, including insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You have the right to obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan administrator may make a reasonable charge for the copies.

You have the right to receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each Participant with a copy of this summary annual report.

Rights to Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions Required of Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee

benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other 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 benefits under the Plan or exercising your rights under ERISA.

Enforcing Your ERISA Rights

If your Claim for a benefit under the Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in 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 Plan administrator.

If Plan fiduciaries are misusing the 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 federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

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

XIII. Plan Information

Plan Administration

Name and Type of Plan

SAG-AFTRA Health Plan

This Plan is a collectively bargained, joint-trusteed labor-management trust.

Plan's Identification Numbers

The Employer Identification Number (EIN) assigned to the Plan by the Internal Revenue Service is 95-6024160.

The Plan number is 501.

Plan Year

The Plan's fiscal year runs from January 1 through December 31.

Administrator

The administrator of the Plan is the Board of Trustees, made up of an equal number of representatives from Contributing Employers and SAG-AFTRA.

The routine administrative functions are performed by the Plan. The chief executive officer is Michael Estrada, who may be reached at the same address and telephone number as the Board of Trustees.

Names and Addresses of the Current Board of Trustees

The names of the Trustees as of the date this SPD was printed are listed on page 3. To contact the Board of Trustees, write, call or fax:

SAG-AFTRA Health Plan
P.O. Box 7830
Burbank, CA 91510-7830
(800) 777-4013
Fax: (818) 953-9880

Website: **www.sagaftraplans.org/health**

Terms to know for Section XIII:

Please refer to the Glossary on pages 129-133 for definitions of these and other capitalized key terms.

Claim

COBRA Continuation Coverage

Collective Bargaining Agreement (CBA)

Contributing Employer

Earned Eligibility

Participant

Trust Agreement

Trustees

Agent for Service of Legal Process

Legal process may be served on the Trustees or the chief executive officer at:

SAG-AFTRA Health Plan

Street Address:
3601 West Olive Avenue
Burbank, CA 91505

Mailing Address:
P.O. Box 7830
Burbank, CA 91510-7830

Collective Bargaining Agreements

The Plan is maintained according to a number of Collective Bargaining Agreements between SAG-AFTRA and employers in the industry.

The Collective Bargaining Agreements are available on the SAG-AFTRA website: **www.sagaftra.org**. Or, you may request that the Plan provide you with a copy of the applicable Collective Bargaining Agreement. You will be charged a reasonable amount for copying. The agreements are available for inspection at the office of the chief executive officer.

Source of Financing

Contributions are made to the Plan by Contributing Employers according to the terms of applicable Collective Bargaining Agreements. In addition, the Plan requires Participants to pay a premium for coverage. Participants and Dependents whose eligibility under the Plan has terminated may continue coverage under COBRA, in accordance with the rules described on pages 37-43.

Plan Changes or Termination/ Reservation of Rights

The benefits provided under the Plan are not guaranteed benefits for either active or retired Participants or for their Dependents. Therefore, the Board of Trustees reserves the right, in its sole discretion at any time and from time to time:

- To terminate or amend the amount or condition of any benefits, in whole or in part, even though such termination or amendment affects Claims which have already been incurred, at any time and for any reason with respect to active or retired Participants and their Dependents who are or who may become covered by the Plan.
- To alter or postpone the method of payment of any benefit.
- To change or discontinue the types and amounts of benefits under the Plan and the qualification rules, including but not limited to the rules for extended eligibility.
- To amend or rescind any other provisions of the Plan.

The Trustees do not promise to continue the benefits and coverage in full or in part in the future, and rights to benefits and coverages are not and under no circumstances will be vested or non-forfeitable. In particular, retirement or the completion of the requirements to receive a pension benefit under the SAG–Producers Pension Plan or under the AFTRA Retirement Plan does not give any Participant or former Participant any vested right to continued benefits or coverages under the Health Plan. If the Plan is amended or terminated, the ability of Participants, retirees or their family members to participate in and receive benefits from the Plan may be modified or terminated. The types and amounts of benefits are always subject to the actual terms of the Plan (and the provisions of any group insurance policies purchased by the Trustees) and to the Trust Agreement that establishes and governs the Plan's operations.

Type of Benefits Provided by the Plan

The Plan provides Hospital, medical, prescription drug, mental health and substance abuse, dental, vision, life insurance and accidental death and dismemberment benefits. It also provides access to discounted eyewear.

