PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

Benefits Packet

PWGA PENSION & HEALTH PLANS
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wgaplans.org

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New Eligibility Packet

- Summary of Benefits Booklet
- PWGA Summary of Benefits and Coverage PPO
- Notice of Privacy Practices
- Extended Coverage Program Guide
- COBRA Continuation Coverage General Notice of Rights

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HEALTH FUND
SUMMARY OF BENEFITS BOOKLET

Effective December 31, 2018

PWGA PENSION & HEALTH PLANS
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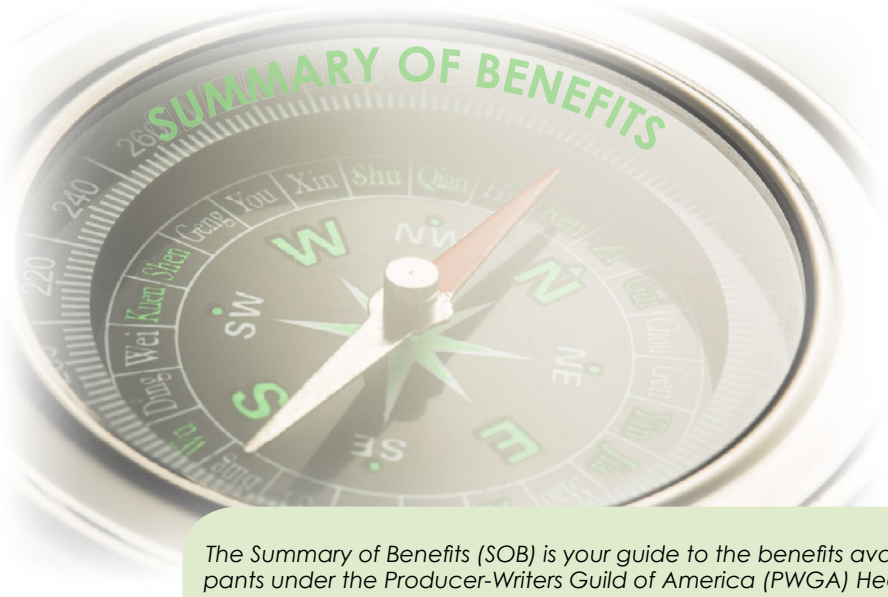
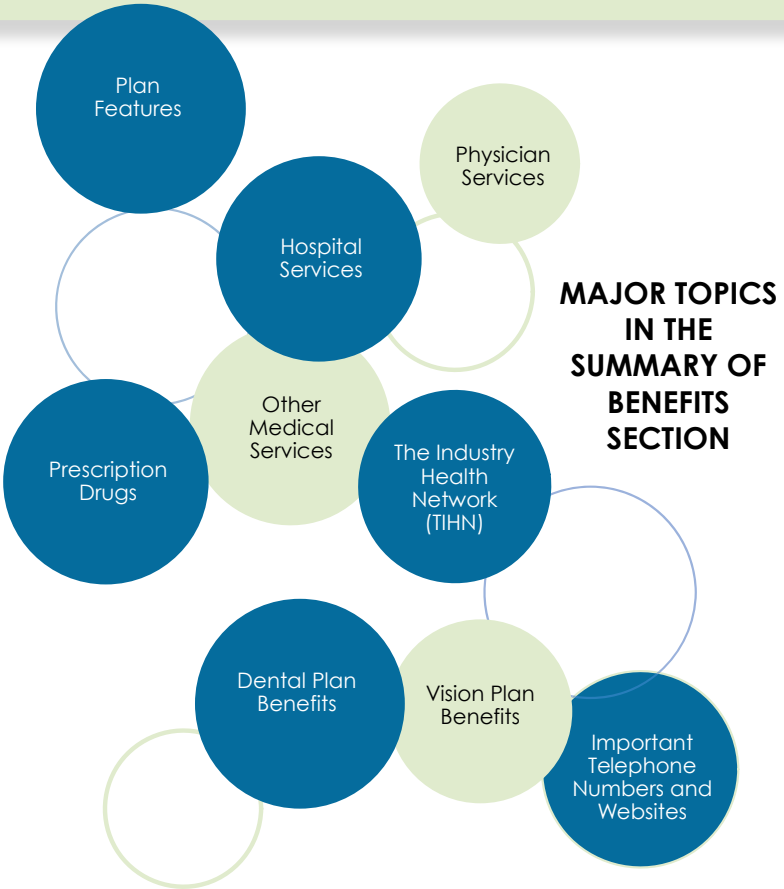
SUMMARY OF BENEFITS



