SAG·AFTRA
HEALTH PLAN

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Summary of Material Modifications – January 2022

Beginning January 1, 2022, the SAG-AFTRA Health Plan (the "Plan") is implementing changes to the Plan as required by the No Surprises Act, which is a new federal law that protects healthcare consumers from receiving surprise bills from out-of-network providers in certain situations. This Summary of Material Modifications describes these changes, which are effective January 1, 2022. Please keep this notice with your SAG-AFTRA Health Plan summary plan description ("SPD") and other Plan documents.

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, beginning January 1, 2022, 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 SMM, 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 the 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/mental health and substance use disorder services) out-of-pocket maximum. Beginning January 1, 2022, the Plan will apply to these out-of-pocket limits

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 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)

- Non-emergency 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 below)

- Out-of-network air ambulance services

Please keep in mind that the special rules described above 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/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.

Definition of Emergency Services

The Plan generally covers emergency care, which is emergency services for the treatment of an emergency medical condition. Effective January 1, 2022, the special rules for the No Surprises Act apply as described above and emergency care and emergency services are defined as follows:

Emergency medical condition means 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/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 non-emergency 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 the SPD.

<u>Consent Requirements</u>

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 (i) non-emergency services provided at an In-Network facility other than ancillary services (described below) or (ii) 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 non-emergency services, this notice must be provided at least 72 hours before the appointment (or 3 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 non-emergency 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 (i) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether provided by a physician or non-physician practitioner); (ii) items and services provided by assistant surgeons, hospitalists, and intensivists; (iii) diagnostic services, including radiology and laboratory services; and (iv) 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, non-emergency services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services within (30) calendar days of receiving a claim from the Out-of-Network Provider or facility that includes all necessary information to decide the claim.

External Review of Adverse Determinations Based on No Surprises Act Protections

Currently, the Plan provides that after you exhaust your internal appeals, you can file a request for external review with the Plan under certain circumstances (including certain retroactive rescissions of coverage and denials involving medical judgments, such as determinations of Medical Necessity, appropriateness, health care setting, level of care and Experimental or Investigative status).

Beginning January 1, 2022, external review will also be available for adverse benefit determinations based on compliance with the surprise billing protections under the No Surprises Act or its implementing regulations.

See the SPD for more information on the external review process.

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 Fund 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 pages 40-41 of the SPD for further information about how to find an In-Network Provider or facility.

Continuity of Coverage

Beginning January 1, 2022, 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 requires specialized medical care over a prolonged period of time); (2) is undergoing a course of institutional or inpatient care from the Provider or facility; (3) is scheduled to undergo non-elective surgery from the Provider, including receipt of postoperative care from such Provider or facility; (4) is pregnant or undergoing a course of treatment for the pregnancy from the Provider or facility; or (5) is or was determined to be terminally ill (under SSA § 1862(dd)(3)(A)) and is receiving treatment for such illness from such Provider or facility.

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You should take the time to read this notice carefully and share it with your family. It is very important that you retain this notice, which is intended to serve as a Summary of Material

Modifications (SMM) to the Plan, with the 2021 SPD and prior notices issued after the SPD. While every effort has been made to make the SMM as complete and as accurate as possible, it does not restate the existing terms and provisions of the Plan other than the specific terms and provisions it is modifying. If any conflict should arise between this summary and the terms of the SPD (other than with respect to the specific terms and provisions this summary is modifying), or if any point is not discussed in this summary or is only partially discussed, the terms of the applicable SPD will govern in all cases. The Board of Trustees or its duly authorized designee reserves the right, in its sole and absolute discretion, to interpret and decide all matters under the Plan. The Board also reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan or any benefits provided under the Plan (or qualification for such benefits), in whole or in part, at any time and for any reason (including, but not limited to, with respect to retirees)