

SAG-AFTRA
HEALTH PLAN

Summary Plan Description

Effective January 1, 2023

Los Angeles

3601 West Olive Avenue
Suite 300
Burbank, CA 91505

Mail: P.O. Box 7830
Burbank, CA 91510-7830

(800) 777-4013
Fax: (818) 953-9880

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I. Introduction

A Letter From the SAG-AFTRA Health Plan Trustees

We are pleased to provide you with this 2023 SAG-AFTRA Health Plan Summary Plan Description (SPD), which describes in detail the benefits available to covered Participants and their Eligible Dependents under the SAG-AFTRA Health Plan (Plan) as of January 1, 2023. 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 notified of the modifications 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.

This SPD, which is effective January 1, 2023, provides current summary information about the Plan and supersedes the prior Plan SPD and all benefits updates and newsletters. For coverage applicable to services rendered before January 2023, please refer to the Plan's 2021 Summary Plan Description and the related notices of material modifications.

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, the Plan's Board of Trustees (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, Retiree and Senior Performers 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, Eligible Dependents and beneficiaries. Plan employees cannot alter benefits and eligibility or other rules, and Plan employees' opinions or interpretations cannot amend what is set forth in this document and are not binding upon the Trustees.

You must keep current with your premium payments to ensure coverage when you receive covered health care services. 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 Eligible Dependents.

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

We look forward to providing you and your family with high-quality benefits.

Sincerely,

SAG-AFTRA Health Plan Board of Trustees

This booklet contains a summary in English of your plan rights and benefits under the SAG-AFTRA Health Plan. If you have difficulty understanding any part of this booklet, contact the Plan at 3601 West Olive Avenue, Suite 200, Burbank, CA 91505. Office hours are from 6:00 a.m. to 5:00 p.m. Pacific, Monday through Friday. You may also call the Plan at (800) 777-4013 for assistance.

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Are You Familiar With Your SAG-AFTRA Health Plan Benefits? Here's a Checklist:

- If you haven't already done so, submit a completed Participant Information Form, and familiarize yourself with this SPD.
- Find out if you qualify for coverage.
- Review Plan benefits.
- Make sure you and your Eligible Dependents are enrolled in coverage.
- Register to manage your benefits through your personal Benefits Manager at www.sagaftraplans.org/health and on the Sydney Health app.
- Update/confirm your contact information (see "About the Participant Information Form" to the right).
- File your Claims for benefits no later than 15 months after the date services are incurred.
- 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 the 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 but not limited to those for Retirees, Senior Performers and their Dependents, are not vested or guaranteed.

The Plan's benefits and eligibility provisions may be modified, reduced or terminated 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). This form is available at www.sagaftraplans.org/health. 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 online through 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.

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. Four 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.
- A New Dependent Form must be submitted with the required documentation to add new Eligible Dependents to your coverage.
- A Spouse Coverage Attestation is required at the beginning of each Benefit Period. It informs the Plan whether your working spouse is enrolled in health coverage offered by their employer, or whether their employer does not offer health coverage. See page 19 for more information on when this form is required.
- A Designation of Beneficiaries Form informs the Plan who you want to receive any benefits that may be payable from the Plan upon your death.

These and other forms related to your coverage under the Plan can be found at www.sagaftraplans.org/health/forms, and certain forms or information can be uploaded to your Benefits Manager, as described on the next 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 Benefits Manager you can:

- Make changes to your address.
- Enroll Qualified Dependents or update or add new Dependent information. A Qualified Dependent is a Dependent for whom the Plan has verified the required documentation.
- Make premium payments.
- View your earnings history and eligibility for benefits.
- View Claims documents and check the status of a Claim for claims with dates of service prior to January 1, 2023. For dates of service after January 1, 2023, access the Sydney Health app or Anthem portal at anthem.com/ca.
- Print Plan ID cards.
- Email us using our secure message center.
- Subscribe to Plan electronic disclosures; by doing so, you can receive the following materials via email:
 - Annual Summary of Earnings;
 - SPD;
 - Premium payment reminders; and
 - Plan newsletters, including notices of changes to your benefits.

To register, go to www.sagaftraplans.org/health, choose **Register**, and follow the prompts. When your registration is complete, you will be assigned a username. Your password will be emailed to you 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 within a few days.

Receiving Plan information via email is completely voluntary. If you do not choose to register, you do not need to do anything, and the site's non-secured content, including SPDs, newsletters and notices of benefit changes, 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

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, starting on page 20.

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 Plan promptly of any changes to your address or contact information and by the required deadline for qualifying life events described on page 20.

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, or if you would like to change your beneficiary. **This Form is used for both the Plan's Life Insurance benefit and the SAG-Producers Pension Plan's pre-retirement death benefit if you do not have a separate beneficiary form on file with the Pension Plan.**

The Plan will use the last beneficiary designation on file in determining who should receive any benefits that may be payable from the Plan, 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.

II. Qualifying for SAG-AFTRA Health Plan Coverage

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.

The Plan does not provide any benefits for Claims for services, supplies or treatments incurred or received after eligibility for coverage under this Plan has ended, even if the condition requiring the service, supply or treatment developed when you were eligible for coverage under this Plan, unless you have elected COBRA.

Understanding Covered Earnings

Before reviewing the different ways that 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.

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.

Contact the Plan for additional examples of non-Covered Earnings.

Special Rule for Work Performed Under the Corporate / Educational & Non-Broadcast Contract

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, your 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 the benefit of your spouse, parent or child).

Earned Eligibility Requirements

Meeting the qualifications for Plan coverage is called Earned Eligibility. Most Participants will qualify based on Covered Earnings or Alternative Days worked; however, certain types of Participants qualify under separate rules:

- Covered Network / Station Staff and Roster Artists qualify under separate rules (see page 23).
- Staff of SAG-AFTRA (the union), the SAG-AFTRA Foundation, the SAG-Producers Pension Plan, and the AFTRA Retirement Fund also qualify under separate rules (see page 23).
- Retirees (including Senior Performers) taking a pension from the SAG-Producers Pension Plan or the AFTRA Retirement Fund qualify under separate rules (see page 24).

The minimum requirements for Earned Eligibility, including the special rules, are outlined below. In addition to satisfying one of these requirements, if you enroll in coverage, you must pay the Plan premium. Refer to www.sagaftraplans.org/health for the current premiums.

The minimum requirements for Earned Eligibility beginning on or after the first day of any Calendar Quarter in 2023 are outlined below. Calendar Quarters begin on January 1, April 1, July 1 and October 1. These minimum earnings and Days requirements are scheduled to increase 2% each year.

Qualifying for Plan Coverage – Active Participants

In order to be considered an Active Participant, you need to meet one of the requirements below to establish Earned Eligibility for the Plan:

For Participants Under Age 65	For Participants Age 65 and Over and Not Taking a Pension From the SAG-Producers Pension Plan or the AFTRA Retirement Fund
Covered Earnings Eligibility Threshold	You must meet the Eligibility Threshold (currently \$26,470) in Covered Earnings during your 12-month Base Earnings Period. Both sessional and residual earnings are included toward the Eligibility Threshold.
Alternative Days Eligibility Threshold	You must meet the Eligibility Threshold for Eligibility Days (currently 102 days) worked during your 12-month Base Earnings Period under specified contracts.

Note: In future years, these minimum earnings requirements are scheduled to increase. If so, the number of days required for Alternative Days Eligibility will be increased proportionately.

Eligibility Days are determined by dividing your total applicable sessional Covered Earnings by the SAG-AFTRA minimum daily rate for the covered Collective Bargaining Agreement, which is based on the type of production. Sessional Covered Earnings from employment under the following agreements may be used to satisfy the Eligibility Days requirement for Alternative Days eligibility: Codified Basic (Theatrical) Agreement, Television Programming Agreement, Television Commercials Agreement, Infomercials Agreement, New Media Agreement, Interactive Media Agreement, Corporate / Educational & Non-Broadcast Contract, Music Videos Agreement, Television Network Code and New Media Network Code (as set forth in the table on the next page).

Sessional Covered Earnings from employment under the following agreements may not be used to satisfy the Eligibility Days requirement for Alternative Days eligibility: 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 next page).

In addition, Alternative Days eligibility is not available to employees of a radio or television station or network or to Staff Employees (see next page).

SAG-AFTRA Agreements

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

How You Qualify for Earned Eligibility

Base Earnings Period

The Plan establishes your Base Earnings Period based on the first four consecutive Calendar Quarter periods during which you meet one of the thresholds for Earned Eligibility. In future years, your Covered Earnings during this same four-quarter period will determine if you continue to qualify for Plan benefits.

You become eligible for 12 months of health coverage.

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 once the Plan reviews your Covered Earnings and Eligibility Days, provided that you pay the required Plan premium. 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

Here's an example of how this works:

Covered Earnings Credited on Your Behalf as of:	Amount of Covered Earnings:
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's Covered Earnings 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.

* You can expect to receive your enrollment packet approximately a week after we determine eligibility. You can also check Benefits Manager to see your progress toward earning eligibility.

Generally, the review and determination of your eligibility occurs approximately six (6) weeks after the end of your Base Earnings Period. This six-week period is needed for the Plan's participating employers to submit reports of your earnings and for the Plan to process these reports.

How the Timing Works

The following are examples of how the timing for eligibility works as we transition to the new thresholds in 2023.

If Your Benefit Period Runs From January 1 – December 31, 2022

- Your coverage ends on December 31, 2022.
- We'll review your Covered Earnings from October 1, 2021 to September 30, 2022.
- If you meet one of the new thresholds, you qualify for the Plan for January 1, 2023 to December 31, 2023.
- If you don't meet a threshold, you may qualify for the Extended Career COBRA benefit, or you can consider other coverage.

If Your Benefit Period Runs From April 1, 2022 – March 31, 2023

- Your coverage ends on March 31, 2023.
- We'll review your Covered Earnings from January 1, 2022 to December 31, 2022.
- If you meet one of the new thresholds, you qualify for the Plan for April 1, 2023 to March 31, 2024.
- If you don't meet a threshold, you may qualify for the Extended Career COBRA benefit, or you can consider other coverage.

If Your Benefit Period Runs From July 1, 2022 – June 30, 2023

- Your coverage ends on June 30, 2023.
- We'll review your Covered Earnings from April 1, 2022 to March 31, 2023.
- If you meet one of the new thresholds, you qualify for the Plan for July 1, 2023 to June 30, 2024.
- If you don't meet a threshold, you may qualify for the Extended Career COBRA benefit, or you can consider other coverage.

If Your Benefit Period Runs From October 1, 2022 – September 30, 2023

- Your coverage ends on September 30, 2023.
- We'll review your Covered Earnings from July 1, 2022 to June 30, 2023.
- If you meet one of the new thresholds, you qualify for the Plan for October 1, 2023 to September 30, 2024.
- If you don't meet a threshold, you may qualify for the Extended Career COBRA benefit, or you can consider other coverage.

Qualifying for Plan Coverage – Network / Station Staff

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 in 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 the Covered Earnings threshold described earlier in this section.

In addition, if you are a Network / 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 the Covered Earnings threshold 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.

How You Qualify for Earned Eligibility

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

Qualifying for Plan Coverage – Covered Roster Artists

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 Plan coverage.

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 Covered Earnings requirements, you will be eligible to enroll in the Plan 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 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 Covered Earnings requirements, 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.

How You Qualify for Earned Eligibility

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 1 – June 30	October 1	October 1 – September 30
July 1 – December 31	April 1	April 1 – March 31

Qualifying for Plan Coverage – Staff Employees

A special qualification rule applies to staff of SAG-AFTRA (Union), the SAG-AFTRA Foundation (Foundation), the SAG-Producers Pension Plan (SAG Pension Plan), and the AFTRA Retirement Fund (AFTRA Retirement Fund) (collectively referred to as "Staff Employees"). Notwithstanding the information set forth herein, an individual who would otherwise be considered a Staff Employee is not eligible to participate in the Plan if they are designated or classified by their employer as:

- A temporary employee (individuals hired to complete a specific project or to fill a vacancy, such as when a full-time employee is on a leave of absence); or
- An independent contractor and not as an employee at the time of any determination, even if they are later retroactively reclassified as a common-law or other type of employee pursuant to applicable law or otherwise.

All regular full-time Staff Employees of the Union, the SAG Pension Plan or the Foundation, and part-time Staff Employees of the Union, the SAG Pension Plan or the Foundation who are regularly scheduled to work a minimum of 25 hours per week are eligible to participate in the Plan. Employees who are eligible to participate and who meet the enrollment and premium payment requirements will receive Plan benefits.

Regular part-time employees of the Union, the SAG Pension Plan or the Foundation who work fewer than 25 hours per week may be eligible to participate in the Plan, provided they meet the Covered Earnings requirements during their Base Earnings Period.

As required by applicable state and federal laws, interim eligibility is offered to newly hired, regular full-time employees of the Union, the SAG Pension Plan or the Foundation and regular part-time employees of the Union, the SAG Pension Plan or the Foundation who work at least 25 hours per week. Exempt employees of the SAG Pension Plan qualify for interim eligibility effective on the first day of the month following 30 consecutive days of employment. Employees of the Union or the Foundation and non-exempt employees of the SAG Pension Plan qualify for interim eligibility effective on the first day of the month following 60 consecutive days of employment. Newly hired part-time employees who work fewer than 25 hours per week are not eligible for interim eligibility.

Following interim eligibility, employees of the Union, the SAG Pension Plan or the Foundation must qualify for Earned Eligibility under the Plan by meeting the minimum Covered Earnings requirements.

Employees of the AFTRA Retirement Fund will qualify to enroll for coverage under the Plan on the first day of the month after the completion of 30 days of full-time or part-time employment with the AFTRA Retirement Fund. For example, if an employee of the AFTRA Retirement Fund is hired on March 15 and thereafter completes 30 days of full-time or part-time employment, then the employee will be eligible to begin coverage under the Plan starting on May 1. After initially qualifying for benefits, for purposes of requalification, the start of an AFTRA Retirement Fund employee's Benefit Period is established as of the first day of the Calendar Quarter following the date the employee qualified for benefits. For example, for an AFTRA Retirement Fund employee who was hired on March 15 and started coverage on May 1, the Benefit Period would start on July 1 and end on June 30.

All full-time employees of the AFTRA Retirement Fund who are eligible to participate and who meet the enrollment and premium payment requirements will receive Plan coverage. Part-time employees of the AFTRA Retirement Fund qualify for Plan coverage based on their scheduled annual earnings on the date coverage begins.

Qualifying for Plan Coverage – Retirees (Including Senior Performers)

If Medicare currently pays your primary benefits, which is the case for most Retirees, you will have access to the SAG-AFTRA Health Plan / Via Benefits program as of January 1, 2021, unless you qualify for Earned Eligibility for Plan coverage, as set forth below.

Retirees can qualify for Earned Eligibility by meeting one of the following requirements.

If you meet the Earned Eligibility requirements, the Plan pays your primary benefits, and Medicare (if you are enrolled) pays secondary.

Retirees who do not qualify for Earned Eligibility under the Plan will have access to the SAG-AFTRA Health Plan / Via Benefits program, where you can shop with Via Benefits for a range of individual insurance policies that you may purchase to enhance and supplement your Medicare coverage. In addition, Senior Performers may be eligible for the SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account (HRA) Plan. Refer to the SAG-AFTRA Health Reimbursement Account (HRA) Summary Plan Description, available at www.sagaftraplans.org/hra for more information about these benefits.

Covered Earnings Eligibility Threshold

Retirees must meet the Eligibility Threshold (currently \$26,470) in Covered Earnings during their Base Earnings Period. Only sessional earnings are included in Covered Earnings, except if you become a Retiree while covered under the Active Plan. In that case, the Plan will include both sessional and residual earnings in Covered Earnings during your first earnings evaluation as a Retiree; afterwards, the Plan will include sessional earnings only in subsequent evaluations. See the examples on the following pages for more details.

