



# Writers' Guild-Industry Health Fund

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Terence L Young, Chief Executive Officer

**September 19, 2005**

**TO: All Covered Plan Participants**  
**FROM: The Writers' Guild-Industry Health Fund Trustee**

*The following changes or benefit clarifications to the Health Plan have been recently approved:*

## **Eligibility - Change in Status**

*(The following wording is being added to this section of your Summary Plan Description, located on page 9)*

Newly born children of participants who have *earned coverage or coverage through any of our COBRA plans* are covered for the first 31 days after birth, but lose coverage thereafter unless 1) the *Health Plan* is notified of the birth, 2) the required documentation is provided **and** 3) the dependent premium is remitted to the Fund if applicable. Please note: if you have already paid the dependent premium for your existing dependents, you do not need to submit an additional premium for the new child.

## **Routine Mammogram Benefits**

*(Change in the Routine Mammogram Benefits, located in your Summary of Benefits booklet, page 7, effective retroactively to January 1, 2004)*

Under 35 years old:	not covered under the plan
Ages 35 – 39:	1 screening mammogram between these ages
Over 40:	1 screening mammogram every year

In addition, routine mammogram screening will be considered under the Wellness Benefit, up to the annual maximum dollar amount.

### **Emergency Ground Ambulance**

*(Change in benefit level, located in your Summary of Benefits, page 5)*

The Regular Plan currently covers emergency ground ambulance transfer to the nearest hospital, payable at the Plan's network or non-network benefit level. ***Effective retroactively to January 1, 2004, the benefit level has been changed.*** All eligible emergency ground ambulance services will be paid at 80% regardless of whether the provider is a contracted or non-contracted PPO provider.

### **Out of Area Benefits**

*(The following wording replaces the section titled "IF YOU LIVE OUTSIDE THE PPO NETWORK AREA", located in your Summary Plan Description, page 27, effective July 1, 2005)*

Participants who live more than 25 miles from a minimum of two providers of any type who participate in the hospital/major medical network available (PHCS outside of California and Blue Cross in California) may be considered for out-of-area benefits. The Regular Plan's out-of-area option pays a percentage of the cost of eligible expenses, up to the Reasonable and Customary (R&C) limit, after you meet the calendar-year deductible.

If you are traveling in an area where there are PPO network providers, you can use them. Or if you live near enough to a PPO provider and want to travel to that provider for care, you may do so. That way, you can receive the advantage of network-negotiated fees and reimbursement of eligible expenses without R&C limits.

If a participant who lives in a network area is being treated for a serious condition that requires a specialist's care, and there are no network specialists in his or her area, the participant may be considered for out-of-area benefits for services rendered by that specialist. A serious condition includes conditions such as cancer and cardiac surgery. It does not include situations of a non-serious nature, such as claims for chiropractic or acupuncture.

The Regular Plan's out-of-area option covers the same medical services and supplies that are otherwise covered under the plan, including prescription drugs and mental health and substance abuse treatment.

You're responsible for contacting the Fund Office to determine if your provider would qualify for out-of-area benefits and you are also responsible for filing claims with the Fund to receive your reimbursement.

*(See the Summary of Benefits Booklet for benefit levels and limitations)*

**Certified Retirees, Medicare and Fund Benefits - Plan Clarification**

*(Replaces the wording in the Summary Plan Description, page 13, Medicare Part B section)*

Medicare is a two-part program. Part A covers hospitalization and certain follow up services, which is at no costs to you. Part B, which helps pay doctor bills and other medical bills, requires payment of a monthly premium. In order for you to receive optimum coverage and reimbursement for your hospital and doctor bills, it is important that you enroll in Part A and Part B of Medicare. *You should be aware that the Fund pays benefits as if you are enrolled in both Part A and Part B, and will coordinate benefits as if you had received reimbursement for your medical expenses from Medicare.*

If you are approaching age 65, you are not automatically enrolled in Medicare unless you have filed an application and establishment for a monthly Social Security benefit. If you have not applied for Social Security benefits, you must file a Medicare application form during the three months prior to the month in which you become age 65 in order for coverage to begin at the start of the month in which you reach age 65. Call or write your nearest Social Security Office 90 days prior to your 65<sup>th</sup> birthday and ask for an application.

**Lifetime Maximum**

*(The following wording is being added to the Lifetime Maximum section, page 25)*

*The lifetime maximum in paid benefits for all sickness and injuries is \$5,000,000 per individual. Prescription Drug and Mental Health and Substance Abuse benefits are included in this maximum. The lifetime maximum is \$5,000,000 whether or not there is an interruption in coverage.*

The lifetime maximum has previously included the Mental Health and Substances Abuse benefits. Effective July 1, 2005, Prescription Drug benefits will be included in calculating the lifetime maximum.

**Total Disability:**

*(The following wording replaces the Total Disability section, located in your Summary Plan Description, page 16, effective July 1, 2005)*

“If at the time coverage ends, you (or a dependent – excluding same-sex domestic partners) are totally disabled, that person may receive extended benefits through the total disability extension offered by the Fund, or through COBRA.”

A Disabled Writer:

- *After completing and returning all required disability forms, including a physician's statement, and being deemed eligible for disability extension of coverage, the totally disabled writer and their covered dependents are entitled to full medical benefits for 6 months from the date coverage ends.*
- *If at the end of the 6-month extension the writer is still disabled, he/she will be entitled to elect an additional 12 months of "comprehensive medical coverage" (out-patient medical and prescription benefits only) **or** COBRA. Dependents are not eligible for the 12-month comprehensive medical coverage extension; however, they will be offered COBRA and the COBRA entitlement will be offset by the 6 –months of extended coverage they received.*
- *If after the 1st 6-month extension of coverage the writer elects COBRA, the COBRA entitlement will be offset by the 6 –month extension previously received. If the 12-month comprehensive medical coverage extension is elected, no COBRA will be offered at the termination of this extension.*

A Disabled Spouse:

- *If at the time coverage ends, the covered spouse is totally disabled, the spouse will be entitled to elect 12 months of comprehensive medical coverage **or** COBRA. If the 12-month extension is elected, no COBRA will be offered at the termination of the 12-month extension.*

A Disabled Child:

- *If at the time coverage ends, a dependent child is totally disabled, the child will be entitled to elect 12 months of comprehensive medical coverage **or** COBRA. If the 12-month extension is elected, no COBRA will be offered at the termination of the 12-month extension.*
- *If a dependent child has been deemed "permanently disabled" by the Fund, the child will be entitled to lifetime coverage. This coverage will be in effect as long as the writer is covered under the Fund and claims will be paid based upon the plan of benefits the writer elects. If the writer loses coverage, the writer and the permanently disabled child will be offered COBRA. Should the writer regain earned coverage, the permanently disabled child's coverage would resume.*