Organizations Through Which Benefits Are Provided

The carrier listed below provides fully insured benefits under the Plan.

COMPANY	BENEFITS
MetLife Group Life Claims (EDM America Building) 2nd Floor 10 E.D. Preate Drive Moosic, PA 18507	Life insurance and AD&D benefits

Metropolitan Life Insurance Company (MetLife) provides life insurance conversion policies.

The Plan is fully self-insured for the benefits obtained through the carriers listed below. These carriers administer at least a portion of the benefits for the Plan, but do not insure or otherwise guarantee any of the benefits of the Plan.

COMPANY	BENEFITS
Anthem Blue Cross 21555 Oxnard Street Woodland Hills, CA 91367	Administers the Hospital and medical benefits and provides access to its network of Hospital and medical care Providers
The Industry Health Network 23388 Mulholland Drive Woodland Hills, CA 91364-2792	Provides access to its network of medical Providers located in California
Express Scripts, Inc. One Express Way St. Louis, MO 63121	Administers the prescription drug benefit and provides access to its network of retail pharmacies and its home delivery pharmacies (Express Scripts Pharmacy and Accredo Specialty Pharmacy)
Beacon Health Options 10805 Holder Street Cypress, CA 90630	Administers the mental health and substance abuse benefit and provides access to its network of behavioral health care Providers
Optum 999 3rd Avenue, Suite 1800 Seattle, WA 98104	Administers the Quit for Life® smoking cessation program and provides access to Quit Coach® staff
Delta Dental of California 100 First Street San Francisco, CA 94105	Administers the dental benefit and provides access to its network of dental Providers
VSP 3333 Quality Drive Rancho Cordova, CA 95670	Administers the vision benefit and provides access to its network of vision care Providers

Requirements With Respect to Eligibility for Participation and Benefits

The eligibility requirements are outlined on pages 8-29 of this SPD. Eligibility rules for staff of SAG-AFTRA (the union), the SAG-AFTRA Foundation, the SAG-Producers Pension Plan, the AFTRA Retirement Fund and the Industry Advancement and Cooperative Fund are outlined in a supplement to the SPD.

Circumstances Resulting in Disqualification, Ineligibility or Denial or Loss of Benefits

Loss of Earned Eligibility is described on pages 35-36 of this SPD. Loss of Earned Eligibility for staff of SAG-AFTRA (the union), the SAG-AFTRA Foundation, the SAG-Producers Pension Plan, the AFTRA Retirement Fund and the Industry Advancement and Cooperative Fund are outlined in a supplement to the SPD.

Loss of COBRA Continuation Coverage is described on pages 42-43 of this SPD.

Audit verification procedures and the recovery and offset of future benefit payments are described on pages 121-123 of this SPD.

Expired Check Limit

Replacement checks will not be issued for any lost or expired checks if more than four years have elapsed from the date of issue.

Procedures to Follow for Filing a Claim

The procedure to be followed in filing a Claim for benefits is described on pages 102-105 of this SPD.

No Liability for the Practice of Medicine

While the Plan provides covered Participants and covered Dependents with health benefits, neither the Plan, the Plan administrator, nor any of their designees are engaged in the practice of medicine. None of them has any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care Provider. Neither the Plan, the Plan administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any health care Provider by reason of negligence, failure to provide care or treatment, or otherwise.

Facility of Payment

Every person receiving or claiming benefits through the Plan will generally be presumed to be mentally and physically competent and of age. However, if the Plan administrator (or its designee) determines that a person entitled to receive benefits hereunder is a minor or is physically or mentally incompetent to receive the payment or to give a valid release for benefits, the Plan may issue payments to the person's legally appointed guardian, committee or representative (upon proof of the appointment) or, if none, to another person or entity that the Trustees determine appropriate in their sole and absolute discretion. Any payment made in accordance with this provision will discharge entirely the obligation of the Plan.

XIV. Health Plan Glossary

Age and Service – A type of Earned Eligibility available under certain Collective Bargaining Agreements based upon meeting a minimum earnings requirement, provided the Participant meets a minimum age requirement and has a minimum number of Age and Service Credits. Participants with Age and Service eligibility qualify for Plan II coverage. For complete information on Age and Service eligibility refer to pages 10-11.