Alternative Days Eligibility Threshold

Retirees must meet the Eligibility Threshold for Eligibility Days (currently 102 days) worked under specified contracts during their Base Earnings Period. For a list of contracts, see page 10. Eligibility Days are determined by dividing total applicable sessional Covered Earnings by the SAG-AFTRA minimum daily rate, which is based on the type of production.

How You Qualify for Earned Eligibility as a Retiree

Benefit Period

Retirees can also qualify for Earned Eligibility under the Plan if they meet the Earned Eligibility requirements set forth on page 11. Beginning in 2021, the Plan transitioned all Retirees to a calendar-year Benefit Period in order to align the Plan with Medicare's annual calendar, making it easier for Retirees to work with Medicare. The Medicare Annual Enrollment Period is October 15 to December 7.

Retirees will transition to the calendar-year Benefit Period as follows:

Retiree Scenario	Alignment to Calendar-Year Benefit Period
Retirees with Medicare primary as of October 1, 2022, and Retirees with Plan primary coverage and a current Benefit Period ending on December 31, 2022	<p>The Plan evaluated earnings from October 1, 2021 to September 30, 2022.</p> <ul style="list-style-type: none">• If the individual was not a Retiree as of October 1, 2021, both sessional and residual earnings were used in its evaluation.• If the individual was a Retiree as of October 1, 2021, only sessional earnings were used in its evaluation. <p>If the Retiree met the Earned Eligibility requirements, Active Plan coverage runs from January 1, 2023 through December 31, 2023.</p> <p>If the Earned Eligibility requirements were not met, the Retiree will have access to the SAG-AFTRA Health Plan / Via Benefits program effective January 1, 2023, and Senior Performers will also be eligible for the HRA Plan.</p> <p>The Retiree's next earnings evaluation is in October 2023. The Plan will evaluate earnings from October 1, 2022 to September 30, 2023, to determine Earned Eligibility offered for calendar year 2024.</p> <ul style="list-style-type: none">• If the Retiree meets the Earned Eligibility requirements, coverage under this Plan is offered for January 1 through December 31.• However, if the requirements are not met, the Retiree will have access to the SAG-AFTRA Health Plan / Via Benefits program, and Senior Performers will be eligible for the HRA Plan. Their earnings will be evaluated again for the next October 1 through September 30 Base Earnings Period to see if they requalify for Earned Eligibility beginning January 1 of the following year. <p>This practice will apply in subsequent years.</p>
Retirees with Plan primary coverage and a Benefit Period ending March 31, 2023, June 30, 2023 or September 30, 2023	<p>The Plan reviewed earnings from October 1, 2021 to September 30, 2022, and if the Retiree satisfied the Earned Eligibility requirements, their Plan primary coverage will be extended through December 31, 2023.</p> <ul style="list-style-type: none">• If the individual was not a Retiree as of October 1, 2021, both sessional and residual earnings were used in the evaluation.• If the individual was a Retiree as of October 1, 2021, only sessional earnings were used in the evaluation. <p>If the requirements were not met, the individual's current coverage will run out at the end of their 2023 Benefit Period (March 31, 2023, June 30, 2023 or September 30, 2023). At that point, the individual will be offered access to the SAG-AFTRA Health Plan / Via Benefits program, and Senior Performers will also be eligible for the HRA Plan.</p> <p>The Retiree's next earnings evaluation will be in October 2023. The Plan will review earnings from October 1, 2022 to September 30, 2023, to determine the coverage offered for calendar year 2024. The Plan will include sessional earnings only in this evaluation.</p> <ul style="list-style-type: none">• If the Retiree meets the Earned Eligibility requirements, Plan coverage is offered for January 1 through December 31.• However, if the requirements are not met, the Retiree will be offered access to the SAG-AFTRA Health Plan / Via Benefits program, and Senior Performers will be eligible for the HRA Plan. Their earnings will be evaluated again for the next October 1 through September 30 Base Earnings Period to see if they requalify for Earned Eligibility January 1 of the following year. <p>This practice will apply in subsequent years.</p>

Retiree Scenario	Alignment to Calendar-Year Benefit Period
<p>Participants reaching Retiree status in 2021 or after, while covered under the Plan</p>	<p>The Participant can run out their current Active Plan coverage. The Plan will evaluate earnings before coverage ends to determine continued Earned Eligibility. The Plan will include residual and sessional earnings for Participants who were not Retirees at the start of their current Base Earnings Period.</p> <ul style="list-style-type: none"> • If the Participant meets the Earned Eligibility requirements, they can enroll in Active Plan coverage for their next Benefit Period. • However, if the requirements are not met, the Participant will be offered access to the SAG-AFTRA Health Plan / Via Benefits program, and Senior Performers will be eligible for the HRA Plan. <p>The Plan will evaluate earnings again in October of the same year for the Base Earnings Period October 1 through September 30, to determine Earned Eligibility for the next calendar year. The Plan will include sessional earnings only in this evaluation.</p> <ul style="list-style-type: none"> • If the Participant meets the Earned Eligibility requirements, Plan coverage is offered for January 1 through December 31. • However, if the requirements are not met, the Participant will be offered access to SAG-AFTRA Health Plan / Via Benefits program, and Senior Performers will be eligible for the HRA Plan. Their earnings will be evaluated again for the next October 1 through September 30 Base Earnings Period to see if they have Earned Eligibility for the Benefit Period starting January 1 of the following year.
<p>Individuals reaching Retiree status in 2021 or after, while <u>not</u> covered by the SAG-AFTRA Health Plan</p>	<p>This practice will apply in subsequent years. Example:</p> <ul style="list-style-type: none"> • A Participant had Plan primary coverage from July 2021 through June 2022. They became a Retiree in February 2022. • The Participant's current coverage ran out on June 30, 2022. • In May of 2022, the Plan evaluated the Participant's earnings during their Base Earnings Period (April 1, 2021 to March 31, 2022). • The Participant met the requirements for Earned Eligibility and was able to enroll in the Active Plan beginning July 1, 2022. • The Plan evaluated the Participant's earnings again in October 2022, for the Base Earnings Period October 1, 2021 to September 30, 2022. The Participant met the Earned Eligibility requirements and was able to continue coverage through December 31, 2023. • The Plan evaluates the Participant's earnings in October 2023, for the Base Earnings Period October 1, 2022 through September 30, 2023. This time, the Participant does not meet the Earned Eligibility requirements. The Participant is given access to purchase insurance policies to supplement or enhance their Medicare coverage through the SAG-AFTRA Health Plan / Via Benefits program. Also, if the Participant meets the criteria for Senior Performer status, the Participant is eligible for the SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan (HRA). • The Participant may enroll in the program and HRA for coverage beginning January 1, 2024 to December 31, 2024. <p>Individuals who retire while not covered by the SAG-AFTRA Health Plan will be evaluated for Earned Eligibility for the calendar year following their retirement date. For example, if an individual becomes a Retiree in April 2024, they may be eligible for coverage beginning January 1, 2025.</p> <p>The Plan will evaluate the individual's earnings in October, for the Base Earnings Period October 1 through September 30, to determine the coverage offered for the next calendar year. The Plan will include residual and sessional earnings for an individual who was not a Retiree at the start of that earnings period; otherwise, only sessional earnings will be included.</p> <ul style="list-style-type: none"> • If the Participant meets the Earned Eligibility requirements, coverage is offered for January 1 through December 31. • However, if the requirements are not met, the Participant will be given access to the SAG-AFTRA Health Plan / Via Benefits program, with Senior Performers eligible for the HRA Plan. Their earnings will be evaluated again for the next October 1 through September 30 Base Earnings Period to see if they requalify for Earned Eligibility January 1 of the following year. <p>This practice will apply in subsequent years.</p>

III. Beginning Coverage

After you become eligible for Plan coverage, you may enroll and must pay the premium to receive coverage. If you are eligible for coverage, you may enroll your Qualified Dependents. Documentation and verification by the Plan are required for any Dependents you want covered.

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. You can find the current Plan premiums at www.sagaftraplans.org/health.

Enrollment

You initially enroll in coverage during your Open Enrollment Period. The timing is 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.

Open Enrollment Period

You may enroll or make changes to your covered Dependent elections during your Open Enrollment Period, which begins when you qualify for coverage. Your Open Enrollment Period is based on your Benefit Period dates, as noted in the table below. The changes made during your Open Enrollment Period will be effective as of your Benefit Period Start Date.

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

The Plan will offer an Open Enrollment Period to all eligible Staff Employees in November of each year. The changes made by Staff Employees during their Open Enrollment Period will be effective as of the following

January 1. Each year, a second Open Enrollment Period is offered to Staff Employees based upon the individual employee's Benefit Period start date. Staff Employees with a January 1 Benefit Period start date will only have one open enrollment opportunity, because their Benefit Period start date coincides with the annual Open Enrollment Period. Generally, four weeks prior to the Benefit Period start date, Staff Employees will be notified by the Plan of this Benefit Period open enrollment.

You will receive an enrollment packet with your Qualified Dependents listed. It will include information about your Benefit Period, your Open Enrollment Period, your premiums, and how to enroll and disenroll Dependents.

You may make changes to your covered Dependents for any reason during the Open Enrollment Period by completing an enrollment packet, paying your premium online through Benefits Manager and providing the required Dependent documentation. After the Open Enrollment Period, you may not make changes to enrollment for yourself 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 seven to ten business days. The NOC mailing includes your Plan ID cards, information regarding your benefit coverage and a list of your enrolled Dependents. You may also print Plan ID cards by visiting www.sagaftraplans.org/health and logging in to Benefits Manager. The ID cards reflect only the Participant's name but are also valid for covered Dependents.

If you think you met the Earned Eligibility requirements but you do not receive an enrollment packet, contact the Plan at (800) 777-4013 or through Benefits Manager's 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 can also keep track of your reported earnings through your Benefits Manager account. Please remember that Benefits Manager may not reflect total Covered Earnings for any particular Calendar Quarter until approximately 60 days after the quarter ends.

Dependent Coverage

Once you qualify for Earned Eligibility as a Participant, coverage is also available to your Eligible Dependents. To cover Dependents, you must enroll the Dependents (including providing the necessary documentation) and pay the applicable premium. Please note that due to reporting requirements under the Affordable Care Act (ACA), you will also be asked to provide your Dependent(s)' Social Security number(s) at the time of enrollment.

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 the following:
 - 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 they were 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. **Note: Even if a Senior Performer does not qualify for Active Plan coverage, their permanently disabled Medicare-eligible child will have access to the SAG-AFTRA Health Plan / Via Benefits program (with no HRA) or can remain on this Plan with coverage secondary to Medicare, subject to payment of this Plan's Dependent premium, set forth on page 26.**

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 page 21 to learn more.

Working Spouse Rule

If your spouse is working for an employer who offers a health plan, the Plan requires them to enroll in that employer-sponsored coverage in order to be eligible for Plan coverage.

If your spouse is enrolled with their employer, you may then choose to cover them under the Plan as well. The spouse's employer's plan will pay benefits first; then, the Plan's cost-sharing may apply for remaining eligible expenses. Please see the Coordination of Benefits section for more information.

If your spouse is not working, or their employer doesn't offer a health plan, you may enroll them with the Plan. Note that if your spouse later becomes eligible for or obtains other employer-sponsored health coverage while covered under this Plan, you must notify the Plan within 30 days of the date of their eligibility for that coverage.

If your spouse is eligible for, or becomes eligible for, but does not enroll in available employer-sponsored health coverage, they will not be eligible for coverage under this Plan, and the Plan will not pay benefits on their behalf.

Action Required!

You must complete a spouse coverage attestation when you qualify for your next annual Benefit Period. The attestation establishes your spouse's eligibility for benefits. The deadline for returning your attestation will be noted in your Notice of Coverage letter. If you do not complete the attestation and return it by the deadline, your spouse's coverage under the Plan will terminate.

Important Note for Senior Performers: Covering Your Dependents

If you do not meet the Plan's Earned Eligibility requirements, and you enroll in an individual Marketplace plan through the SAG-AFTRA Health Plan / Via Benefits program:

- You can cover your Medicare-eligible spouse (and other Medicare-eligible Dependents) through the Via Benefits marketplace plan(s);
- You can cover your spouse under age 65, and your eligible children under age 26, through the Plan, subject to payment of a monthly premium, as set forth on page 26. The Working Spouse rule applies to your spouse.

You must complete a spousal coverage attestation (as described above) and submit all required verifications to the Plan before enrolling your eligible family members.

Enrollment of an individual who does not meet the Plan's eligibility requirements may 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.

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 from the occurrence of the event 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 and provide you with an enrollment opportunity:

- A new child
- Marriage
- Divorce
- A change in your spouse's employment status or employer-provided health coverage
- Death of a Participant or Dependent

Remember to notify the Plan if you change your address or change your legal or professional name in order to keep your contact information and eligibility up to date.

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

The 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 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 1 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 or 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	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.
Permanently 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 Senior Performer Surviving Dependent benefit following the death of a Participant and you remarry, your Plan coverage will terminate.

² In the event of a divorce, health 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 for themselves. 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.

When a covered Dependent no longer qualifies as a Dependent due to a life event, Participants must contact the Plan within 60 days of the occurrence of the event to remove the individual from coverage. If you fail to do so, you could be responsible for reimbursing the Plan for any Claims paid by the Plan incorrectly on behalf of the former Dependent. See page 36 for additional details. Also, failure to notify the Plan in this situation may affect your Dependent's eligibility for COBRA.

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 (including a National Medical Support Notice), the Plan must first determine that the order is a Qualified Medical Child Support Order (QMCOSO). 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 QMCOSO.

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 the Open Enrollment Period because you intend to travel and would like coverage, 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 Senior Performer 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, 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 Senior Performer Surviving Dependent benefit, 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.

- **Children's Health Insurance Program (CHIP) and 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 or 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) KIDS-NOW 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 or log in to Benefits Manager.

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

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. 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 responsible for reimbursement to the Plan for any benefits paid by the Plan following the date of divorce if your ex-spouse or former stepchildren do not elect COBRA.

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. For more information, see page 7.

IV. Continuing Earned Eligibility

Continuing Eligibility – Minimum Earnings and Alternative Days

Your Earned Eligibility for health coverage will continue without interruption as long as you meet the requirements for minimum Covered Earnings or Eligibility Days 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 Earned Eligibility requirement to continue coverage, or when you transition to a calendar year based upon retirement and Medicare eligibility. See page 9.

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 in Section II 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, 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.

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, 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.

Continuing Eligibility – Covered Staff Employees

If you are covered as a Staff Employee, your coverage continues based upon the minimum earnings requirements described above.

V. Retiree and Senior Performers Coverage

As a Retiree, if you meet certain requirements, you may also be considered a Senior Performer (see page 99 for a definition of Senior Performer). As noted in Section II:

- Retirees who meet the Plan's Earned Eligibility requirements applicable to Retirees and Senior Performers may enroll in the Plan, with the Plan paying primary benefits and Medicare (if you are enrolled) paying secondary.
- Retirees who do not meet the Earned Eligibility requirements will have access to the SAG-AFTRA Health Plan / Via Benefits program, with options to enhance and supplement Medicare coverage. In addition, Retirees who meet the requirements to be a Senior Performer are eligible for the SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account (HRA) Plan if they are not eligible for coverage under this Plan. Refer to the SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account (HRA) Summary Plan Description at www.sagaftraplans.org/health for more information about these benefits.

