



Writers' Guild-Industry Health Fund

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SUMMARY OF MATERIAL MODIFICATION (SMM)

March 1, 2005

The Writers' Guild-Industry Health Fund ("WG-IHF") released an updated version of the Summary Plan Description (SPD) in early May 2004. This communication will detail some clarifications to the SPD identified over the past few months.

We are providing the actual revised wording as well as a summary of the modifications for your ease of reading. The clarifications within this document **do not** change the way we have been handling your health plan benefits since the effective dates of the provisions addressed. The revised language contained in the first column replaces the actual SPD language and will be used to interpret plan benefits and the administration of such benefits.

If you have any questions regarding the modifications, please do not hesitate to contact the Fund Office.

How The Special Features Of The Regular Plan, Open Access Plan And Low Option Plan Work

Revised Language	Summary
<p>The following replaces the SPD language for “Special Rules For Using Certain Non-Network Providers At Network Facilities (Regular Plan and Open Access Plan Only)” located at the bottom of page 35.</p> <p><i>“Starting April 1, 2004*, when you receive treatment at a network facility and your treating physician (that is, the physician who ordered your treatment at the facility) is a network provider, any eligible services you receive from non-network anesthesiologists, radiologists, pathologists and emergency room physicians at that facility will be paid at the network percentage* of the reasonable and customary (R&C) charge. That means that once you’ve met the deductible**, you’ll be responsible for the network coinsurance plus any amount over the R&C charge for each service.</i></p> <p><i>However, if you go to a non-network facility, you may not take advantage of this special rule. That means you’ll be responsible for a higher percentage of the cost (the non-network coinsurance) and any amount over the R&C limit.</i></p> <p><i>*The following network rate has been in place</i></p>	<p>The revised wording clarifies that the coverage rate for Open Access participants is 85% under this special rule.</p> <p>The Fund has been handling things this way for the Open Access Plan since April 2002.</p> <p>This amendment does not change the coverage rate for the Regular Plan (85%), which was implemented on April 1, 2004.</p>

<p><i>for Open Access for this special rule.</i></p> <p><i>July 1, 2000: 100% for emergency care</i> <i>April 1, 2002: 85% for non-emergency care</i></p> <p><i>**This applies to the Regular Plan only as there is no deductible for in-network coverage under the Open Access Plan.**</i></p>	
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If You're Covered By More Than One Plan – Certified Retirees

Revised Language	Summary
<p>The following replaces the first paragraph of the SPD language for “If You're Covered By More Than One Plan – Certified Retiree” located at the top of page 41.</p> <p><i>“If you're a participant who retired with Certified Retiree status after March 1, 1997 or you're a participant who retired with Certified Retiree status on or before March 1, 1997 and you're receiving a benefit from the Producer – Writers Guild of America Pension Plan of \$800 or more per month, when you become eligible for Medicare, the Fund coordinates your benefits with Medicare so that the combined medical payments of Medicare and the Fund are equal to but not more than what the Fund would have paid if Medicare were not involved. Surviving Spouses or Same Sex Domestic Partners of such Certified Retirees, upon their becoming eligible for Medicare, will then have their medical benefits coordinated with Medicare in the same way.</i></p> <p><i>If you're a participant who retired with Certified Retiree status on or before March 1, 1997 and you're receiving a benefit from the Producer – Writers Guild of America Pension Plan of less than \$800 per month, when you become eligible for Medicare, the Fund coordinates your benefits with Medicare with the method that was in effect on April 1, 1997. This approach allows for reimbursement up to - 100% of the Medicare allowed amount. Surviving Spouses or Same Sex Domestic Partners of such Certified Retirees, up their becoming eligible for Medicare, will have their medical benefits coordinated with Medicare in the same way.</i></p>	<p>The revised wording clarifies the treatment of all categories of Certified Retirees and the appropriate methods used when combining our payment with Medicare's.</p> <p>The prior SPD language discussed the Coordination of Benefits (COB) for Certified Retirees that retired after March 1, 1997 and receiving a benefit from the Producers – Writers Guild of America Pension Plan of at least \$800 a month, but did not address the COB for other categories of Certified Retirees.</p> <p>There are three categories of Certified Retirees. They include:</p> <ol style="list-style-type: none"> 1. those that retired after March 1, 1997; 2. those that retired on or before March 1, 1997 and are receiving a benefit from the Producers – Writers Guild of America Pension Plan of \$800 or more per month; and 3. those that retired on or before March 1, 1997 and are receiving a benefit from the Producers – Writers Guild of America Pension Plan of less than \$800 per month. <p>The revised wording clarifies that for categories 1 and 2, the Medicare and Fund benefit payments are added together. The combined benefits will not exceed what the Fund would have paid if you did not have Medicare.</p> <p>For category 3, the Medicare and Fund benefit payments are added together. The</p>