Age and Service Credit – A credit toward Age and Service eligibility under the Plan which is established through obtaining a certain amount of Covered Earnings under certain Collective Bargaining Agreements during a Participant's Base Earnings Period. Age and Service Credits, including the required Covered Earnings thresholds and eligible CBAs, are described on pages 10-11.

Allowable Charges/Allowed Amount/Allowance – The maximum amount the Plan will allow for a covered service. In the case of charges billed by an In-network Provider (except for in-network chiropractic care), the Plan's Allowance will be equal to the Contract Rate. In the case of charges billed by an Out-of-network Provider (or an in-network chiropractor), the Plan's Allowance is determined in the sole discretion of the Board of Trustees and is established based on the area in which the charges are incurred. The Plan's Allowance is updated periodically. The Plan's Allowance is not based on the amount billed by the Provider and will never be more than the incurred charges.

Alternative Days – A type of Earned Eligibility available under certain Collective Bargaining Agreements based upon obtaining a minimum number of Eligibility Days during a Participant's Base Earnings Period. Participants with Alternative Days eligibility qualify for Plan II coverage. For complete information on Alternative Days eligibility refer to pages 9-11.

Base Earnings Period – The period spanning four consecutive Calendar Quarters during which the Participant satisfies the Plan's eligibility requirements. The Participant must continue to meet the annual eligibility requirements in each consecutive Base Earnings Period to remain qualified for coverage.

Benefit Period – The 12-month period during which the Participant is eligible for Plan coverage.

Benefits Manager – Your personal online account for managing your benefits online. Registration is required.

Calendar Quarter – Any one of four three-month periods throughout the calendar year which are defined as follows: January 1 – March 31; April 1– June 30; July 1 – September 30; and October 1 – December 31. The Plan uses Calendar Quarters to determine initial and continued qualification for coverage.

Case Management – A program in which a care coordinator works with the patient, his or her Physician, the patient's family, and the Plan to meet the patient's comprehensive health needs using available resources in the event of catastrophic or chronic sickness or injury.

Claim – A request for a benefit made in accordance with the Plan's Claims procedures.

COBRA Continuation Coverage – Continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (and subsequent amendments), or COBRA Continuation Coverage, is a temporary extension of coverage under the Plan. It can become available when a Participant loses Earned Eligibility or when a Dependent no longer meets the Plan's definition of a Dependent. A premium is required for COBRA Continuation Coverage and the premium amount is determined in accordance with federal law.

Coinsurance – The percentage of Covered Expenses that you must pay, in addition to the Deductible and any Copay. For example, if the Plan pays 90% of Covered Expenses from an In-network Provider, the 10% of Covered Expenses you have to pay is your Coinsurance.

Collective Bargaining Agreement (CBA) – The agreement or agreements between SAG-AFTRA and Contributing Employers that govern Covered Employment, including the requirement for Contributing Employers to make contributions to the Plan.

Concurrent Care Claim – A Claim that involves an approved, ongoing course of treatment for a specific period of time or a specific number of treatments.

Contract Rate – The amount an In-network Provider must accept as the total charge for a covered service. In-network Providers cannot bill you for Covered Expenses in excess of the Contract Rate.

Contributing Employer – Any employer who is required and permitted under the Trust Agreement to contribute to the Plan under the terms of a Collective Bargaining Agreement with SAG-AFTRA or a written agreement with the Plan.

Coordination of Benefits (COB) –The method of dividing responsibility for payment among multiple health plans that cover an individual so that the amount paid by all plans will never exceed 100% of the allowable expenses.

Copay – The flat dollar amount that you pay for some common covered services under the Plan, such as Hospital admissions or prescription drugs. Copays are applied after your Deductible and before the Coinsurance, where applicable.

Cosmetic Surgery – Any surgery or procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

Covered Earnings – Earnings paid to you and reported to the Plan by a Contributing Employer for Covered Employment performed under a Collective Bargaining Agreement which requires the employer to contribute to the Plan on your behalf with respect to those earnings.

Covered Employment – Work performed for employers under a Collective Bargaining Agreement that requires the employer to make contributions to the Plan. Contributions may only be made by signatory employers in accordance with the Trust Agreement.

Covered Expenses – The Allowable Charges for covered services that the Plan will pay in full or in part.

Covered Roster Artist – A vocal recording artist whose qualification for Earned Eligibility is based on the artist's exclusive recording agreement with a record label. Covered Roster Artists qualify for coverage under the applicable Covered Roster Artists side letter agreement to the SAG-AFTRA National Code of Fair Practice for Sound Recordings.