If you meet the Earned Eligibility requirements and decide to enroll in coverage under this Plan, your medical, prescription drug, dental, life insurance and vision benefits for Senior Performers are the same as those offered to Active Participants. See page 68 for more information regarding life insurance benefits.

It is important to note that benefits for Senior Performers (including access to the SAG-AFTRA Health Plan / Via Benefits Program and the SAG-AFTRA Senior Performers HRA) are offered under the SAG-AFTRA Health Fund 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, Retiree and 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.

Regaining Earned Eligibility

Each year, the Plan will evaluate covered earnings during the Base Earnings Period from October 1 to September 30, to determine the coverage offered for the next calendar year. See page 9 for additional information as to what earnings are considered in determining eligibility for coverage.

You may meet the requirements for Earned Eligibility if:

- You meet the minimum Covered Earnings threshold for Earned Eligibility.
- You meet the Alternative Days requirement.
- You become a Covered Roster Artist.
- You become a Network / Station Staff.
- You become a Staff Employee.

If you meet one of the requirements, you may enroll in Active Plan coverage, and Medicare will become secondary to the Plan. Refer to Section II for more details on Plan eligibility.

Senior Performer Surviving Dependent Eligibility Following the Death of a Senior Performer

The Senior Performer Surviving Dependent benefit provides health benefits upon the death of a Senior Performer (or a Participant or former Participant who meets certain requirements described below) to their Eligible Dependents, provided the deceased individual meets certain requirements at the time of their death. An Eligible Dependent includes the deceased individual's Dependent children and surviving legal spouse, provided the deceased individual and their spouse were married for at least 12 months immediately preceding the individual's death.

The Senior Performer Surviving Dependent benefit is provided to the deceased individual's Eligible Dependents if at least one of the following applies:

- The Senior Performer was at least age 65 at death and had at least 20 Retiree Health Credits;
- The Senior Performer was 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 was age 55 or older on December 31, 2016; or

- The Participant or former Participant was at least age 50 at death, had at least 20 Retiree Health Credits, and their age plus Retiree Health Credits was at least 75. Coverage for their Dependents will begin on the date the deceased individual would have turned 65.
- Coverage for the surviving spouse will continue, provided they enroll in the Health Plan, until the spouse remarries or dies and provided the Plan premium is paid. See page 33 for more details. Coverage for the Senior Performer's surviving spouse is subject to termination under the Working Spouse rule. See page 19. Coverage for the Senior Performer's surviving spouse will also end once the spouse becomes Medicare-eligible, at which point they will have access to the SAG-AFTRA Health Plan / Via Benefits program. See page 31.
- Coverage for Dependent children will continue until they no longer meet the Plan's definition of a Dependent, provided the Plan premium is paid.

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 Senior Performer Surviving Dependent benefits ends. The Dependents will be notified by the Plan if this additional coverage is available.

Senior Performer Surviving Dependent eligibility may be replaced with Earned Eligibility if the Participant met one of the requirements outlined on the previous page under "Regaining Earned Eligibility" (i.e., if sessional earnings are attributed to the deceased Participant).

Note: Senior Performer Surviving 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 were eligible for or were receiving health coverage as a Senior Performer Surviving Dependent under either the AFTRA Health Plan's Senior Citizen Health Program or the SAG-Producers Health Plan's extended spousal benefit, you became eligible for Senior Performer Surviving Dependent coverage under the 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 Performer Dependent coverage and the Senior Performer Surviving Dependent benefit.

Earned Eligibility Premium

For most Participants with Earned Eligibility, the premium is due quarterly. This premium also applies to those covered under the Plan's Total Disability Extension (see page 36). Your quarterly premium costs will be based on the number of family members you cover. The premiums below are effective as of January 1, 2023 and are subject to adjustment at the Trustees' sole discretion. Refer to www.sagaftraplans.org/health for the current premiums.

Coverage Elections	Premium Costs for 2023
Participant Only	\$375 per quarter
Participant Plus One Dependent	\$531 per quarter
Participant Plus Two or More Dependents	\$747 per quarter

As set forth on page 15, Retirees and Senior Performers who do not meet the Earned Eligibility requirements may enroll in plan(s) through the SAG-AFTRA Health Plan / Via Benefits program.

Senior Performers who enroll in a Via Benefits Medicare plan, or who enroll in a Medicare plan through AHIRC and EHIS (in connection with the Actors Fund and the MPTF) may choose to enroll their Eligible Dependents with the Plan as Senior Performer Dependents. These may include your legal spouse under age 65 and your eligible children under age 26. The premium cost for Dependents of such Senior Performers is \$250 per month, which covers all your eligible family members (one or more). The Working Spouse rule applies to spouses of Senior Performers who are eligible for coverage under this Plan. See page 19.

The premium cost may vary for Senior Performer Surviving Dependents. Contact the Plan, or log in to Benefits Manager to see the applicable premium.

Premium Changes and Dependent Coverage

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 you return a Dependent Enrollment Form and the required documentation to the Plan. For additional information about notification requirements and deadlines related to enrolling or disenrolling Dependents, refer to the "Life Events and Dependent Coverage" section of this SPD.

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 but within a special enrollment period, the premium change will be effective back to the first 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 first day of the month following the month in which the event occurred.

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 be able to 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.

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 under those plans' coordination of benefits rules. Please contact your other health plan for more information.

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 premium from your U.S. checking or savings account. Payments are deducted on approximately the 25th day 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 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 or debit card. Simply visit www.sagaftraplans.org/health, and enter your U.S. checking or savings account number or your credit or 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 every time 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 or 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 — If you don't pay by one of the methods above, 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 Plan ID number (found on your premium billing statement or Plan ID card) 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.

Premium Due Dates

Your premium is due on the first day of each Calendar Quarter for Earned Eligibility coverage. For Senior Performers enrolling eligible family members in the Plan or Senior Performer Surviving Dependent coverage, the premium is due on the first day of each month, unless you are paying by mail, in which 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 for monthly Senior Performer Dependent premium payments and a 30-day grace period for quarterly Earned Eligibility premium payments, 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 (including the grace period), 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, 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 30, you will not be entitled to Plan coverage until the following January 1, provided you requalify 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. For Earned Eligibility, the Plan allows one late payment waiver per three-year waiver period. The first three-year waiver period begins on January 1, 2023 and is reset every three years thereafter. The three-year reset period applies to all Participants and is not dependent on when you use a waiver. For example, if you use your one waiver in March 2024, you will again have a waiver available as of January 1, 2026. Senior Performer Dependents and Senior Performer Surviving Dependents 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 your late payment waiver (if available), and your coverage will be reinstated retroactively. If you are changing your enrollment due to a Life Event as defined on page 20, a waiver will not apply.

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 Performer Surviving Dependent benefits or COBRA and must meet the following requirements:

1. The applicant has a catastrophic illness or injury, which means an illness or injury which prevents them from performing the material and substantial duties of their 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 them 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 or Senior Performer Surviving Dependent benefits, grant funds will automatically be applied to the cost of the premium of your coverage.

If a grant is approved for COBRA, the grant funds will be applied to the cost of the COBRA premium for medical coverage. The applicant is responsible for paying the dental portion of the COBRA premium.

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 their portion of the premium (if applicable).

Contact the Plan for an application or more information about the SAG-AFTRA Foundation and other assistance organizations, or visit <https://sagaftra.foundation>.

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 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.

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

- The Extended Career COBRA program – for eligible Participants
- COBRA, see page 30
- Total Disability Extension, see page 36

Loss of Earned Eligibility – Participants

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

Minimum Covered Earnings and Alternative Days

You will lose Earned Eligibility as a Participant at the end of your 12-month Benefit Period if you have not satisfied either the minimum Covered Earnings or Alternative Days requirement during your Base Earnings Period.

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.

- 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.

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 one of the Plan's Earned Eligibility requirements.

Staff Employees

An employee of the Union, the SAG Pension Plan or the Foundation may cancel their participation in the Plan at any time by filing an Election / Waiver Form with their employer and providing evidence of alternative health coverage. Coverage will end on the last day of the month in which the properly completed Election / Waiver Form is received by the employer. An employee who cancels their coverage will not be eligible to re-enroll in the Plan until the next Open Enrollment Period available to that employee, as set forth on page 18.

If an employee of the Union, the SAG Pension Plan or the Foundation resigns or is terminated before the end of their interim eligibility period, their coverage will end on the last day of the month in which the employee resigns or is terminated.

For employees of the Union, the SAG Pension Plan or the Foundation whose employment ends due to resignation, retirement or termination, Earned Eligibility coverage will end as follows:

- For employees of the SAG Pension Plan hired on or after January 1, 2003, coverage will end on the last day of the month following 60 days from the employment termination date, provided that the employee continues to pay the required premium.
- For (1) employees of the Union or the Foundation, or (2) employees of the SAG Pension Plan hired prior to January 1, 2003, coverage will continue until the end of the Benefit Period accrued as a result of their reported income, provided the employee continues to pay the required premium.

If an employee of the AFTRA Retirement Fund loses employment, the following rules will determine the end of coverage under the Plan:

- If the employee was continuously enrolled in Earned Eligibility coverage under the Plan and / or active coverage under the AFTRA Health Plan (not including COBRA or the Total Disability Extension) for less than five years, the employee's coverage will end on the last day of the month following the month in which their employment ends.
- If the employee was continuously enrolled in Earned Eligibility coverage under the Plan and / or active coverage under the AFTRA Health Plan (not including COBRA or the Total Disability Extension) for five or more years, the employee's coverage will end on the last day of the last Benefit Period for which the employee qualified for coverage based on their Covered Earnings under the Plan's general qualification rules.
- Notwithstanding the rules set forth above, employees of the Retirement Fund whose employment is terminated for gross misconduct, will lose coverage on a date to be determined by the AFTRA Retirement Fund's chief executive officer in their discretion.

AFTRA Retirement Fund employees may not cancel or change their Plan coverage outside the Open Enrollment Period described on page 18, unless they qualify for a special enrollment opportunity as set forth on page 21.

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.

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 Dependent benefit, COBRA or the Total Disability Extension (if eligible).

Conversion of Life Insurance Benefit After the Loss of Earned Eligibility

A life insurance conversion policy is available through Metropolitan Life Insurance Company (MetLife) to Participants who lose Earned Eligibility. If you are a Senior Performer and are no longer covered under the SAG-AFTRA Health Plan, you will be eligible for a \$5,000 life insurance benefit by choosing a supplemental Medicare plan through Via Benefits or as allowed through the HRA Plan. If you are not a Senior Performer, 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.

Loss of Senior Performer Surviving Dependent Eligibility

If a surviving spouse has extended coverage as a Senior Performer Surviving Dependent and remarries, their coverage will end on the date they remarry. If the surviving spouse's eligibility for the Senior Performer Surviving Dependent benefit ends, the surviving spouse may be eligible for COBRA.

Senior Performer Surviving Dependent coverage for Dependent children will end when they no longer meet the Plan's definition of a Dependent.

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) Continuation Coverage

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

The right to COBRA was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA 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 depends on several factors, including which qualifying event caused the loss of Earned Eligibility.

As you consider COBRA, note that you may be eligible for the Plan's Extended Career COBRA benefit. Effective January 1, 2021, the Plan introduced the Extended Career COBRA benefit for performers with continuous, long-term service in the industry. If you lose Earned Eligibility, as noted above, you can continue Plan coverage through COBRA. If you qualify for the Extended Career COBRA benefit — and elect it within the deadline — you pay a reduced premium of 20% of the COBRA rate.

To qualify for Extended Career COBRA, you need to meet the following thresholds:

Note: The reduced COBRA rate is subject to change.

Covered Earnings During Your Most Recent Base Earnings Period	Currently \$20,400 (this earnings requirement is scheduled to increase 2% each year)
Extended Career Credits	With at least 12 Extended Career Credits, you will pay a reduced premium of 20% of the COBRA rate for up to 12 months. If you have 20 or more Extended Career Credits, you will pay a reduced premium of 20% of the COBRA rate for up to 18 months.

You receive an Extended Career Credit each time you meet the Plan's Covered Earnings Eligibility Threshold and qualify for 12 months of coverage.

A Participant who elects COBRA at the reduced rate and subsequently meets the Plan's Earned Eligibility requirements for another year may again be offered the reduced Extended Career COBRA rate if the Participant again loses Earned Eligibility in the future.

Retirees, Roster Artists, Station Staff, and employees of SAG-AFTRA, the SAG-AFTRA Foundation, the SAG Producers Pension Plan and the AFTRA Retirement Fund are not eligible for the Extended Career COBRA benefit.

COBRA Is Not Your Only Option

You may have additional choices when you lose group health coverage, as follows.

- **Through Via Benefits:**
 - Medicare-eligible Participants and their Medicare-eligible Dependents can shop for supplemental Medicare coverage through the Via Benefits Medicare marketplace plans.
 - Participants under age 65 and their Dependents can explore different private health insurance options.
 - Participants and Dependents can connect with a personal Via Benefits advisor to compare Plan benefits to the alternatives that may be available.
- **Through the Actors Fund's AHIRC program or through EHIS (the MPTF and Actors Fund's joint program):**
AHIRC and EHIS representatives can help you find coverage and can help find other financial assistance that may be available.
- **Through your spouse's employer-sponsored plan:**
Losing your Plan coverage may trigger a special enrollment period, which allows enrollment in your spouse's or partner's plan.
- **Medicare:** Don't put off your Medicare enrollment. Be sure to enroll in Part A and Part B when you're eligible! Remember that losing your Plan coverage triggers a Medicare special enrollment period for you.
- **Medicaid / Medi-Cal / Children's Health Insurance Program:** Your state's Medicaid program (Medi-Cal in California) and Children's Health Insurance Program (CHIP) provide low-cost health insurance to eligible individuals and families, based on family size and income level. Contact Via Benefits and ask if your state-provided programs are an option for you.
- **Your state's health insurance marketplace:** You can shop for an individual plan through the marketplace. Depending on where you live, you may have a wide variety of plans available. Also, based on your household income, you may be eligible for a tax credit that lowers your monthly premiums and cost-sharing. If you or your Dependents ever lose eligibility for coverage under this Plan, feel free to contact Via Benefits, and ask if your state's marketplace plans might be right for you.

To contact Via Benefits, Medicare-eligible Participants call (833) 981-1280; Participants under age 65 call (833) 963-1230.

Can I Enroll in Medicare Instead of COBRA After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA instead, you may have to pay a Part B late enrollment penalty, and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA and later enroll in Medicare Part A or B before COBRA ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA and Medicare, Medicare will generally pay first (primary payer), and COBRA will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information, visit <https://www.medicare.gov/medicare-and-you>.

What Is COBRA?

COBRA 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 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 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 is not available to you if your Earned Eligibility ends for these reasons.

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

- As a Participant, you may qualify for COBRA 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.
 - As a Dependent spouse or child, you may qualify for COBRA 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 their Covered Earnings or Eligibility Days;
 - A change in their qualification as a Covered Roster Artist;
 - The termination of their employment for any reason other than gross misconduct; or
 - Their death.
 - Also, a divorce from the Participant; or
 - 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, even if the Participant does not elect COBRA.

When Is COBRA Available?

The Plan will offer COBRA 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, 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 their right to enroll in COBRA.

How Long Is COBRA Provided?

Once the Plan receives notice that a qualifying event has occurred, COBRA will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA.

Participants may elect COBRA on behalf of their spouses, and parents may elect COBRA on behalf of their children.

COBRA 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 (18) months of COBRA is available to Participants (and their covered Dependents) who lose eligibility 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 (36) months of COBRA 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 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, for a maximum of 29 months. The disability must have started at some time before the 60th day of COBRA and must last at least until the end of the 18-month period of COBRA. You must provide the Plan with a copy of your determination letter from the Social Security Administration before the 18-month period of COBRA expires in order to receive this extension.