	<p>combined benefits <u>will not</u> exceed the Medicare allowed amount.</p> <p>Please contact the Fund Office directly to discuss the details of each method of COB.</p> <p>The Fund has been handling things this way since March 1997.</p>
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What's not covered: Prescription Drug Benefits – Erectile Dysfunction Prescription Drugs

Revised Language	Summary
<p>The following replaces the SPD single bullet point exclusion wording for “Testosterone replacement and erectile dysfunction drugs” located at the bottom of page 47.</p> <ul style="list-style-type: none"> • <i>“Testosterone replacement drugs, except in certain cases if your physician provides a letter explaining why the drug is medically necessary. The Fund will review the letter and forward it to case management for a final decision;”</i> • <i>“Erectile dysfunction prescription drugs;”</i> 	<p>The revised wording clarifies that erectile dysfunction prescription drugs are excluded from coverage, and makes the information on page 47 consistent with the information provided on page 59 of the SPD.</p>

Protection Benefits: Life Insurance for Certified Retirees

Revised Language	Summary
<p>The following replaces the SPD language for “How The Life Insurance Plan Works: If You Retire” located at the bottom of page 79.</p> <p><i>“If you retire and you’re a Certified Retiree, your coverage will remain \$5,000.”</i></p>	<p>This revised wording clarifies that life insurance benefits are not reduced when you retire as a Certified Retiree. The life insurance benefits are the same as all other eligible participants.</p> <p>This has been in effect since April 2003 when the life insurance for all participants changed to \$5000.</p>

Summary of Benefits: Ambulatory Surgery Center

Revised Language	Summary
<p>The following replaces the Summary of Benefits grid for “Ambulatory Surgery Center” located at the top of page 6. The Summary of Benefits is a benefit booklet separate from your SPD.</p> <p>See grid below for the revised language.</p>	<p>Effective April 1, 2004, a \$1500 incident maximum on all out of network, non-contracted ambulatory surgery centers was implemented.</p> <p>The Summary of Benefits grid showed that the incident maximum applied to all out of network and in network ambulatory surgery centers.</p> <p>The revised grid clarifies that the \$1,500</p>

				incident maximum only applies when you use a non-network or out of area ambulatory surgery center.			
Regular Plan PPO				Open Access Plan (For California, Illinois, New Jersey, and New York participants Only)		Low Option Plan (For COBRA participants and Extended Coverage Participants Only)	
	Network Provider	Non-Network Provider	Out of Area (for residents residing outside the PPO service area)	Network Provider	Non-Network Provider	Network Provider	Non-Network Provider
Ambulatory Surgery Center	85%	\$1,500 incident maximum	\$1,500 incident maximum	100%	\$1,500 incident maximum	70%	\$1,500 incident maximum