Custodial Care – Treatment or services, regardless of who recommends them or where they are provided, that could be given safely and reasonably by a person not medically skilled and are designed mainly to help the patient with the activities of daily living. Examples include help with walking, bathing, dressing and using the toilet.

Deductible – The amount of Covered Expenses you must pay each calendar year before the Plan begins to pay certain benefits. There are separate Deductibles for Hospital, medical, prescription drug and dental coverage. Deductibles may be higher when you use Out-of-network Providers.

Dentist – A person duly licensed to practice dentistry by the government authority having jurisdiction over the licensing and practice of dentistry where the service is rendered.

Dependent – An individual who may be covered under the Plan based upon his or her relationship with the Participant, including:

- A legal spouse;
- Children under age 26, including:

- Biological children;
- Legally adopted children and children placed for adoption;
- Stepchildren;
- Foster children;
- Children for whom the Participant or spouse are the legal guardian; and

- Unmarried children age 26 or older who continue to be dependent on the Participant or spouse due to an inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental permanent disability. Such an older child may qualify as a Dependent if he or she was disabled prior to turning age 26 and the Participant was eligible for coverage when the child became disabled, regardless of whether or not the Participant was enrolled in the Plan at that time.

Disability Claim – A Claim that requires a finding of total disability as a condition of eligibility. Under the Plan, this would be a Claim for the waiver of the life insurance premium or coverage under the total disability extension.

Durable Medical Equipment (DME) – Medical supplies such as oxygen and equipment for the administration of oxygen, wheelchairs or Hospital-type beds, mechanical equipment for the treatment of respiratory paralysis and surgical supplies such as appliances to replace lost physical organs or parts or to aid in their functions when impaired.

Earned Active Eligibility – A sub-category of Earned Eligibility applied to Participants who are eligible for Medicare. If a Participant (or Dependent) who is eligible for Medicare has Earned Active Eligibility, the Plan pays benefits before Medicare.

Earned Eligibility – Eligibility for health coverage when the Participant has satisfied one of the earnings requirements (Plan I, Plan II, Age and Service) or special qualification requirements (Alternative Days, Network/Station Staff or Covered Roster Artist). For complete information about Earned Eligibility, refer to pages 8-23.

Earned Inactive Eligibility – A sub-category of Earned Eligibility applied to Participants who are eligible for Medicare. If a Participant (or Dependent) who is eligible for Medicare has Earned Inactive Eligibility, the Plan pays benefits after Medicare.

Eligibility Days – Days worked during a Participant's Base Earnings Period that are used to determine qualification for Alternative Days eligibility. A Participant's number of Eligibility Days is determined by dividing the Participant's total applicable sessional Covered Earnings under certain Collective Bargaining Agreements by the SAG-AFTRA minimum daily rate, which is based on the type of production. Eligibility Days, including the minimum requirement and eligible CBAs, are described on pages 9-11.

Entertainment Industry Coordination of Benefits (EICOB) – Special rules for Coordination of Benefits for individuals who are covered under the Plan and another entertainment industry health plan(s).

ERISA – The Employee Retirement Income Security Act of 1974 (and subsequent amendments). ERISA is the federal law that governs the administration of this Plan.

Experimental or Investigative Procedure – A drug, device, medical treatment or procedure is considered experimental or investigative if any of the following apply:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not been granted at the time the drug or device is furnished; or
2. The drug, device, medical treatment or procedure (or the patient-informed consent document utilized with the drug, device, treatment or procedure) was reviewed and approved by the treating facility's Institutional Review Board, or another body serving a similar function, or if federal law requires such review or approval; or
3. Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, or in the research, experimental, study or investigative arm

of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis; or

4. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis.

Explanation of Benefits (EOB) – A statement that summarizes the services provided and the amounts paid by the Plan.

Hospital – An institution legally operating as a Hospital which (i) is primarily engaged in providing, for compensation from its patients, inpatient medical and surgical facilities for diagnosis and treatment of sickness or injury and the care of pregnancy and (ii) is operated under the supervision of a staff of Physicians and (iii) continuously provides nursing services by graduate registered nurses 24 hours per day.

The term Hospital shall not include:

- any institution which is operated primarily as a rest, nursing or convalescent home;
- any institution or part thereof which is principally devoted to the care of the aged; or
- any institution engaged in educating its patients.