- **Second Qualifying Event Extension:**

If your family experiences another qualifying event during the 18 months of COBRA, the spouse and Dependent children in your family can get up to 18 additional months of COBRA, 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 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 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. Additionally, individual COBRA may be available if a Dependent loses Dependent status while enrolled in Senior Performer Surviving Dependent coverage. This would include situations in which a surviving spouse remarries.

Individual COBRA 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 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. The maximum period of COBRA availability 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 coverage due to any of the Qualifying Events listed above, you will be offered a one-time opportunity to enroll in COBRA.

COBRA is identical to the coverage provided to Participants with Earned Eligibility, except that COBRA Participants are not entitled to life insurance or accidental death and dismemberment benefits.

Enrollment Process

When you lose coverage due to a Qualifying Event, the Plan will send you a termination notice describing the available COBRA, 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 on an individual basis. If you do not enroll in COBRA following the loss of your Earned Eligibility or other Qualifying Event, the Dependents that were covered under the Plan when your coverage 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 also be downloaded from the forms section of www.sagaftraplans.org/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 another special enrollment qualifying event.

COBRA Premiums

The premium required for COBRA is determined by:

- Your eligibility for the Plan's Extended Career COBRA benefit versus regular COBRA; and
- The number of Dependents you enroll.

COBRA premium rates are determined in accordance with federal law and are subject to change as permitted by law. The premium is based on a three-tier structure: individual only, individual plus one Dependent, or individual plus two or more Dependents. You can find the current COBRA premiums at www.sagaftraplans.org/health.

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. Visit <https://sagaftra.foundation>.

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 when you enroll in COBRA. 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 Plan ID cards will be sent to you within 10 business days. You can also print Plan 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, 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.

COBRA Premium Payment Procedures

There are several ways to pay your monthly COBRA 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 first. The Plan will continue to deduct the monthly premium as long as you remain continuously eligible for COBRA, 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. 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 or debit card. Simply visit www.sagaftraplans.org/health, and enter your checking or savings account number or your credit or 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 every time 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 or 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 ID number (found on your premium billing statement or Plan ID card) 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 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 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 Changes

Annual Open Enrollment

If you are enrolled in COBRA, your Benefit Period is January 1 through December 31, and your Open Enrollment Period will generally occur from December 1 through January 15. During your Open Enrollment Period, 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 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.

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 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 you or your spouse is covered by Medicare, you may also enroll in COBRA when you lose Earned Eligibility.

Medicare will be your primary plan, and this Plan will be your secondary plan. Please see the section on "Coordination of Benefits With Medicare" 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

Your COBRA 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 is based on you being Totally Disabled;
- The first of the month following the expiration of the maximum COBRA period for which you qualify;
- The first of the month for which you qualify for Earned Eligibility; 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 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. If the disabled individual qualifies for Medicare, they must enroll in Medicare Parts A and B. The Plan will pay benefits as if Medicare were the primary coverage, even if the disabled individual does not enroll in Medicare.

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.

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 Qualified Dependent is Totally Disabled if they are prevented, solely because of sickness or accidental bodily injury, from performing the material and substantial duties of their regular occupation. A minor Participant or minor Dependent is Totally Disabled if they are 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 them from engaging in most of the normal activities of a person of like age and sex in good health.

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 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

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 have elapsed, provided they are still considered Totally Disabled and are 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 while you are covered under the Total Disability Extension, they may be added to your COBRA 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. 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 ends (unless you become Totally Disabled due to a new disability).

In addition, if the disabled individual does not want to choose either of the options set forth above and if they are eligible for Medicare based on their disability, they can instead access the SAG-AFTRA Health Plan / Via Benefits program to explore options for individual Medicare plans offered through Via Benefits.

Extended Coverage for Military Service

In accordance with the Uniformed Services Employment and Reemployment 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 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

The Plan provides an extensive package of benefits that helps you pay for everyday medical costs and wellness services, as well as expenses resulting from illness or injury. The Plan pays benefits toward covered Physician charges, Hospital and surgical expenses, laboratory and radiology charges, mental health and substance use disorder treatment, and prescription drugs, among other medical 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 or ordered by your Physician.

Coverage Highlights

- For medical and Hospital care, the Plan uses the nationwide Anthem Blue Cross Preferred Provider Organization (PPO), which includes the nationwide BlueCard PPO network.
- For most services, once you meet your annual Deductible, you pay a percentage of the cost, called your Coinsurance.
- The Plan's annual Deductible combines medical and Hospital care.
- Once you reach the Plan's annual out-of-pocket maximum for In-Network services, the Plan pays 100% of Covered Expenses In-Network. (There is no cap on Out-of-Network service expenses that you are responsible for.)
- For outpatient care, the Plan will pay benefits based on whether you received care from an In-Network Provider or an Out-of-Network Provider. Visit a Provider that participates in Anthem's BlueCard PPO network, and, generally, you'll save money on your care. PPO Providers have agreed to accept lower, negotiated rates for their services.
- For inpatient Hospital care, you must use an In-Network facility, or you will not receive coverage, except in an emergency, as described on page 44.
- For inpatient and alternative levels of care for mental health and substance use disorder care, you must use facilities within the Beacon Health Options network, except for emergencies, as described on page 44.
- CVS Caremark, Delta Dental and VSP provide the networks for pharmacy, dental and vision care respectively.

Pre-Authorization

Certain procedures have pre-authorization requirements, as described below and throughout this SPD. While a Claim will not be denied, nor payment reduced, simply because it was not pre-authorized, it is very important that you and your Provider seek pre-authorization for these services. The pre-authorization process can assist you, your Provider and the Plan in detecting any issues before the service is performed, so that you can avoid issues later on. Payment for Plan benefits is based upon, among other considerations, whether the treatment or procedure is Medically Necessary or Experimental or Investigative, as defined in the Health Plan Glossary starting on page 99, and obtaining pre-authorization can address these issues before services are rendered.

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

- Transplants (see page 52)
- Bariatric surgery (see page 52)
- Eyelid surgery (see page 52)
- Gender reassignment / confirmation surgery (see page 52)
- Genetic testing
- Outpatient monitored anesthesia care
- Nasal surgery (see page 53)
- Neuropsychological testing
- Reconstructive surgery and other breast surgeries (other than as required under the Women's Health and Cancer Rights Act, see page 53)
- Sleep study
- Spinal surgery (see page 53)
- TMJ therapy
- Any potentially Investigative or Experimental testing or treatment

Even if pre-authorization is not required by the Plan, you may request certain pre-authorizations in order to have a better idea as to whether and to what extent a service will be covered.

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

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

Also, please refer to the SPD's prescription drug benefits for information regarding pre-authorization for medications, which is not handled by Anthem and may be required in order to obtain coverage.

You should note that, if your Provider participates with Anthem, the contract between the Provider and Anthem may require the Provider to obtain pre-authorization from Anthem for services not listed in this SPD. Those requirements are between the Provider and Anthem and are separate from the Plan's requirements and can affect the Provider's right to payment under the Anthem contract.

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

How to Get Care Quickly – Virtual Visit Options

Virtual Visits With Your Medical or Mental Health Provider

Virtual visits allow you to visit with your Provider about a medical or mental health issue from your mobile device or computer. Virtual visits are best for nonemergency issues. Contact your Provider to see if they offer virtual visits or to make an appointment. Regular cost-sharing for an office visit applies. Note: After the end of the COVID-19 emergency period, this benefit will be available only for visits with In-Network Providers.

LiveHealth Online

For treatment of medical issues, you also have access to virtual visits through the Plan's LiveHealth Online benefit. This includes:

- An in-person visit with a board-certified medical professional through your phone, tablet or desktop.
- Help with nonemergency medical problems, like a cold, flu, ear or sinus infection and allergies.
- Short-term prescriptions, if needed.

You can register at www.livehealthonline.com, or download the app to your mobile device.

MDLIVE

For treatment of mental health issues, you can also take advantage of virtual visits through Beacon's MDLIVE resource (available through mobile app, website and by phone). Register at www.mdlive.com/counseling, or download the app to your mobile device. The Plan

Deductible and regular cost-sharing for an office visit apply.

How to Access Virtual Care

Virtual Care Quick Reference

- Virtual Care Quick Reference
- Call your Provider's office
- LiveHealth Online (medical care):
www.livehealthonline.com
- MDLIVE (mental health):
www.mdlive.com/counseling

Use Network Providers to Get Quality Care at Lower Costs

The Plan generally pays higher benefits for medical care if you choose an In-Network Provider than if you choose an Out-of-Network Provider.

Network Providers discount their fees and agree to accept the "contracted rate" as payment for services. After you meet your Deductible, as applicable, your share of the cost for covered In-Network services is based on a percentage of this lower contracted rate.

When you use an Out-of-Network Provider, the Plan Allowance will be used to determine the amount the Plan will consider in determining the benefits payable on your Claim, instead of the In-Network contracted amount. The Out-of-Network Provider can then bill you for any amount they charge that is above the Plan's Allowance for a service. This is called "balance billing" and is your responsibility to pay.

Please note: While Plan staff will do their best to answer any questions you have concerning the Plan's Allowance for a particular service 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.

Another advantage to using an In-Network Provider is that the In-Network Provider will usually file a Claim for benefits with the Plan on your behalf. If you choose an Out-of-Network Provider, you may have to pay the entire cost of your care up front, then file a Claim for benefits with the Plan in order to receive reimbursement of the Plan's share of your covered care.

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.

The Plan's Network Providers

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

IMPORTANT! You Must Use In-Network Hospitals

In order to have Plan coverage for Medically Necessary services, you must seek medical care from Hospitals in the BlueCard PPO and the Beacon Health Options network for mental health and substance use disorder higher levels of care. **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 44.**

Medical and Hospital Care

Anthem BlueCard PPO

The Plan contracts with Anthem's BlueCard PPO network, giving you access to one of the nation's largest networks of doctors, Hospitals, and other health care facilities. Search for Providers on the Sydney Health app, at <https://anthem.com/find-care>, or call (800) 810-BLUE (2583).

Mental Health and Substance Use Disorder Services

Beacon Health Options

(866) 277-5383

www.achievesolutions.net/sag-aftra

MDLIVE

(888) 430-4827

www.mdlive.com/sagaftra

Prescription Drugs, Including Specialty Drugs Through CVS Specialty Pharmacy

Caremark

(833) 741-1361

www.caremark.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 (784-8454)

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

If you are receiving services from an Out-of-Network Provider, ask them how much they will charge for a service before you receive it. In addition, the website www.fairhealthconsumer.org can provide a ballpark estimate for Out-of-Network costs. Note that the site provides estimates only and does not take into account the Plan's benefits, limits and exclusions, and that some Out-of-Network Providers charge far more than the FAIR Health amount.

How the Plan Covers Out-of-Network Care in Special Situations

The nationwide BlueCard Program gives you access to a network of doctors and Hospitals when you're traveling. However, 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 (or have traveled to), you are considered to be outside a network area. This means that you will receive the Plan's In-Network Level of Benefits for covered services. Always call the number on your medical ID card to verify your In-Network Provider options.

Important Note:

In-Network Providers can change on an ongoing basis. New Providers are added to the network, and sometimes other Providers drop out of the network. 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.**

This same rule applies if you need mental health or substance use disorder treatment and live or have traveled more than 25 miles from two facilities or Providers of any type who participate in the Beacon Health Options network.

Serious Conditions

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 their 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 spinal manipulation, holistic treatment services or treatment for generalized anxiety disorder.

The personal 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.

Out-of-Network Provider Claims Repricing

The Plan offers one of the broadest networks by providing access to Anthem's BlueCard network, and you receive the best value from your benefits when you visit a network Provider. We do understand that sometimes Participants and Qualified Dependents need to seek care from an Out-of-Network Provider, and the benefits payable under the Plan for Out-of-Network Providers are set forth in this SPD.

Out-of-Network Claims are generally subject to higher out-of-pocket costs for Participants and their families, because the Out-of-Network Provider has not agreed upon a rate for their services in advance.

The Plan uses Anthem's Out-of-Network pricing schedule to determine the Allowable Amount. For more information or to see what the Allowable Amount would be for a service from an Out-of-Network Provider, log in to Sydney Health, or call Anthem at (833) 414-5790.

Out-of-Network Hospital services are covered only in the event of an emergency.

An emergency medical condition is a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious medical complications, loss of life, serious impairment of bodily functions, or serious dysfunction of a body part.

Emergency services means, with respect to an emergency medical condition:

- An appropriate medical screening examination that is within the capability of an emergency room of a Hospital or independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Such further medical examination and treatment as are required to stabilize the patient within the capabilities of the staff and facilities available at the Hospital or the independent freestanding emergency department, as applicable (regardless of the department of the Hospital in which such further examination or treatment is furnished); and
- Post-stabilization services, which are services furnished by Out-of-Network Providers or Out-of-Network facilities after the patient is stabilized as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition (regardless of the department of the Hospital in which such further examination or treatment is furnished), until: (1) the treating provider or facility determines that the individual is able to travel using non-medical transportation or nonemergency medical transportation; and (2) the patient is provided with appropriate written notice to consent to Out-of-Network treatment (see below) and gives informed consent to such Out-of-Network treatment.

This definition applies even if it is more than 72 hours after an accident or 24 hours of a sudden and serious illness.

If you receive emergency services for treatment of an emergency medical condition that is covered under the No Surprises Act, you are not required to obtain authorization for the coverage.

For pregnant Dependent children, charges for treatment that qualifies as emergency care for emergency services as defined above are covered and paid in accordance with the No Surprises Act.

Ground ambulance services are not emergency services for the purposes of the No Surprises Act and will be covered under the normal terms set forth in the SPD.

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.

Important Note:

In-Network Providers 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.

No Surprises Act

The Plan has implemented the changes below as required by the No Surprises Act, which is a federal law that protects healthcare consumers from receiving surprise bills from Out-of-Network Providers in certain situations.

In-Network Cost-Sharing / No Balance Billing for Services Covered Under the No Surprises Act

Typically under the Plan, if you receive medical services from an Out-of-Network Provider or facility, you are responsible for Out-of-Network cost-sharing amounts (including any Copay, Coinsurance and Deductible) plus the amount, if any, by which the Out-of-Network Provider or facility's actual charge exceeds the Plan's Allowance for the covered services. However, if you received Plan-covered services that are also covered under the No Surprises Act, your cost-sharing will be the same as if you had received those services from an In-Network Provider or facility. This means that you will not have to satisfy the Out-of-Network Deductible, Copay or Coinsurance for these services, and you will not have to pay any amount billed by the Out-of-Network Provider or facility that exceeds the Plan's normal Allowance for the covered services. Instead, you will only pay In-Network cost-sharing, including the In-Network Deductible, Coinsurance and Copay.

Since there is no "contracted rate" with the Out-of-Network Provider or facility on which to base your Coinsurance, it will instead be based on a percentage of the following (in order of priority):

- An amount determined by an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act;

- An amount determined by a specified state law to which the Plan opts in (as of the date of this SPD, the Plan has not opted in to a specified state law); or
- The lesser of the amount billed or the qualifying payment amount (which is, generally, the median contracted rate for the item or service in the same geographic region, as adjusted under Department of Labor Regulations).

Further, typically, cost-sharing for Out-of-Network services other than Emergency Services does not apply to your Coinsurance out-of-pocket limit or your comprehensive (Hospital, medical, prescription drugs, and mental health and substance use disorder services) out-of-pocket maximum; however, the Plan applies these out-of-pocket limits to cost-sharing for Out-of-Network covered services that are also covered under the No Surprises Act.