When Coverage Ends: Same-Sex Domestic Partners

Revised Language	Summary
<p>The following replaces the SPD language for “When Coverage Will End For Your Same-Sex Domestic Partner” located at the bottom of page 11.</p> <p>“Your same-sex domestic partner’s coverage ends on the last day of the month prior to the beginning of the next calendar quarter in which:</p> <ul style="list-style-type: none"> <i>You failed to pay the required taxes</i> <i>You failed to pay the required dependent premiums;</i> <p>or</p> <p><i>Coverage will end on the last day of the month in which:</i></p> <ul style="list-style-type: none"> <i>The partnership ended”</i> 	<p>The revised wording clarifies that both tax payments and dependent premium payments are due quarterly and must be paid in advance. Therefore, if one or both payments are not received before the quarter commences, coverage for your partner will end on the last day of the month of the previous quarter.</p> <p>If you notify the Fund that your partnership has ended, coverage for your partner will end on the last day of the month in which the partnership terminated.</p>

Dependent Premiums And When They Apply: Certified Retirees

Revised Language	Summary
<p>The following replaces the second and third paragraphs of the SPD language for “Certified Retirees” located at upper middle section of page 12.</p> <p>“As a Certified Retiree, you’re required to pay a premium for dependent coverage if you:</p> <ul style="list-style-type: none"> <i>Are on active coverage</i> <i>or</i> <i>You are between the ages of 60 and 65</i> <p><i>You’re not required to pay a premium for dependent coverage, if you:</i></p>	<p>The revised wording clarifies the premium payment requirements for Certified Retirees that have met the coverage requirements. In particular, a Certified Retiree between the ages of 60 and 65 must pay quarterly dependent premiums to cover his or her dependents.</p> <p>Once a Certified Retiree is eligible for Medicare (65 or older), the Certified Retiree will not be required to pay quarterly dependent premiums to cover his or her dependents.</p>

<ul style="list-style-type: none"> • <i>Aren't eligible for active coverage under the Fund</i> <li style="text-align: center;"><i>and</i> • <i>"Are age 65 or older"</i> 	<p>However, if a Certified Retiree who is Medicare eligible becomes an active participant because he or she obtains employment and meets the covered earnings minimum, the Certified Retiree will be required to pay dependent premiums to cover his or her dependents for the duration of the Certified Retiree's active coverage.</p>
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Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

Revised Language	Summary
<p>The following replaces the SPD language for "Second Qualifying Event Extension of 18-Month Period of Continuation Coverage" located in the middle of page 19.</p> <p><i>"If your family experiences another qualifying event during the COBRA continuation coverage period, your spouse and dependent children can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to your spouse and dependent children if you die, get divorced or legally separated or enroll in Medicare (Part A, Part B or both) after your COBRA coverage has commenced. The extension is also available to a dependent child when that child stops being eligible as a dependent child. In all of these cases, you must make sure that the Administrative Office is notified of the second qualifying event within 60 days of the event. If you don't provide the Administrative Office with notice of a second qualifying event within the 60-day period, coverage won't continue past the 18 month period."</i></p>	<p>The revised wording clarifies that to be eligible for the 36-month extension, the second qualifying event (that is, your death, divorce or legal separation, or enrollment in Medicare) must occur <i>after</i> your COBRA continuation period has commenced.</p> <p><i>Please note: If you elect COBRA continuation coverage after you enroll in Medicare, you can keep your COBRA continuation coverage. If you only have Medicare Part A when your group health plan coverage ends, you can enroll in Medicare Part B during a Special Enrollment Period without paying a Part B premium penalty.</i></p> <p>For further questions about COBRA and Medicare enrollment, you should call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for your free copy of the Guide to Health Insurance for People with Medicare.</p>