Nor does it include any facility when used for the treatment of substance abuse, except for inpatient and alternative levels of care as authorized by Beacon Health Options.

In-network Level of Benefits – The level of benefits paid by the Plan when an In-network Provider is used. The in-network Deductibles and Coinsurance are lower than the out-of-network amounts. There are also certain times the Plan pays the In-network Level of Benefits when you use Out-of-network Providers (for example, if there are no In-network Providers in your area). In these cases, you are responsible for the in-network Copays, the lower Deductibles and Coinsurance, plus the difference between the Plan's Allowance and the billed amount.

In-network Provider – A Provider who participates in one of the Plan's networks, which are outlined on page 48. Services from In-network Providers result in lower out-of-pocket expenses for you.

Medically Necessary/Medical Necessity – The Plan determines if a service or supply is Medically Necessary (or meets Medical Necessity standards) for the diagnosis or treatment of an accidental injury, sickness, pregnancy or other medical condition. This determination is based on and consistent with standards approved by the Plan's medical consultants. These standards are developed, in part, with consideration as to whether the service or supply meets all the following conditions:

1. It is appropriate and required for the diagnosis or treatment of the accidental injury, sickness, pregnancy or other medical condition;
2. It is safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications;
3. There is not a less intensive or more appropriate diagnostic or treatment alternative that could have been used in lieu of the service or supply provided; and
4. It is ordered by a Physician (except where the treatment is rendered by a medical Provider and is generally recognized as not requiring a Physician's order).

Network/Station Staff – A Participant whose initial qualification for Earned Eligbility is based on his or her status as a full-time staff employee of a radio or television station or network.

Open Enrollment Period – A period of approximately 45 days that begins when you qualify for coverage during which you may pay the premium and enroll in Plan coverage or make changes to the enrollment of your Dependents. The timing of your Open Enrollment Period depends on the start date of your Benefit Period and your type of eligibility.

Out-of-network Provider – A Provider who has not agreed to participate in one of the Plan's Provider networks. Your out-of-pocket expenses are usually greater using Out-of-network Providers.

Participant – An individual who performs SAG-AFTRA Covered Employment on whose behalf contributions to the SAG-AFTRA Health Plan are required to be made by one or more employers under terms of a Collective Bargaining Agreement.

Physician – A duly licensed doctor of medicine (MD) or doctor of osteopathic medicine (DO) authorized to perform a particular medical or surgical service within the lawful scope of his or her practice.

Post-service Claims – Post-service Claims are Claims (including those for which pre-authorization has been obtained) after medical treatment, services or supplies have been provided.

Pre-service Claims – Pre-service Claims are Claims that require you to obtain pre-authorization, that is, approval in advance of obtaining medical treatment, services or supplies.

Provider – A licensed or board-certified Provider of medical or behavioral health services, including (but not limited to) Physicians, nurses, physiotherapists, speech therapists, Dentists, pharmacists, psychiatrists, counselors, chiropractors, acupuncturists, midwives, podiatrists and optometrists who act within the scope of their license or certification and perform services that are Medically Necessary.

Retiree Health Credit – A credit toward eligibility for future Senior Performers coverage under the Plan which is earned through Covered Employment during a calendar year. Retiree Health Credits, including the required Covered Earnings thresholds, are described on pages 25-27.

Senior Performer(s) – A Participant who meets the requirements for retiree health coverage under the Plan.

Surviving Dependent – A Dependent of a deceased Participant who meets the requirements for continued Senior Performers coverage under the Plan.

Totally Disabled – With respect to an adult Participant or adult Dependent, a person who is prevented, solely because of sickness or accidental bodily injury, from performing the material and substantial duties of his or her regular occupation. With respect to a minor Participant or minor Dependent, Totally Disabled means a person who is presently suffering from a sickness or accidental bodily injury, the effects of which are likely to be of long or indefinite duration and which will prevent him or her from engaging in most of the normal activities of a person of like age and sex in good health.

Trust Agreement – The SAG-AFTRA Health Plan Trust Agreement entered into as of January 1, 2017 and any modification, amendment, extension or renewal thereof.

Trustees – The Board of Trustees (and its respective authorized agents) as established and constituted in accordance with the Trust Agreement.

Urgent Care Claims – A Pre-service Claim for medical treatment, services or supplies where the application of the time periods for making pre-service determinations could seriously jeopardize the life, health or well-being of the patient as described on page 105.