In addition, if you receive covered services that are also covered by the No Surprises Act, the Plan pays the Out-of-Network Provider or facility directly, based on the terms of the No Surprises Act. The Out-of-Network Provider or facility is prohibited from sending you a balance bill for charges for those services that exceed the amount on which the Plan based its payment.

Services Covered by the No Surprises Act

The following services are covered under the No Surprises Act:

- Emergency services (defined on page 44) at an Out-of-Network health care facility (unless you consent to be treated by the Out-of-Network Provider for certain post-stabilization services; see below)
- Nonemergency services provided by an Out-of-Network Provider at an In-Network health care facility (unless you consent to be treated by the Out-of-Network Provider, if applicable; see next page)
- Out-of-network air ambulance services

Please keep in mind that the special rules described within this section only apply to covered services that are also covered by the No Surprises Act. Other Out-of-Network covered services remain subject to the normal rules of the Plan. In addition, all expenses for inpatient Out-of-Network Hospital or facility services (except for emergency services) continue not to be covered under the Plan. Please also note that regardless of whether a Plan-covered service is also covered under the No Surprises Act, you are always responsible for any expenses or charges billed by any Provider or facility that are not medically necessary or are otherwise not covered services under the Plan.

Consent Requirements

The special rules for services covered under the No Surprises Act will not apply in certain circumstances if you consent to receiving treatment from an Out-of-Network Provider. These consent rules apply to (1) nonemergency services provided at an In-Network facility other than ancillary services (described on the next page) or (2) emergency services that are post-stabilization services. If you do consent, as with other Out-of-Network services, you will be responsible for payment of the applicable Out-of-Network cost-sharing, as well as any balance bills for amounts in excess of the Plan's Allowance for those services.

In order for the consent to be valid, certain regulatory requirements must be satisfied, including the following:

- You are provided with written notice: (1) that the provider is an Out-of-Network Provider; (2) of any estimated charges for treatment; (3) of any applicable advance limitations under the Plan; (4) that consent to receive treatment by such Out-of-Network Provider is voluntary; and (5) that you may instead seek care from an In-Network Provider. In the case of nonemergency services, this notice must be provided at least 72 hours before the appointment (or three hours in advance of services rendered in the case of a same-day appointment), and on the day of the appointment.
- You give signed, informed consent (consistent with regulatory requirements) to treatment by the Out-of-Network Provider, acknowledging that you understand that treatment by the Out-of-Network Provider may result in greater out-of-pocket costs compared to treatment by an In-Network Provider. For nonemergency services, the "notice and consent" exception above does not apply to ancillary services or to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished. For this purpose, ancillary services include (1) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether provided by a physician or non-physician practitioner); (2) items and services provided by assistant surgeons, hospitalists, and intensivists; (3) diagnostic services, including radiology and laboratory services; and (4) items and services provided by an Out-of-Network Provider if there is no In-Network Provider who can furnish such items or services at the facility.

Claim Determinations for Claims Subject to Surprise Billing Protections

The Plan will make an initial payment or notice of denial of payment for emergency services at Out-of-Network health care facilities, nonemergency services provided by Out-of-Network Providers at In-Network facilities,

and Out-of-Network air ambulance services within (30) calendar days of receiving a claim from the Out-of-Network Provider or facility that includes all necessary information to decide the claim.

Provider Directory Updates

To help you find care from In-Network Providers and facilities, Anthem, Beacon and Caremark maintain a provider directory. Anthem, Beacon and Caremark update these directories every ninety (90) days and will respond to your inquiry about the network status of a Provider or facility within one business day. If you receive inaccurate information from Anthem, Beacon, Caremark or the Plan office about a Provider or facility's network status, you will be liable only for In-Network cost-sharing for the services underlying your inquiry. However, it is your responsibility to confirm that the Provider or facility that you have selected is In-Network at the time you receive services. See page 40 for further information about how to find an In-Network Provider or facility.

Continuity of Coverage

The Plan will provide "continuity of coverage" in certain situations where a termination of a contractual arrangement changes the In-Network status of a Provider or facility to Out-of-Network (except in the case of a termination of the contract for failure to meet applicable quality standards or for fraud).

Specifically, if you are a "Continuing Care Patient," you will be notified of the contract termination and your right to elect continued transitional care from the Provider or facility, and you will be allowed ninety (90) days of continued transitional care from the Provider or facility at In-Network cost-sharing to allow you time to transition to a new In-Network Provider or facility (provided you remain eligible for Plan coverage).

A Continuing Care Patient is an individual, who, with respect to a Provider or facility: (1) is undergoing a course of treatment for an acute illness (serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm) or chronic illness or condition (life-threatening, degenerative, potentially disabling, or congenital, and who requires specialized medical care over a prolonged period of time); (2) is undergoing a course of institutional or inpatient care from the Provider or facility; (3) is scheduled to undergo nonelective surgery from the Provider, including receipt of postoperative care from such Provider or facility; (4) is pregnant or undergoing a course of treatment for the pregnancy from the Provider or facility; or (5) is or was determined to be terminally ill (under SSA § 1862(dd)(3)(A)) and is receiving treatment for such illness from such Provider or facility.

Plan Cost-Sharing

Annual Deductible

The annual Deductible is the dollar amount of most covered charges that you must pay before the Plan begins to pay benefits each calendar year. Note that there are two Deductible amounts – an In-Network Deductible and an Out-of-Network Deductible.

The annual Deductible is a combined amount that includes Medically Necessary medical and Hospital charges.

Generally, the Deductible does not apply to In-Network preventive care. There are separate annual Deductibles for prescription drugs and dental care.

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.

Please note that 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. Therefore, a Claim for a later date of service may be applied to the Deductible before a Claim for an earlier date of service, depending on when we receive and process each Claim.

Copays, Coinsurance and Out-of-Pocket Limits

Once you have satisfied the annual Deductible, the Plan will provide reimbursement of Covered Expenses. You are responsible for payment of the applicable Copays and Coinsurance. For example, there is a \$100 Copay required when you use the Hospital as an inpatient, for outpatient surgery or in the emergency room. Refer to the benefit summary chart on page 103 for 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 you satisfy your Deductible and pay your Copays.

Once you have satisfied your Deductible, paid any applicable Copays and met the maximum Coinsurance out-of-pocket amount, the Plan will pay 100% of Covered Expenses for In-Network Providers, with the exception of office visit Copays. Your total In-Network out-of-pocket

expenses are also limited by the Comprehensive Out-of-Pocket Maximum, described below.

NOTE: There is no out-of-pocket maximum for Out-of-Network services. While the Plan pays benefits for Out-of-Network services as described in this document (other than nonemergency facility or Hospital Claims), there is no maximum amount at which the Plan pays 100% of Covered Expenses for Out-of-Network Providers.

Comprehensive Out-of-Pocket 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 use disorder 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 ACA and updated annually.

Hospital Benefits (Including Mental Health and Substance Use Disorder)

The Plan uses the national BlueCard PPO network (through a contract with Anthem Blue Cross of California) for all Hospital benefits except mental health and substance use disorder care.

The Plan uses the Beacon Health Options network for mental health and substance use disorder benefits. Hospital benefits include all higher level of care benefits such as residential treatment centers, partial hospitalization and intensive outpatient programs.

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.

Emergency Care

An emergency medical condition is a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious medical complications, loss of life, serious impairment of bodily functions, or serious dysfunction of a body part.

Emergency services means, with respect to an emergency medical condition:

- An appropriate medical screening examination that is within the capability of an emergency room of a Hospital or independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Such further medical examination and treatment as are required to stabilize the patient within the capabilities of the staff and facilities available at the Hospital or the independent freestanding emergency department, as applicable (regardless of the department of the Hospital in which such further examination or treatment is furnished); and
- Post-stabilization services, which are services furnished by Out-of-Network Providers or Out-of-Network facilities after the patient is stabilized as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition (regardless of the department of the Hospital in which such further examination or treatment is furnished), until: (1) the treating provider or facility determines that the individual is able to travel using non-medical transportation or nonemergency medical transportation; and (2) the patient is provided with appropriate written notice to consent to Out-of-Network treatment (see below) and gives informed consent to such Out-of-Network treatment.

This definition applies even if it is more than 72 hours after an accident or 24 hours of a sudden and serious illness.

If you receive emergency services for treatment of an emergency medical condition that is covered under the No Surprises Act, you are not required to obtain authorization for the coverage.

For pregnant Dependent children, charges for treatment that qualifies as emergency care for emergency services as defined above are covered and paid in accordance with the No Surprises Act.

Ground ambulance services are not emergency services for the purposes of the No Surprises Act and will be covered under the normal terms set forth in the SPD.

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.

Covered Hospital Benefits

The Plan's Hospital benefits cover facility charges for medical and surgical treatment as well as mental health and treatment. Like medical and surgical treatment,

mental health and substance use disorder treatment is covered for a vast number of conditions. Among them are anxiety, stress, eating disorders, depression, bipolar disorders, psychosis, schizophrenia and substance use disorder (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 use disorder 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. See pages 48 – 51.
- In-Network alternative levels of mental health and substance use disorder 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. Note that 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.
- Cardiac care unit.
- Medical supplies and devices, splints, casts and dressings.
- Operating, delivery, treatment and recovery rooms.
- Oxygen.
- Physical therapy 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.

As a reminder, for pregnant Dependent children, charges for treatment that qualifies as emergency care for emergency services as defined on page 41 are covered and paid in accordance with the No Surprises Act.

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).

Travel Benefits

The Plan provides travel benefits under the following circumstances:

- To reimburse reasonable travel expenses for covered Dependent children (in case of emergency abortion only), Participants, and covered Dependent spouses who are unable to obtain abortion services without traveling because they reside in a state or temporarily work in Covered Employment in a state where abortion is illegal.

You are eligible for reimbursement of reasonable travel expenses to receive abortion services covered by the Plan only if you are a Participant, covered Dependent spouse, or a covered Dependent child (in case of emergency abortion only), and you are unable to obtain abortion services without traveling because you reside or temporarily work in Covered Employment in a state where abortion is illegal. When "you" is used in this section of the SPD, it refers to a Participant, covered Dependent spouse, or to the extent applicable, covered Dependent child who is eligible for the travel reimbursement benefit.

You may travel to a provider in the state or major metropolitan area closest to you where the services are legal. If you are away from home in a temporary work location, you can instead choose to travel to your state of residence if abortion is legal there.

Travel under this provision is limited to travel within the United States.

In all instances, travel expenses must be primarily for, and essential to, obtaining abortion services covered by the Plan that are performed by a licensed medical provider acting within the scope of their license. Travel expenses that are not primarily for and essential to obtaining covered abortion services are not Covered Expenses and will not be reimbursed.

Transportation

- Bus, taxi, train, or plane fares (only coach or economy fare is a Covered Expense).
- Transportation expenses for one caregiver or travel companion.

- If you use your own car, mileage is reimbursable at the business mileage rate set by the IRS (currently \$0.62 per mile). Parking fees and tolls are also Covered Expenses, but gas is not. Mileage rates for medical travel are currently lower than the business mileage rate that the Plan will use to reimburse travel expenses. As a result of these IRS rules, you will be taxed on the reimbursed difference between the two mileage rates in effect at the time of your trip.
- If you use a rental car, reasonable rental car expenses are reimbursable up to \$65 per day. In this case, gas, parking fees, and tolls are also Covered Expenses, but mileage is not.

Lodging

- Lodging for you and your travel companion for the night prior and the night of the abortion is covered, as well as a subsequent night(s) if medically necessary. The lodging expense amount must be reasonable as determined by the Plan, but in no event greater than \$300 per night (in total, not per person).
- Please note that under IRS rules, if your lodging is more than \$50 per person per night, you will be taxed on the amount in excess of the IRS limit.
- Lodging will not be reimbursed if you travel home to receive abortion services.

Required Receipts and Documentation

- Reimbursement for the cost of lodging (hotel, motel) requires a copy of the paid invoice.
- Reimbursement of transportation requires a copy of itinerary and paid ticket receipt.
- Reimbursement for mileage requires a printout documenting the shortest route showing the mileage associated with that route.
- Reimbursement for rental cars and gas for rental cars requires paid receipts.
- Reimbursement of parking requires paid parking receipts.
- Reimbursement of tolls requires a toll receipt or printout of a toll pass paid invoice.

Non-Covered Expenses

- Meals (other than meals provided through inpatient care).
- Childcare expenses or babysitting.
- Extending an otherwise medical trip for personal reasons.

- Expenses for more than one caregiver or travel companion.
- Travel outside of the United States.

Employment Taxes

In addition to the reimbursements for travel and lodging described above, the Plan will also pay your share of applicable employment taxes on those reimbursements that are in excess of the IRS limits.

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 use disorder, 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 49.
- 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 71 – 72.

Medical Benefits

The Plan's medical benefits provide coverage for medical and surgical treatment as well as mental health and substance use disorder treatment. Like medical and surgical treatment, mental health and substance use disorder treatment is covered for a vast number of conditions. Among them are anxiety, stress, eating disorders, depression, bipolar disorders, psychosis, schizophrenia and substance use disorder (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 Anthem at (833) 414-5790.
- For mental health or substance use disorder treatment, contact Beacon Health Options at (866) 277-5383 or www.achievesolutions.net/sag-afta.

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 51 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 voluntary sterilization, subdermal implants, intrauterine devices (IUDs) and Depo-Provera. Birth control received from an In-Network Provider is not subject to the Deductible or Coinsurance if covered as Preventive Services under the Health Resources and Services Administration Women's Preventive Services Guidelines. See page 106. (Birth control pills, diaphragms, vaginal rings and patches that qualify as Covered Expenses under the Plan are covered by the Plan's prescription drug benefits through Caremark.)
- Blood and plasma, except platelet-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 (see coverage of mastectomy and reconstruction below). Please see page 53 for surgery pre-authorization information.
- 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 an acute brain injury or clinical cardiac or CVA (cerebrovascular accident) episode.
- Certified nurse practitioner services, when the nurse is acting within the scope of their 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 neuropath, to the extent the exclusion is permitted by law).
- 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 (applied without respect to when the individual is enrolled in the Plan). 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 infusible and administered by the Physician's office. (Specialty medications are covered under Caremark prescription drug benefits and must be obtained through the CVS 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 Caremark prescription drug benefits (see page 59). Benefits are payable at the Out-of-Network level subject to the 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 (except as otherwise required by the ACA), 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; nor is DME prescribed by a Provider outside the scope of their license. DME purchased from a non-qualified supplier such as Amazon or eBay is not covered. 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 workup 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 Caremark prescription drug benefits), laboratory testing (to monitor the safety of continuous hormone therapy) and gender reassignment surgery (pre-authorization recommended). Voice modification surgery and voice therapy are not covered. See page 52 for additional details and limitations regarding gender reassignment surgery.
- Genetic or 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. 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 57 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 or as otherwise required to be covered under the ACA. 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.
- In-Network lactation support and counseling services deemed to be preventive 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 only in certain limited circumstances to diagnose the extent of a physical injury. Please contact Anthem for more information.
- 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 or a mental health or substance use disorder, such as an eating disorder. 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. Please contact Anthem for additional information.
- 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 Health Care Provider, 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. See page 56.
- 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. Pre-authorization is required. For additional information, see page 57.
- 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 unless deemed to be preventive services. 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). Anthem 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 CPAP 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. Pre-authorization is required. See page 38.
- Temporomandibular joint dysfunction (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. Pre-authorization is recommended.
- Therapy benefits, subject to specific limitations. Refer to pages 54 – 55.
- 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 coordinated with Anthem and the Plan (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 57.
- 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.

Note that RAP services provided by Out-of-Network providers at In-Network facilities are subject to the No Surprises Act as described on pages 42 – 43.