Extended Coverage Program – Writer's Point System

Amended Wording	Summary
<p>The following amendment replaces the SPD language explaining how the second and third Extended Coverage Point is awarded, located in the middle of page 14.</p> <p>"1 point for one of the following:</p> <p>Each four-quarter earnings cycle ending on or after September 30, 1989 and before January 1, 2001.....At least \$100,000</p> <p>Each four-quarter earnings cycle beginning on or after January 1, 2001 and before January 1, 2002At least \$103,252</p>	<p>This amendment wording addresses the point threshold amounts. It has been determined that there was a slight miscalculation for the earnings cycles beginning January 1, 2003 and beyond.</p> <p><i>Please note:</i> This adjustment may result in some participants receiving one or more additional extended coverage points. If it is determined that the adjustment will effect any participants eligibility, they will be notified in writing.</p>

<p>Each four-quarter earnings cycle beginning on or after January 1, 2002 and before January 1, 2003At least \$106,089</p> <p>Each four-quarter earnings cycle beginning on or after January 1, 2003 and before January 1, 2004At least \$108,741</p> <p>Each four-quarter earnings cycle beginning on or after January 1, 2004 and before January 1, 2005At least \$ 111,460</p> <p>Each four-quarter earnings cycle beginning on or after January 1, 2005 and before January 1, 2006At least \$ 113,968</p> <p><u>The New Amount For A Third Point:</u> Each four-quarter earnings cycle beginning on or after January 1, 2005 and before January 1, 2006At least \$204,500</p>	<p>The Board of Trustees recently evaluated how a <i>third point</i> is awarded. The decision was made to amend the program as follows: <i>Effective January 1, 2005, and the first day of each calendar year thereafter, the eligible earnings level for which an additional or third point is awarded will be increased by an amount proportionally equivalent to the increase (if any) in the Guild minimum for a 1/2 hour Network Primetime Story and Teleplay.</i></p>
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When COBRA Continuation Coverage Ends

Revised Language	Summary
<p>The following replaces the SPD language for “When COBRA Continuation Coverage Ends” for the 6th bullet located in the middle of page 20.</p> <p>“COBRA continuation coverage takes effect on the date of your qualifying event and continues until the earliest of the following:</p> <ul style="list-style-type: none"> • <i>The date you or your dependents become enrolled in Medicare, after the date you or your dependents elect COBRA continuation coverage; or</i>” 	<p>This revised wording clarifies that COBRA coverage will end if you or your dependents <i>enroll</i> in Medicare Part A, Part B or both, after the date you or your dependents elect COBRA continuation coverage.</p> <p>The Fund office will request proof of enrollment prior to terminating COBRA coverage.</p>

Mental Health and Substance Abuse Benefits

Revised Language	Summary
<p>The following replaces the wording at the end of the section on page 51 regarding the precertification requirements for inpatient and outpatient mental health treatment:</p> <p>“Precertification (for PBH providers) is required for:</p> <ul style="list-style-type: none"> • All inpatient admissions for mental health care; and • All outpatient mental health treatment. 	<p>A patient can be treated for a mental health or substance abuse condition in an Intensive Outpatient Program (IOP). This revised wording clarifies that beginning October 1, 2004, one IOP visit is equal to one outpatient visit and will be applied toward the outpatient benefit maximum.</p> <p>Prior to October 1, 2004, IOP visits were applied to the patient's inpatient benefit.</p>

<p>Generally, you should precertify inpatient treatment 7 to 10 days in advance by calling PBH. Any facility-based treatment - for example, inpatient rehabilitation, partial hospitalization*, residential treatment* or an intensive outpatient program** - that is pre-planned should be precertified ahead of time.</p> <p>If you're admitted to the hospital or other facility because you have a mental health emergency, you must precertify within 48 hours (or two business days) of your admission by calling PBH. Your case will be assigned to a team of clinical care managers.</p> <p>During a stay at a hospital or mental health facility, you may not use your outpatient benefits.</p> <p>* For benefit purposes, one partial hospitalization or residential treatment day is equal to one inpatient hospitalization day.</p> <p>* Beginning October 1, 2004, for benefit purposes, intensive outpatient visits are equal to one outpatient visit.”</p>	<p>Any IOP that occurred and applied to the inpatient benefit prior to October 1, 2004 will remain in the inpatient benefit maximum and only the IOP visits that occur on or after this date will be applied toward the outpatient benefits.</p>
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Dental DPO Plan Limitations