Plan I – Benefits Summary - Effective January 1, 2017

Hospital and Medical

BENEFIT	PLAN I	
Hospital	**In-network Provider**	**Out-of-network Provider**
Calendar Year Deductible	The Industry Health Network - $150 / person; $300 / family BlueCard PPO/Beacon Health Options - $250 / person; $500 / family	Not covered
Inpatient (Room and Board and Ancillary Services)	90% after $100 copay	Not covered[15]
Outpatient Surgery	90% after $100 copay	Not covered
Emergency Room	90% after $100 copay; emergency room copay is waived if immediately confined	Not covered[15]
Coinsurance Out-of-pocket Limit	$1,750 / person; $3,500 / family	Not covered
Medical	**In-network Provider**	**Out-of-network Provider**
Calendar Year Deductible	The Industry Health Network - None BlueCard PPO/Beacon Health Options - $250 / person; $500 / family	$500 / person; $1,000 / family
Office Visit	No deductible; 100% after $25 copay	70%
Surgeon	90%	70%
X-ray and Lab	90%	70%
Therapy (Occupational, Osteopathic, Physical, Speech, Vision)	90%	70%
Maternity Care		
Prenatal Visits	No deductible; 100%	70%
Delivery	90%	70%
Routine Physical Exam	No deductible; 100%	70%
Routine Child Exam	No deductible; 100%	70%
Mammogram/Pap	No deductible; 100%	70%
Hearing Aids	90% up to a maximum payment of $1,500 per device; one device per ear per three-year period	70% up to a maximum payment of $1,500 per device; one device per ear per three-year period
Coinsurance Out-of-pocket Limit	$1,000 / person; $2,000 / family	$2,500 / person; $5,000 / family
Hospital / Medical / Rx Out-of-pocket Maximum (includes Deductibles, Copays, Coinsurance)	$7,150 / person; $14,300 / family	None

[15] Emergency treatment within 72 hours after an accident or within 24 hours of a sudden and serious illness will be covered at the In-network Level of Benefits.

Plan II – Benefits Summary - Effective January 1, 2017

Hospital and Medical

BENEFIT	PLAN II	
Hospital	**In-network Provider**	**Out-of-network Provider**
Calendar Year Deductible	The Industry Health Network - $150 / person; $300 / family BlueCard PPO/Beacon Health Options - $500 / person; $1,000 / family	Not covered
Inpatient (Room and Board and Ancillary Services)	80% after $100 copay	Not covered[16]
Outpatient Surgery	80% after $100 copay	Not covered
Emergency Room	80% after $100 copay; emergency room copay is waived if immediately confined	Not covered[16]
Coinsurance Out-of-pocket Limit	$2,000 / person; $4,000 / family	Not covered
Medical	**In-network Provider**	**Out-of-network Provider**
Calendar Year Deductible	The Industry Health Network - None BlueCard PPO/Beacon Health Options - $500 / person; $1,000 / family	$1,000 / person; $2,000 / family
Office Visit	No deductible; 100% after $25 copay	60%
Surgeon	80%	60%
X-ray and Lab	80%	60%
Therapy (Occupational, Osteopathic, Physical, Speech, Vision)	80%	60%
Maternity Care		
Prenatal Visits	No deductible; 100%	60%
Delivery	80%	60%
Routine Physical Exam	No deductible; 100%	60%
Routine Child Exam	No deductible; 100%	60%
Mammogram/Pap	No deductible; 100%	60%
Hearing Aids	80% up to a maximum payment of $1,000 per device; one device per ear per three-year period	60% up to a maximum payment of $1,000 per device; one device per ear per three-year period
Coinsurance Out-of-pocket Limit	$1,200 / person; $2,400 / family	$3,000 / person; $6,000 / family
Hospital / Medical / Rx Out-of-pocket Maximum (includes Deductibles, Copays, Coinsurance)	$7,150 / person; $14,300 / family	None

[16] Emergency treatment within 72 hours after an accident or within 24 hours of a sudden and serious illness will be covered at the In-network Level of Benefits.