Surgical Benefits

Contact Anthem 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. See page 53 for information on pre-authorization for surgeries.

Transcarent Surgery Care

The Transcarent Surgery Care program covers 100% of the preoperative appointment, surgery, and postoperative appointment costs for participants and their enrolled Dependents. Transcarent Surgery Care includes bariatric, cardiac, general, neurological, orthopedic, spinal, women's health, and vascular procedures. Not all surgeries are available in all geographic areas.

Speak with a Care Coordinator by calling (855) 601-0667 or send an email to surgerycare@transcarent.com for details.

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 or 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 45 through 75.

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 they intend 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.

As a reminder, anesthesia services provided by Out-of-Network Providers at In-Network facilities are subject to the No Surprises Act as described on pages 42 – 43.

Transplants

Pre-authorization of charges incurred in connection with organ transplants (with the exception of corneal transplants) is required.

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 their own medical insurance plan. Written documentation from the donor's insurance plan is required to establish that there is no other coverage for the expenses.

If you are donating an organ to another person, the Plan does not consider your donor expenses for coverage, because the donation 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

Pre-authorization of charges incurred in connection with bariatric surgery is required.

Charges incurred in connection with bariatric surgery will be considered for payment if you have at a minimum:

- 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.

There are other requirements for pre-authorization of this surgery. 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 or Confirmation Surgery

Pre-authorization of charges incurred in connection with gender reassignment or confirmation surgery is required.

Charges incurred in connection with gender reassignment or confirmation surgery will be considered for payment if you meet the criteria adopted by the Plan for such surgeries, which are available from Anthem upon request. 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 or enhancement; and
- Pectoral implants.

To obtain pre-authorization for a gender reassignment or confirmation 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. Pre-authorization of charges incurred in connection with eyelid, nasal and breast surgeries is required.

The Plan will cover reconstructive 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, you must 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 in the breast or an endocrine-producing tumor.
- 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 49 for information on breast implant removal.
- Rhinoplasty (nose procedure).
- Rhytidectomy (face lift).
- Telangiectasia (spider veins) treatment.

Pre-Authorization for Surgery

As set forth above, you must obtain pre-authorization for transplants, bariatric surgery, spinal surgery, gender reassignment or confirmation surgery, and eyelid, nasal and certain breast surgeries. Note that while a Claim will not be denied, nor payment reduced, simply because it was not pre-authorized, it is very important that you and your Provider seek pre-authorization for these services. The pre-authorization process can assist you, your Provider and the Plan in detecting any issues before the service is performed, so that you can avoid coverage issues later.

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 49 for information on these surgeries.

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

- You must advise your Physician of the Plan's pre-authorization recommendation. Your Physician is required to contact Anthem and provide all the necessary information.

- 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 Anthem and include the patient's history and physical report, along with diagnostic quality preoperative photographs for eyelid, nasal and breast surgeries.
- Anthem will review the information, and Anthem 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.

Note that Out-of-Network assistant surgeon services provided at In-Network facilities are subject to the No Surprises Act as described on pages 42 – 43.

Anesthesiologist Services

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

- Page 51 for special rules on when In-Network benefits are paid for anesthesiology and other RAP services; and
- Page 51 for important information regarding anesthesia coverage for colonoscopies and upper gastrointestinal endoscopies.
- Pages 42 – 43 for special rules applicable for anesthesiology and other RAP services subject to the No Surprises Act.

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 Anthem (or Beacon for mental health-related therapies) 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 101 .

Medically Necessary therapy for mental health and substance use disorder 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 their license. Applied Behavioral Analysis (ABA) therapy is covered by the Plan to help children with autism learn skills and lessen problematic behavior through different forms of specialized therapy with trained professionals. Call Beacon Health Options at (866) 277-5383. Beacon's care advisors can walk you through the process and help coordinate care. If your family incurred ABA therapy claims between January 1, 2022 and the date of this SPD, your provider can submit them to Beacon Health Options through the provider portal for consideration.

- Biofeedback, if 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 or other conditions as medically necessary. We recommend that your Provider contact Anthem for pre-authorization.
- Spinal manipulation, when performed by a Doctor of Chiropractic (DC) or other Health Care Provider who is acting within the scope of their license or certification under applicable state law, as well as related initial physical examination, subsequent spinal 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 they are duly licensed by a state agency and authorized to provide such services within the scope of their 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 or voice therapy when performed by a speech and 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 hydro therapists 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 certain 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 right 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 Anthem.

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*
Biofeedback	Contract Rate	\$55 per visit	9 visits
Chiropractic	\$45 per visit	\$45 per visit	12 visits*
Physical, Occupational and Osteopathic	Contract Rate	\$65 per visit	None
Speech and Vision	Contract Rate	\$55 per visit	None

* 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 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 health care services at no cost to you when you use an In-Network Provider, so long as the services are Medically Necessary and you meet

any age, risk or frequency requirements for the services. Preventive health care is defined under federal law as:

- Services rated A or B by the United States Preventive Services Task Force (USPSTF). <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>
- Immunization recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. <https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html>
- Preventive care and screenings for women as recommended by the Women's Preventive Services Initiative. <https://www.womenspreventivehealth.org/wellwomanchart/>
- Preventive care and screenings for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration.
- PSA tests (prostate-specific antigen tests) for males between ages 40 and 69.

Contact Anthem with questions about what types of preventive care are covered and to find out if any age, risk or frequency limitations apply. You can also go to <https://www.healthcare.gov/preventive-care-benefits> for a summary. Note that the list of covered preventive care changes from time to time as preventive care services and supplies are added to or taken off the government-mandated list of required preventive care. The Plan follows federal law that determines when these changes take effect. A list of required preventive health care services as of January 1, 2023 is included as Addendum A to this document and is subject to change as the federal requirements and guidelines change.

You may need a prescription in order to get preventive health care under the prescription drug benefits.

Many of these services are provided during routine physicals and well-person exams. Routine physicals and well-person exams are limited to one per calendar year. Well-child exams are also limited to one per calendar year after age 4, although more frequent exams may be covered before that age. Preventive health care services rendered by an In-Network Provider are covered without cost-sharing, whether they are performed separately or in the course of an annual physical. However, to avoid cost-sharing for preventive health care services rendered by In-Network Providers, the primary purpose of your office visit must be for preventive care.

Cost-sharing will be applied 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, that test is subject to cost-sharing, as it is provided in connection with a diagnosed medical condition and not as a preventive measure.

The Plan will not deny coverage for sex-specific benefits for which an individual is otherwise eligible because their 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 and for postmenopausal women under age 65 at increased risk 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, 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 section on the right). 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

Anthem 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).
- 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.

Anthem will review your Physician's report and the nursing notes. If the nursing care is approved, the approval will specify the number of days that will be covered and the amount per visit that will be allowed. If your Physician prescribes private duty nursing care, please contact Anthem 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 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 Anthem 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 their license.
- 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, unless they are duly licensed by a state agency and authorized to provide such services within the scope of their license.
- Condoms (covered under the prescription drug benefits).
- Cord blood harvesting and storage charges.
- Cosmetic Surgery and procedures, except where otherwise noted (see page 49 under "Medical Benefits" and page 52 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 66 – 67).
- 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 or as provided through VSP).
- Food supplements, herbs, minerals, vitamins and other nutritional supplements, except as otherwise required under the ACA.
- 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 preapproved by Caremark under the prescription drug benefit as outlined on page 63).
- 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.
- Masseurs, masseuses, 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, postnatal care (except as otherwise required under the ACA) 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 (other than intensive counseling as required by the ACA), 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 71.

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 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, text or chat-based support from expert Quit Coaches®.

The Quit For Life Program includes:

- Up to three scheduled one-on-one coaching sessions via text, chat or phone, plus up to two group video sessions.
- Unlimited toll-free access to Quit Coaches via chat, text or phone.
- Access to resources, videos and the ability to connect with a Coach on the Quit For Life portal and mobile app.
- 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 bupropion 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.

Prescription Drug Benefits

The Plan's prescription drug benefits are administered by Caremark. All Participants eligible for these benefits will receive a Caremark ID card, which should be presented at retail pharmacies when filling prescriptions. For Participants who are not eligible for the Caremark benefits, prescription drug coverage is provided under the medical benefits at the Out-of-Network level.

Rx Savings Solutions is an additional free, confidential prescription pricing service that provides you and your enrolled Dependents with cost-saving opportunities on your medications. Rx Savings Solutions looks at the medications you take and determines all the ways you can save money on your prescriptions. When there is an opportunity to save, Rx Savings Solutions automatically notifies you via direct mail or email. Additionally, you can search for medication pricing in your portal.

Go to myrxss.com and sign up to get started.

If you have questions or need to talk with someone, the Rx Savings Solutions Pharmacy Support Team is staffed with Certified Pharmacy Technicians who are available to assist with prescription questions at no cost to you. They can be reached Monday-Friday from 7:00 a.m. to 8:00 p.m. CT at 1 (800) 268-4476 or email support@rxsavingssolutions.com.

Eligibility

You and your covered Dependents are eligible for prescription drug benefits provided through Caremark 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 Caremark 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 Department, your prescription drug benefits will be covered under medical benefits at the Out-of-Network level.

Annual Pharmacy Deductible

The calendar-year Deductible for Caremark prescription drug coverage is outlined in the table on page 104. The Deductible applies to both retail pharmacy purchases and home delivery purchases, including specialty medications received through CVS Specialty Pharmacy if you disenroll in the PrudentRx program (see page 61). 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.

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 page 104. 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 or 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 Caremark's Advanced Control 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 formulary exclusions is available online at www.caremark.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 Caremark 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 your retail pharmacy whether it participates in the Caremark network;

- Visit www.caremark.com, log in to the secure website, and click **Locate a Pharmacy**. If you have not registered on Caremark's website, you will need to do so; or
- Call Caremark at (833) 741-1361.

If you use an Out-of-Network pharmacy, you must pay the entire cost of the prescription, and then submit a Claim form to Caremark as described on page 79. 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 Caremark, 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 106 – 110.

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 or CVS 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 (833) 741-1361 to obtain fax instructions.
- Online — Visit www.caremark.com, and follow the instructions to register for Caremark Pharmacy's home delivery services. Once you have registered, click Manage prescriptions and follow the instructions. Caremark 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 Caremark by calling the number on your ID card. Mail your prescription and the required Copay along with the completed order form in the envelope.

Caremark Home Delivery Service

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.

Please Note: The pharmacist's judgment and dispensing restrictions, such as quantities allowable, govern certain controlled medications.

Home Delivery or Pickup: Pharmacy Benefits Through Caremark's Maintenance Choice®

If you are taking a long-term* medication, now you can choose to receive your 90-day** supplies by mail or pick them up at a CVS Pharmacy near you. Whether you choose delivery or pickup, you will pay the same Copay. This choice is being offered to you by the Plan as a way to help you and the Plan save money.

Fill Limit for Long-Term Medications

The Plan allows two 30-day fills of long-term medications at any pharmacy in the Caremark network. After that, the Plan will cover long-term medications only if you have 90-day supplies filled through mail service or at a CVS Pharmacy. If you continue to have 30-day supplies of long-term medications filled at a retail pharmacy after two fills, you will pay the entire cost of the medication.

With Maintenance Choice, you can avoid paying more for your long-term prescriptions. All you need to do is have 90-day supplies filled by mail or at any CVS Pharmacy. For more information about Maintenance Choice, call (833) 741-1361.

CVS 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.

Specialty medications that are self-injectable, self-administered infusions, or pills must be obtained through CVS Specialty Pharmacy, which is a dedicated specialty pharmacy within the Caremark family of pharmacies, rather than at your local retail pharmacy or through your Physician's office or outpatient facility. If you choose to use a pharmacy other than CVS Specialty Pharmacy, you will be responsible for the entire cost of the prescription.

CVS Specialty Pharmacy 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 (833) 741-1361.

* A maintenance medication is taken regularly for chronic conditions or long-term therapy. A few examples include medications for managing high blood pressure, asthma, diabetes or high cholesterol.

** Quantities may vary depending on plan design.

PrudentRx Copay Program for Specialty Medications

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, the Plan has contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications. The PrudentRx Copay Program helps Participants and Qualified Dependents enroll in manufacturer copay assistance programs. Enrolled Participants and their Qualified Dependents will get a copay card for their specialty medication (if applicable) and will have a \$0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program. However, if they disenroll from the PrudentRx program, specialty medications will be subject to 30% Coinsurance.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost-share for select medications – in particular, specialty medications. The PrudentRx Copay Program will assist Participants and their Qualified Dependents in obtaining copay assistance from drug manufacturers to reduce a Participant's cost-share for eligible medications, thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible Participants and their Qualified Dependents will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call (800) 578-4403 to opt out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. In that case, you must speak to someone at PrudentRx at (800) 578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance program for any medication that you take. If you do not return their call, choose to opt out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer, you will be responsible for the full amount of the 30% coinsurance on specialty medications that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx, or they will proactively contact you so that you can take full advantage of the PrudentRx program.

PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by you, another plan or a manufacturer's copay assistance program, will not count toward your Plan Deductible or the Plan's Overall Out-of-Pocket Maximum.

Because certain specialty medications do not qualify as "essential health benefits" under the ACA, Participant cost-share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count toward the Plan's Overall Out-of-Pocket Maximum. A list of specialty medications that are not considered to be essential health benefits is available upon request to PrudentRx. An exception process is available for determining whether a medication that is not an essential health benefit is Medically Necessary for a particular individual.

PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

Other Pharmacy Benefit Features

No-Cost Immunizations

The following vaccines are covered at no cost to you if received from a Caremark participating pharmacy:

- COVID-19;
- Diphtheria, 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 Caremark ID card, and the pharmacy will take care of the rest.

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. 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 Caremark at (833) 741-1361 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 Caremark 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 frontline 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 Caremark, 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 subject to the step therapy requirements may change from time to time. Your pharmacist can tell you if your prescription requires step therapy. Or you can find out yourself by logging in to www.caremark.com.

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 Caremark, 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 82 – 87. 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 pharmacist submits a Claim electronically. In other cases, you must submit a Claim for reimbursement to Caremark, 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.

Important Note About Coverage of Compound Medications

Coverage limits apply to compound medications. The Plan will only reimburse the cost of the approved ingredients, up to \$300, minus the Copay. In addition, if one ingredient is a noncovered item, the compound Claim will be denied.

Growth Hormones

Growth hormones are considered specialty medications and are covered only when purchased through Caremark. They also require prior authorization from Caremark 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 prior authorization from Caremark.

If you use a non-participating pharmacy and 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 Caremark.

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 prior authorization.

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 pre-authorization from Caremark. Contact them for a list of the information needed to complete the pre-authorization.

Smoking Deterrents

Medications used to help you stop smoking, such as bupropion and Chantix, are not covered unless you are enrolled in the Quit For Life Program. 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 Caremark 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 for the following, to the extent they are considered to be ACA preventive services (see page 56):

- You have a prescription for an over-the-counter medication that appears on the list of ACA preventive services.
- Aspirin to prevent cardiovascular disease.
- FDA-approved contraceptives for women.
- Folic acid supplements for women who may become pregnant.

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. To receive reimbursement for Claims for covered over-the-counter medications, submit a copy of the drug bill to Caremark. 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. We reserve 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 Caremark 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 Caremark (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 Caremark by visiting www.caremark.com or calling (833) 741-1361.

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.
- 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 (e.g., Rogaine, Propecia) or drugs for cosmetic purposes (e.g., 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 they are 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.
- 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 6 or younger.
- Relenza for children age 6 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.
- Therapeutic devices or appliances.
- Yohimbine.
- Federal legend vitamins, except as otherwise required under the ACA.

For additional information, refer to the general exclusions which are listed beginning on page 71.