Revised Language	Summary
<p>The following plan limitations are being added to this section on page 68.</p> <ul style="list-style-type: none"> • Full-mouth debridement (gross scale) is limited to one treatment in a lifetime • Periodontal treatments (root planing/subgingival curettage) are limited to four quadrants during any 24 consecutive months. 	<p>The revised wording clarifies that these procedures are limited as described with respect to the DPO.</p>

Understanding Coordination of Benefits (COB)

Revised Language	Summary
<p>The “Who’s on First? –The Primary-Secondary Rule” section on page 39 is revised as follows.</p> <p>Who’s On First? - The Primary-Secondary Rule</p> <p>The plan with the first obligation to pay the claim is called the primary plan, and the other plan is the secondary plan. Usually, the plan covering</p>	<p>This revised wording clarifies that COB applies only to group health plans, not to individual policies.</p>

<p>someone as a participant based on employment is the primary plan, and the plan covering someone as a dependent is the secondary plan. However, a plan is also primary if it doesn't have COB rules.</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;"><i>Important!</i></td> </tr> <tr> <td>COB applies only to group health plans, not to individual policies.</td> </tr> </table>	<i>Important!</i>	COB applies only to group health plans, not to individual policies.	
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Important Telephone Numbers and Websites

Revised Language	Summary
<p>The following information from the Mental Health and Substance Abuse Benefits section, contact information on page 14 is revised as follows.</p> <p>Mental Health and Substance Abuse Network Nationwide: PacifiCare Behavioral Health (PBH) Network (888) 301-0056 www.PBHI.com</p>	<p>This revised wording clarifies that the only contact information for the Mental Health and Substance Abuse benefits is PacifiCare Behavioral Health (PBH) Network. Blue Cross and PHCS are not contacts for these benefits.</p>

Vision Benefits – POV

Revised Language	Summary								
<p>The following replaces the Vision Benefit grid located on page 51.</p> <p>See grid below for the revised language.</p>	<p>The Vision Benefit grid showed that the calendar-year deductible doesn't apply if you use an Open Access network provider.</p> <p>The revised grid clarifies that the calendar year deductible does not apply whether you use an Open Access network or out-of network provider.</p>								
<p>VISION BENEFITS AVAILABLE</p>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25%;">REGULAR PLAN & OUT-OF-AREA BENEFITS</td> <td style="width: 25%;">OPEN ACCESS PLAN</td> <td style="width: 25%;">LOW OPTION PLAN</td> <td style="width: 25%;"></td> </tr> <tr> <td style="vertical-align: middle;">•</td> <td style="vertical-align: middle;">• (Calendar-year deductible doesn't apply)</td> <td style="vertical-align: middle;">Not Covered</td> <td></td> </tr> </table>	REGULAR PLAN & OUT-OF-AREA BENEFITS	OPEN ACCESS PLAN	LOW OPTION PLAN		•	• (Calendar-year deductible doesn't apply)	Not Covered	
REGULAR PLAN & OUT-OF-AREA BENEFITS	OPEN ACCESS PLAN	LOW OPTION PLAN							
•	• (Calendar-year deductible doesn't apply)	Not Covered							

Summary of Benefits: Vision Benefits

Revised Language	Summary
<p>The following footnote is added to the Vision Benefits³¹ section of the Summary of Benefits, page 8.</p>	<p>The Summary of Benefits indicated that vision services for any of the plans were subjected to the annual deductible. The added footnote indicates that services from an Open Access Network or Non-network provider are not subject to the annual deductible.</p>

³¹ Services from an Open Access Network or Non-network provider are not subject to the annual deductible.