Plan I– Benefits Summary (Continued) - Effective January 1, 2017

Prescription Drugs, Mental Health and Substance Abuse, Dental Vision

BENEFIT	PLAN I	
Prescription Drugs	Express Scripts Participating Retail Pharmacy	Express Scripts Home Delivery (includes Specialty)
	Specialty medications must be obtained by mail through the specialty pharmacy, Accredo, beginning with the first fill. Long-term medications must be obtained by mail through the home delivery pharmacy beginning with the third fill. Non-formulary drugs are not covered.	
Calendar Year Deductible	$75 / person; $150 / family	
Supply	Up to a 30 day supply / prescription or refill	Up to a 90 day supply / prescription or refill
Copay	The greater of:	The greater of:
Generic	$10 or 10%	$20 or 10%; max Copay is $50 / prescription
Preferred Brand	$25 or 25%	$50 or 25%; max Copay is $125 / prescription
Non-Preferred Brand	$40 or 40%	$100 or 40%; max Copay is $300 / prescription
	In addition, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication.	In addition to the maximum Copays listed above, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication.
	Generic prescription contraceptives are covered at 100% with no Deductible or Copay.	
Mental Health and Substance Abuse	Beacon Health Options Provider	Out-of-network Provider
Hospital and Alternative Levels of Care[17]	Covered under the Hospital Benefit	Not covered[18]
Medical	Covered under the Medical Benefit	Covered under the Medical Benefit
Dental	Delta Dental PPO Provider	Delta Premier and Out-of-network Providers
Calendar Year Deductible	$75 / person; $200 / family	$75 / person; $200 / family
Diagnostic and Preventive Benefits	No deductible; 100%	75%
Basic Benefits	75%	75%
Major Benefits	50%	50%
Calendar Year Maximum[19]	$2,500	$2,500
Vision - Exam Plus Plan	Vision Service Plan Provider	Out-of-network Provider
Eye Exams	100% after $10 Copay; one exam / calendar year	80% up to maximum payment of $50; one exam / calendar year
Glasses	20% discount	No benefit
Professional Services for Contact Lenses	15% discount	No benefit

[17] Alternative levels of care include residential treatment center, partial Hospital program and intensive outpatient program.
[18] Emergency treatment within 72 hours after an accident or within 24 hours of a sudden and serious illness will be covered at the In-network Level of Benefits.
[19] There is no dental maximum for individuals under age 19.

Plan II – Benefits Summary (Continued) - Effective January 1, 2017

Prescription Drugs, Mental Health and Substance Abuse, Dental Vision

BENEFIT	PLAN II	
Prescription Drugs	**Express Scripts Participating Retail Pharmacy**	**Express Scripts Home Delivery (includes Specialty)**
	Specialty medications must be obtained by mail through the specialty pharmacy, Accredo, beginning with the first fill. Long-term medications must be obtained by mail through the home delivery pharmacy beginning with the third fill. Non-formulary drugs are not covered.	
Calendar Year Deductible	$175 / person; $350 / family	
Supply	Up to a 30 day supply / prescription or refill	Up to a 90 day supply / prescription or refill
Copay	The greater of:	The greater of:
Generic	$10 or 10%	$20 or 10%; max Copay is $50 / prescription
Preferred Brand	$25 or 25%	$50 or 25%; max Copay is $125 / prescription
Non-Preferred Brand	$40 or 40%	$100 or 40%; max Copay is $300 / prescription
	In addition, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication.	In addition to the maximum Copays listed above, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication.
	Generic prescription contraceptives are covered at 100% with no Deductible or Copay.	
Mental Health and Substance Abuse	**Beacon Health Options Provider**	**Out-of-network Provider**
Hospital and Alternative Levels of Care[20]	Covered under the Hospital Benefit	Not covered[21]
Medical	Covered under the Medical Benefit	Covered under the Medical Benefit
Dental	**Delta Dental PPO Provider**	**Delta Premier and Out-of-network Providers**
Calendar Year Deductible	$100 / person; no family maximum	$100 / person; no family maximum
Diagnostic and Preventive Benefits	No deductible; 100%	60%
Basic Benefits	60%	60%
Major Benefits	50%	50%
Calendar Year Maximum[22]	$1,000	$1,000
Vision - Exam Plus Plan	**Vision Service Plan Provider**	**Out-of-network Provider**
Eye Exams	Not covered	
Glasses		
Professional Services for Contact Lenses		

[20] Alternative levels of care include residential treatment center, partial Hospital program and intensive outpatient program.
[21] Emergency treatment within 72 hours after an accident or within 24 hours of a sudden and serious illness will be covered at the In-network Level of Benefits.
[22] There is no dental maximum for individuals under age 19.

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Notes

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