Dental Benefits

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, you will receive the highest value. Your diagnostic and preventive services are covered at 100% and are not subject to the Deductible. Payment is based on a preapproved 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-afta
- Call your Dentist and ask if they are 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.

Deductible

Dental benefits are payable after you meet the annual Deductible. This dental Deductible is a separate Deductible from the medical, Hospital and prescription drug Deductibles. The amount of the dental Deductible is \$75 per person or \$200 per family (no Deductible applies for preventive care and diagnostic services from a Delta Dental PPO Dentist). Note that if two or more members of your family are injured in the same accident, only one dental Deductible will be applied against all the covered dental charges incurred during any one year as a result of such accident.

Once you meet the annual Deductible, the Plan pays a percentage of the Dentist's charges for covered services. See the chart on page 105 for dental benefit details.

Annual Maximum Dental Benefit

The maximum amounts that the Plan will pay for all covered dental charges in a calendar year is \$2,500 per person. There is no calendar-year maximum for covered individuals under age 19.

Details About Your 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 is 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 page 105, 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 or scaling is available for women while they are pregnant). In addition, 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.
- 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 or tissue examination.
- Emergency palliative treatment.
- 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 dentures.
- Repair and rebasing of existing dentures.

Major Services

Major services under the dental benefits include the following:

- Restorative services — Gold fillings, inlays, onlays and crowns.
- Crown replacement — If crown is over three years old.
- Gold filling replacement — If filling is over five years old.
- Inlay and onlay replacement — If inlay or onlay are over three 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, onlays and crowns are payable when they are necessary to restore the

structure of the tooth broken down by decay or nonaccidental 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 below) so you will know how much the Plan will pay.

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 above). 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 79.

Questions

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

Non-Covered Dental Expenses

- Accidental injury to natural, sound teeth. (This coverage is provided under the medical benefits. See page 48.)
- 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 dysfunction (TMJ) treatment. (In certain circumstances, this coverage may be provided under the medical benefits.)
- 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 71.

Vision Benefits

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. When you visit a VSP Provider, you can get an eye exam each year for just a \$10 Copay, and a discount on prescription glasses and professional services for contact lenses. The chart on page 105 highlights the Plan's vision coverage.

Eligibility for Vision Benefits

All covered Participants and Dependents are eligible for VSP's Exam Plus Plan.

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 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 Participants and Qualified 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 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).

You must fill out a Beneficiary Designation form in order to be eligible for this benefit. Make sure to keep your listed beneficiaries up to date.

Note: This Beneficiary Designation form is used by the SAG-Producers Pension Plan (SAG-PPP) if you die before you retire and have not filled out a separate SAG-PPP beneficiary form.

You can fill out a form online or contact the Plan.

Eligibility

To qualify for the life insurance benefit, you must meet the Plan's Earned Eligibility requirements or the Senior Performer requirements at the time of your death. The life insurance benefit is not available if you are covered under COBRA, nor is it available to Dependents.

Your life insurance coverage begins when your Earned Eligibility 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).

Benefit Amount

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

- Plan Participants with Earned Eligibility (including Retirees and Senior Performers with Earned Eligibility) – \$10,000
- Senior Performers who do not have Earned Eligibility and are participants in the HRA Plan – \$5,000

Your life insurance benefit is payable to the beneficiary or beneficiaries that you named on the most recent valid Beneficiary Designation Form on file with the Plan, so please make sure you keep this information updated.

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 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, they are 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, 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. Senior Performers will maintain a \$5,000 life insurance benefit but not the accidental death and dismemberment benefit.

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 Earned Eligibility but are a Senior Performer. If you are not a Senior Performer, you may convert \$10,000. If, however, 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 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 are a Senior Performer without Earned Eligibility, nor are these benefits available to Dependents.

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 seventh day of a coma	\$100 per 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)

AD&D Benefits

Benefits are payable if you are involved in an accident, and you suffer any of the losses indicated above 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.

Note: 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, pickup truck or minivan. 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 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).
- Charges for military-related injury or illness. However, the Veterans Benefits 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 payer.
- 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 services 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 Caremark 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, unless covered by the telehealth benefit .
- Charges in excess of the Contract Rate (see Glossary). 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).
- Charges in excess of the reasonable charge.
- Charges incurred for a service or supply that is not Medically Necessary (see Glossary). 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 or for network providers, by the timely filing date specified in their contract, whatever date is sooner.
- 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 92 – 93 and unless such injury or illness is the result of domestic violence).
- Charges for services or supplies that are ordered from internet retailers such as Amazon, Overstock and eBay.

IX. Understanding Medicare

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 in Medicare Part A when each of you reaches 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. Remember, for most people, there is no premium for Part A. Please contact Medicare to confirm your eligibility for premium-free 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. 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 Senior Performer 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 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, 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 their 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 plan providing self-paid coverage, such as COBRA.

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 noncustodial 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 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 78 – 79). 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 78 – 79). 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 were 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.

Important Notes:

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.

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 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

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.

How Benefits Are Calculated When Coordinating With Medicare

The Medicare COB method described in this section applies to all Participants and Dependents with Medicare.

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 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 Deductible.

To better understand how this works, refer to the following examples:

Example 1

In this example, a Participant receives medical services and has had \$250 applied toward the Plan's In-Network Deductible of \$500. The following additional assumptions are used:

Medicare

Medicare-covered Allowance	\$2,500
Medicare pays	-2,000
Balance after Medicare payment	\$500
Remainder of annual In-Network Deductible	-250
Balance after remaining Deductible	\$250
Plan pays 90% of remaining balance	\$225
Participant balance due to Provider (\$500 minus \$225)	\$275

Example 2

In this example, the Participant has satisfied the annual In-Network Deductible. All the other assumptions are the same as those used in the previous example.

Medicare-covered Allowance	\$2,500
Medicare pays	-2,000
Balance after Medicare payment	\$500
Remainder of annual In-Network Deductible	-0
Balance after remaining Deductible	\$500
Plan pays 90% of remaining balance	\$450
Participant balance due to Provider (\$500 minus \$450)	\$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 their 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 uses 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.

XI. Claims and Appeals

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 page 82.

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, they 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

The Plan will accept Hospital and medical expenses for up to 15 months after the date of service. Any requests for payment of Hospital or 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 the United States, submit a detailed bill (along with an English translation, if applicable) to Anthem. 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 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. Copies of the operative pathology reports are 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. Please call Anthem to complete an Authorization for Release of Health Information.
9. Do not forget to sign the form. Your business manager or legal representative cannot sign for you unless they have power of attorney. If that is the case, please include a copy of the authorizing document (e.g., power of attorney).
10. If you have questions, contact Anthem at (833) 414-5790, or log in to the Sydney Health app or Anthem portal.

Claims for Mental Health and Substance Use Disorder 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
P.O. Box 1852
Hicksville, NY 11802-1852

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 CVS Caremark. 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 Caremark at (833) 741-1361.

Non-participating retail pharmacy Claims should be submitted to CVS Caremark. Call (833) 741-1361, or go to www.caremark.com for specific instructions.

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 Plan's medical benefits, 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.

There are certain services and supplies under the Hospital and Medical benefits for which prior approval is strongly recommended but is not required; therefore, Claims for these benefits are not considered Pre-service Claims. Certain prescription drugs, however, require prior approval. Your Provider or pharmacy will tell you if a drug requires prior approval, or you may search CVS Caremark's website, www.caremark.com, 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 Health Care Provider 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 Health Care Provider 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. In order to be legally considered an Urgent Care Claim, it must be a Pre-service Claim (a Claim for which preapproval is required). Therefore, only Claims for prescription drugs that require preapproval can fall under the requirements for Urgent Care Claims set forth in this SPD.

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.

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 the 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: <ul style="list-style-type: none">• The day you respond; or• The end of the 45-day response period.	Within 48 hours of the earlier of: <ul style="list-style-type: none">• The day you respond; or• The end of the 48-hour response period.	Within 15 days of the earlier of: <ul style="list-style-type: none">• The day you respond; or• The end of the 45-day response period.	Within 30 days of the earlier of: <ul style="list-style-type: none">• The day you respond; or• The end of the 90-day response period.

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, including the following:

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; was because the treatment was an Experimental or Investigative Procedure; or was based on the determination of Total Disability, an explanation of the scientific or clinical judgment for the determination applied to the claimant's circumstances or a statement that such explanation 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.

8. For Disability Claims, the notice will include a discussion of the decision, including an explanation of the basis for any disagreement of the Plan with any views presented by the claimant to the Plan or any health care professionals treating the claimant or vocational professionals who evaluated the claimant, the views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, or the disability determination by the Social Security Administration.

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 or 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 or 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."

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 85 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 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 or Medical (including Utilization Management Review)	Anthem Blue Cross
Life Insurance Premium Waiver	MetLife
Mental Health and Substance Use Disorder	Beacon Health Options
Prescription Drug	Caremark
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 to the right.

If your appeal is for a Concurrent Care Claim, and the Plan has terminated or reduced the course of treatment early or you have requested an extension of a previously approved course of treatment involving urgent care, the Plan will provide continued coverage for the course of treatment during the appeal process.

Urgent Care Appeals		
Benefit	Company	Phone Number
Hospital	Anthem Blue Cross	(800) 274-7767
Mental Health and Substance Use Disorder	Beacon Health Options	(866) 277-5383
Prescription Drug – Clinical Appeals	Caremark	(833) 741-1361
All Other Benefits	Plan	(800) 777-4013

Internal Appeal Process

You have the right to review documents relevant to your Claim. On request, 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

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 or 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 81 and 82. 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.

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.* You will be notified within five days of the determination. Two levels 30 days for each level*	One level Usually, appeals will be decided at the next Appeals Committee meeting.* You will be notified within five days of the determination. Two levels 30 days for each level*

* 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. Only Claims involving a medical judgment (such as Medical Necessity and Experimental or Investigative), adverse benefit determinations based on compliance with the surprise billing protections under the No Surprises Act or its implementing regulations, and rescission of coverage are eligible for external review.

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 Investigative 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 does 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: (1) an explanation of the primary reason(s) for the IRO's decision; 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; (2) the binding effect of the decision with a statement that judicial review may be available to you; (3) the binding effect of the decision with a statement (that judicial review may be available to you; and (4) 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 has 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 has 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 Use Disorder	Beacon Health Options	(866) 277-5383
Prescription Drug – Clinical Appeals	Caremark	(833) 741-1361
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: (1) the date you receive the Plan's or IRO's written decision on your appeal; or (2) 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

This section provides additional important information for Plan Participants.

Notice of Privacy Practices

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

Definitions

"Health information" generally means information: (1) 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; (2) that is created, received, transmitted or maintained by the Plan; and (3) 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 precertifications which are sent to you.

- **Health care operations:** The Plan may use or disclose your health information for purposes of Case Management, underwriting or 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: (1) determining your eligibility for benefits under the Plan; (2) computing any premium or contribution amounts under the Plan; (3) applying any pre-existing condition exclusion; and (4) 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.

- **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, Caremark, Via Benefits, 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 their duties. The Plan may disclose such information in reasonable anticipation of death. Your health information may be used and disclosed for cadaveric organ, eye or tissue donation and for transplant purposes.

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

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

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

governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may disclose your health information to the institution or law enforcement official if the health information is necessary for the institution to provide you with health care or protect the health and safety of you or others, or for the security of the correctional institution.
- **Criminal activity:** Consistent with applicable federal and state laws, the Plan may disclose your health information if it believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan may also disclose your health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- **As required by law:** The Plan will disclose your health information as required by law.

Use and Disclosure With Your Permission

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

- **Personal representatives:** In situations where you wish to appoint a personal representative to act on your behalf or make medical decisions for you in situations where you are otherwise unable to do so, the Plan will require your written authorization before disclosing your health information to that individual. The Plan will recognize your previous written authorization designating such individual to act on your behalf and receive your health information until you revoke the authorization in writing.
- **Trustee(s) as your representative:** In some circumstances, you may request that a Trustee receive your health information if you request the Trustee to assist you in your filing or perfecting of a Claim for benefits under the Plan. In these situations, the Plan will first request that you complete a written authorization before disclosing the health information.
- **Disclosure to others involved in your care or payment of your care:** You may designate a manager, agent, accountant, personal assistant or other third party to receive 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 must 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, 2023. 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: Complianceofficer@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 is 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 slips and falls or is otherwise injured under circumstances that you claim resulted from the act or omission of another person or third party.
- You or your Dependent suffers 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, attorney's 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* or otherwise;

*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.

- That, in the event that you or your Dependent(s), legal representative or agent elects not to pursue any claim(s) against a third party, the Plan shall be 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 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 attorney's 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.

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.

The SAG-AFTRA Health Plan has partnered with Meridian through Anthem. Meridian is a third-party recovery group that specializes in pursuing reimbursement for subrogation-related liens for ERISA plans. Meridian will work closely with Anthem, the Plan, its Participants, Dependents, a Participant's counsel, and other involved parties to recover any charges the Plan is entitled to from legal proceedings. Plan Participants, Dependents, and their counsel may contact Anthem for all subrogation-

related inquiries. Plan Participants have the right to request that their case be handled internally by the Plan office. If you'd like to request that your subrogation case be reviewed and / or transferred to the Plan office, please contact the Plan at (800) 777-4013.

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 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 in 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 nonqualified 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 number 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, attorney's 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 canceled 30 days after the Plan provides the individual with notice of cancellation. If the coverage is canceled 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.

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 their 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 Office 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 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 is 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 NW, Washington, DC 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 5. 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

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 31 - 37.

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 use disorder, 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.

Metropolitan Life Insurance Company (MetLife) provides life insurance conversion policies.

The Plan is 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.

Requirements With Respect to Eligibility for Participation and Benefits

The eligibility requirements are outlined on pages 8 – 17 of this SPD.

Circumstances Resulting in Disqualification, Ineligibility or Denial or Loss of Benefits

Loss of Earned Eligibility is described on pages 29 – 30 of this SPD. Loss of COBRA is described on page 36 of this SPD. Audit verification procedures and the recovery and offset of future benefit payments are described on page 93 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 78 – 87 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.

Organizations Through Which Benefits Are Provided

The carrier listed below provides fully insured benefits under the Plan.

Metropolitan Life Insurance Company (MetLife) provides life insurance conversion policies.

The Plan is 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 21215 Burbank Blvd. Woodland Hills, CA 91367	Administers the Hospital and medical benefits and provides access to its network of Hospital and medical care Providers
Beacon Health Options 10805 Holder Street Cypress, CA 90630	Administers the mental health and substance use disorder benefit and provides access to its network of mental Health Care Providers
CVS Caremark P.O. Box 6590 Lee's Summit, MO 64064-6590	Administers the prescription drug benefit and provides access to its network of retail pharmacies and its home delivery pharmacies
Delta Dental of California 100 First Street San Francisco, CA 94105	Administers the dental benefit and provides access to its network of dental Providers
Alere 999 3rd Avenue, Suite 1800 Seattle, WA 98104	Administers the Quit For Life smoking cessation program and provides access to Quit Coach staff
VSP 3333 Quality Drive Rancho Cordova, CA 95670	Administers the vision benefit and provides access to its network of vision care Providers
MetLife Group Life Claims (EDM Americas Building) 2nd Floor 10 E.D. Preate Drive Moosic, PA 18507	Life insurance and AD&D benefits

XIV. Health Plan Glossary

ACA – The Affordable Care Act.

Active Participant – A performer who participates in the SAG-AFTRA Health Plan and has met the Earned Eligibility requirements of the Plan (also referred to as “Participant with Earned Eligibility”).

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 coverage.

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, their 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 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, 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 or other written agreement with the Plan which requires the employer to contribute to the Plan on your behalf with respect to those earnings, or earnings reported to the Plan pursuant to a written agreement between the Contributing Employer and the Plan.

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 is a combined Deductible for hospital and medical coverage, and separate Deductibles for 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 / Eligible Dependent — An individual who may be covered under the Plan based upon their relationship with the Participant, as set forth on page 19.

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 subcategory 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 the earnings requirements or special qualification requirements (Alternative Days, Network / Station Staff or Covered Roster Artist). For complete information about Earned Eligibility, refer to Section II.

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 in Section II.

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.

Extended Career COBRA Credit — Used to determine your eligibility for the Plan's Extended Career COBRA benefit, which reduces your COBRA premium. You receive an Extended Career Credit each time you meet the Plan's earnings requirements and qualify for 12 months of coverage.

Health Plan or Plan — The SAG-AFTRA Health Plan.

Hospital — An institution legally operating as a Hospital which (1) 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 (2) is operated under the supervision of a staff of Physicians and (3) 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 use disorder, except for inpatient and alternative levels of care as authorized by Beacon Health Options.

In-Network — In one of the Plan's Provider networks.

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. 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 Eligibility is based on their status as a full-time staff employee of a radio or television station or network.

Open Enrollment Period — A period of approximately 60 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 — Outside the Plan's Provider networks.

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 Active Participant, Retiree or Senior Performer Surviving Dependent who is eligible for coverage under this Plan.

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 their 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 / Health Care Provider — A licensed or board-certified Provider of medical or mental 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.

Qualified Dependent — A Dependent for whom all necessary documentation has been obtained for the Plan to verify that they are eligible to be covered under the terms of this Plan.

Retiree — Participants age 65 or older who are taking a pension under the SAG-Producers Pension Plan or the AFTRA Retirement Fund.

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 page 15.

Senior Performer(s) — A Participant who is 65 or older, receiving a pension from either the SAG-Producers Pension Plan or AFTRA Retirement Fund, who meets the requirements for participation in the SAG-AFTRA Health Plan Senior Performers HRA Plan.

Senior Performer Surviving Dependent — A Dependent of a deceased Senior Performer who meets the requirements for continued coverage under the SAG-AFTRA Health Plan or, for spouses 65 or over, will become Participants in the SAG-AFTRA Health Plan Senior Performers HRA Plan.

Staff Employees — Staff of SAG-AFTRA (Union), the SAG-AFTRA Foundation (Foundation), the SAG-Producers Pension Plan (SAG Pension Plan), and the AFTRA Retirement Fund (AFTRA Retirement Fund).

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 their 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 them 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.

Benefits Summary – Effective January 1, 2023

Benefit		
Hospital	In-Network Provider	Out-of-Network Provider
Calendar-Year Deductible	BlueCard PPO or Beacon Health Options: \$500 per person; \$1,000 per family (combined w/ Medical)	Not covered
Inpatient (Room and Board and Ancillary Services)	90% of Contract Rate after \$100 Copay	Not covered*
Outpatient Surgery	90% of Contract Rate after \$100 Copay	Not covered
Emergency Room	90% of Contract Rate after \$100 Copay; emergency room Copay is waived if immediately confined	Not covered*
Coinsurance Out-of-Pocket Limit	\$2,750 per person; \$5,500 per family Combined Hospital and Medical (including MHSA)	None
Medical**		
Calendar-Year Deductible	BlueCard PPO or Beacon Health Options: \$500 per person; \$1,000 per family (combined w/ Medical)	\$500 per person; \$1,000 per family
Office Visit	No Deductible; 100% of Contract Rate after \$25 copay (including telehealth)***	Medical: 60% of Plan's Allowance MHSA: 70% of Plan's Allowance
Surgeon	90% of Contract Rate	60% of Plan's Allowance
X-Ray and Lab	90% of Contract Rate	60% of Plan's Allowance
Therapy(Occupational, Osteopathic, Physical, Speech, Vision)	90% of Contract Rate	60% of Plan's Allowance
Maternity Care — Prenatal Visits	No Deductible; 100% of Contract Rate	60% of Plan's Allowance
Maternity Care — Delivery	90% of Contract Rate	60% of Plan's Allowance
Routine Physical Exam	No Deductible; 100% of Contract Rate	60% of Plan's Allowance
Routine Child Exam	No Deductible; 100% of Contract Rate	60% of Plan's Allowance
Routine Mammogram / Pap	No Deductible; 100% of Contract Rate	60% of Plan's Allowance
Hearing Aids	90% of Contract Rate up to a maximum payment of \$1,500 per device; one device per ear per three-year period	60% of Plan's Allowance up to a maximum payment of \$1,500 per device; one device per ear per three-year period
Coinsurance Out-of-Pocket Limit	\$2,750 per person; \$5,500 per family Combined Hospital and Medical (including MHSA)	None
Hospital / Medical / Rx Out-of-Pocket Maximum (includes Deductibles, Copays, Coinsurance)^	\$9,100 per person; \$18,200 per family	None

* 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

*** Telehealth includes medical and mental health office visits conducted virtually.

** Mental Health and Substance Use Disorder (MHSA) Out-of-Network Provider services are covered at 70% of Plan's allowance.

^ Certain specialty medications are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs, though reimbursed by the manufacturer at no cost to you, will not be applied toward satisfying your out-of-pocket maximums.

Benefit	CVS Caremark Participating Retail Pharmacy	CVS Caremark Home Delivery (includes Specialty)
Prescription Drugs		
Calendar-Year Deductible	\$75 per person; \$150 per family	
Supply	Up to a 30-day supply per prescription or refill	Up to a 90-day supply per prescription or refill
Copay	The greater of:	The greater of:
Generic	Tier 1: \$10 or 10%	Tier 1: \$20 or 10%; max Copay is \$50 per prescription
Preferred Brand	Tier 2: \$25 or 25%	Tier 2: \$50 or 25%; max Copay is \$125 per prescription
Non-Preferred Brand	Tier 3: \$40 or 40%	Tier 3: \$100 or 40%; max Copay is \$300 per 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 preventive services medications, including contraceptives, are covered at 100% with no Deductible or Copay.	
Specialty Medications*	Generic: 30% Preferred Brand: 30% Non-Preferred Brand: 30% Note: Copay applies to all drugs in Specialty contract at all network pharmacies. Additional savings on drugs may be available through Rx Savings Solutions.**	Generic: 30% Preferred Brand: 30% Non-Preferred Brand: 30% Note: Copay applies to all drugs in Specialty contract at all network pharmacies. Additional savings on drugs may be available through Rx Savings Solutions.**

Benefit		
Mental Health and Substance Use Disorder	Beacon Health Options Provider	Out-of-Network Provider
Hospital and Alternative Levels of Care***	Covered under the Hospital Benefit	Not covered^
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 per person; \$200 per family	\$75 per person; \$200 per family
Diagnostic and Preventive Benefits	No Deductible; 100%	75%
Basic Benefits	75%	75%
Major Benefits	50%	50%
Calendar-Year Maximum^^	\$2,500	\$2,500
Vision	Vision Service Plan Provider	Out-of-Network Provider
Eye Exams	100% after \$10 copay; one exam per calendar year	80% up to a maximum payment of \$50; one exam per calendar year
Glasses	20% discount	No benefit
Professional Services for Contact Lenses	15% discount	No benefit

* Certain specialty medications are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs, though reimbursed by the manufacturer at no cost to you, will not be applied toward satisfying your out-of-pocket maximums.

** Rx Savings Solutions is an online service through which you and your enrolled Dependents can find prescription medications at a lower cost. Register at myrxss.com.

*** Alternative levels of care include Residential Treatment Center, Partial Hospital Program and Intensive Outpatient Program.

^ 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.

^^ There is no dental maximum for individuals under age 19.

Preventive Care Services Chart – Effective January 1, 2023

(From the U.S. Preventive Services Task Force website)

Topic	Description
Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked	The USPSTF recommends one-time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men aged 65 to 75 years who have ever smoked.
Anxiety in Children and Adolescents: Screening: children and adolescents aged 8 to 18 years	The USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 years.
Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality: Preventive Medication: pregnant persons at high risk for preeclampsia	The USPSTF recommends the use of low-dose aspirin (81 mg per day) as preventive medication after 12 weeks of gestation in persons who are at high risk for preeclampsia. See the Practice Considerations section for information on high risk and aspirin dose.
Asymptomatic Bacteriuria in Adults: Screening: pregnant persons	The USPSTF recommends screening for asymptomatic bacteriuria using urine culture in pregnant persons.
BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with BRCA1 or BRCA2 gene mutation	The USPSTF recommends that primary care clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1 and BRCA2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.
Breast Cancer Medication Use to Reduce Risk: Screening: women at increased risk for breast cancer aged 35 years or older	The USPSTF recommends that clinicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.
Breast Cancer: Screening: women aged 50 to 74 years	The USPSTF recommends biennial screening mammography for women aged 50 to 74 years. [†]
Breastfeeding: Primary Care Interventions: pregnant women, new mothers, and their children	The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.
Cervical Cancer: Screening: women aged 21 to 65 years	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). See the Clinical Considerations section for the relative benefits and harms of alternative screening strategies for women 21 years or older.

[†]The Department of Health and Human Services, under the standards set out in revised Section 2713(a)(5) of the Public Health Service Act and Section 223 of the 2021 Consolidated Appropriations Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2016 recommendation on breast cancer screening, go to <http://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening1>.

Topic	Description
Chlamydia and Gonorrhea: Screening: sexually active women, including pregnant persons	The USPSTF recommends screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection.
Colorectal Cancer: Screening: adults aged 45 to 49 years	The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years. See the Practice Considerations section and Table 1 for details about screening strategies.
Colorectal Cancer: Screening: adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years. See the Practice Considerations section and Table 1 for details about screening strategies.
Depression and Suicide Risk in Children and Adolescents: Screening: adolescents aged 12 to 18 years	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.
Falls Prevention in Community-Dwelling Older Adults: Interventions: adults 65 years or older	The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.
Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication: women who are planning or capable of pregnancy	The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.
Gestational Diabetes: Screening: asymptomatic pregnant persons at 24 weeks of gestation or after	The USPSTF recommends screening for gestational diabetes in asymptomatic pregnant persons at 24 weeks of gestation or after.
Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions: adults with cardiovascular disease risk factors	The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.
Healthy Weight and Weight Gain In Pregnancy: Behavioral Counseling Interventions: pregnant persons	The USPSTF recommends that clinicians offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
Hepatitis B Virus Infection in Adolescents and Adults: Screening: adolescents and adults at increased risk for infection	The USPSTF recommends screening for hepatitis B virus (HBV) infection in adolescents and adults at increased risk for infection. See the Practice Considerations section for a description of adolescents and adults at increased risk for infection.
Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women	The USPSTF recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.
Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years	The USPSTF recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.
Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened. See the Clinical Considerations section for more information about assessment of risk, screening intervals, and rescreening in pregnancy.

Topic	Description
Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons	The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown.
Hypertension in Adults: Screening: adults 18 years or older without known hypertension	The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment
Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening: women of reproductive age	The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services. See the Clinical Considerations section for more information on effective ongoing support services for IPV and for information on IPV in men.
Latent Tuberculosis Infection: Screening: asymptomatic adults at increased risk for infection	The USPSTF recommends screening for latent tuberculosis infection (LTBI) in populations at increased risk.
Lung Cancer: Screening: adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Obesity in Children and Adolescents: Screening: children and adolescents 6 years and older	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.
Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.
Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years at increased risk of osteoporosis	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. See the Clinical Considerations section for information on risk assessment.
Osteoporosis to Prevent Fractures: Screening: women 65 years and older	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.
Perinatal Depression: Preventive Interventions: pregnant and postpartum persons	The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.
Prediabetes and Type 2 Diabetes: Screening: asymptomatic adults aged 35 to 70 years who are overweight or obese	The USPSTF recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who are overweight or obese. Clinicians should offer or refer patients with prediabetes to effective preventive interventions.

Topic	Description
<p>Preeclampsia: Screening: pregnant women</p>	<p>The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.</p>
<p>Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions: children younger than 5 years</p>	<p>The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.</p>
<p>Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions: children younger than 5 years</p>	<p>The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.</p>
<p>Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis: persons at high risk of HIV acquisition</p>	<p>The USPSTF recommends that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. See the Clinical Considerations section for information about identification of persons at high risk and selection of effective antiretroviral therapy.</p>
<p>Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit</p>	<p>The USPSTF strongly recommends Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.</p>
<p>Rh(D) Incompatibility: Screening: unsensitized Rh(D)-negative pregnant women</p>	<p>The USPSTF recommends repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh(D)-negative.</p>
<p>Screening for Depression in Adults: general adult population, including pregnant and postpartum women</p>	<p>The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.</p>
<p>Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults at increased risk</p>	<p>The USPSTF recommends behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs). See the Practice Considerations section for more information on populations at increased risk for acquiring STIs.</p>
<p>Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children</p>	<p>The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.</p>
<p>Statin Use for the Primary Prevention of Cardiovascular Disease in Adults Preventive Medication: adults aged 40 to 75 years who have 1 or more cardiovascular risk factors and an estimated 10-year cardiovascular disease (CVD) risk of 10% or greater</p>	<p>The USPSTF recommends that clinicians prescribe a statin for the primary prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.</p>
<p>Syphilis Infection in Nonpregnant Adolescents and Adults: Screening: asymptomatic, nonpregnant adolescents and adults who are at increased risk for syphilis infection</p>	<p>The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.</p>

Topic	Description
Syphilis Infection in Pregnant Women: Screening: pregnant women	The USPSTF recommends early screening for syphilis infection in all pregnant women.
Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.
Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions: pregnant persons	The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.
Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco	The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.
Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.
Unhealthy Drug Use: Screening: adults aged 18 years or older	The USPSTF recommends screening by asking questions about unhealthy drug use in adults aged 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)
Vision in Children Ages 6 Months to 5 Years: Screening: children aged 3 to 5 years	The USPSTF recommends vision screening at least once in all children aged 3 to 5 years to detect amblyopia or its risk factors.
Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults	The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.

Appendix: Senior Performer Status

This Appendix describes the requirements to be a Senior Performer. Senior Performers who participate in the HRA Plan may enroll their qualified Dependents in the Active Plan. For more information about the HRA Plan or health plan options through Via Benefits, visit www.sagaftraplans.org/hra.

A Senior Performer is anyone who satisfies the following eligibility requirements:

- A former participant in the Active Plan who has satisfied the following requirements as of their attainment of age 65 or thereafter:
 - Completed 20 Retiree Health Credits; and
 - Started their pension from the SAG-Producers Pension Plan or the AFTRA Retirement Fund.
- A former participant in the SAG-Producers Health Plan or the AFTRA Health Plan who has satisfied the following requirements as of their attainment of age 65 or thereafter, and who, as of January 1, 2017:
 - Had attained age 55;
 - Had started their pension from the SAG-Producers Pension Plan or AFTRA Retirement Fund; and
 - Had at least 15 qualifying years under the AFTRA Health Plan or at least 15 pension credits under the SAG-Producers Pension Plan.
- A former participant in the AFTRA Health Plan who has satisfied the following requirements as of their attainment of age 65:
 - Was born on or before January 1, 1943; and
 - Has at least 10 qualifying years under the AFTRA Health Plan. A former participant in the AFTRA Health Plan who has satisfied the following requirements as of their attainment of age 65:
 - Was born before December 1, 1937 and, as of December 1, 1992;
 - Was vested in a regular annuity based on at least 10 years of credit under the AFTRA Retirement Plan (including at least five base years in which covered earnings were at least \$2,000 or more); or
 - Met the requirements in effect at that time for retiree coverage under the AFTRA Health Plan.