The Summary of Benefits (SOB) is your guide to the benefits available to eligible Participants under the Producer-Writers Guild of America (PWGA) Health Plan (the Plan). These benefits include coverage for medical, prescription drug, dental, and vision. The SOB contains details about the Plan's earnings requirements, dependent coverage premiums, Plan options, and benefit levels, along with PWGA contact information.

The SOB is not a guarantee of benefits. Covered services are subject to preauthorization or Medical Necessity review. The benefits outlined in the SOB may change from time to time. Terms not specifically defined in the SOB are defined in the Summary Plan Description (SPD). The Trustees reserve the right to terminate or change all or any part of the Health Plan at any time. Between published updates to this SOB, the Plan office will notify you of benefit changes by mail — in the form of Plan change announcements (Summary Material Modifications, or SMMs) or newsletters — and online announcements at pwga.org.



MAJOR TOPICS IN THE SUMMARY OF BENEFITS SECTION

Summary of Benefits

PLAN FEATURES

MEDICAL					
	PPO PLAN			**LOW OPTION PLAN (COBRA and Extended Coverage Participants only)**	
	In-Network Provider	**Out-of-Network Provider**	**Out-of-Area Provider**	**In-Network Provider**	**Out-of-Network Provider**
	Contracted rate applies	Allowed Charge applies	For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies.	Contracted rate applies	Allowed Charge applies
Plan Features					
Calendar Year Deductible Applies to all benefits unless otherwise noted	$400/person; $1,200/family	$400/person; $1,200/family	$400/person; $1,200/family	$750/person; $2,250/family	$750/person; $2,250/family
Coinsurance Out-of-Pocket (OOP) Limit	$1,000/person (coinsurance only)	$20,000/person (coinsurance only)	$1,000/person (coinsurance only)	$4,500/person (coinsurance only)	$20,000/person (coinsurance only)
ACA In-Network Out-of-Pocket (OOP) Limit Includes in-network deductible, coinsurance, and copays.	$7,350/ person $14,700/ family/yr.	Not applicable	Not applicable	$7,350/ person $14,700/ family/yr.	Not applicable
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

IMPORTANT NOTES:

- All services are subject to Medical Necessity review at the time of payment.
- Calendar-year deductible, office visit copays, and hospital copays do not apply toward the Coinsurance Out-of-Pocket Limit. They do apply to the ACA In-Network Out-of-Pocket Limit if services are received in-network.
- The Plan's out-of-pocket maximum (after deductible) for Medicare-eligible Certified Retirees who retired prior to March 1, 1997 and who are receiving a benefit from the Producer-Writers Guild of America Pension Plan of greater than $800 per month is $400 for in-network providers (with coverage at 85%) and $600 for out-of-network providers (with coverage at 70%).

Summary of Benefits

The ACA out-of-pocket maximum of $7,350/person and $14,700 per family per year applies to in-network services only and changes automatically each year to reflect the ACA permitted maximum. You can contact the Fund Office for the current limit.

COVERED EARNINGS MINIMUM

Eligibility Earnings Minimum (effective July 1, 2016):	$38,302 (One-hour network prime-time story and teleplay)
Eligibility Earnings Minimum (effective July 1, 2017):	$38,685 (One-hour network prime-time story and teleplay)
Eligibility Earnings Minimum (effective July 1, 2018):	$39,072 (One-hour network prime-time story and teleplay)
Eligibility Earnings Minimum (effective July 1, 2019):	$39,463 (One-hour network prime-time story and teleplay)
Premium for Dependent Coverage:	$50 per month, payable quarterly, in advance
Life Insurance Benefit for Active Participants and Certified Retirees: PPO Plan only	$5,000

Summary of Benefits

PHYSICIAN SERVICES

MEDICAL					
	PPO PLAN			**LOW OPTION PLAN (COBRA and Extended Coverage Participants only)**	
	In-Network Provider	**Out-of-Network Provider**	**Out-of-Area**	**In-Network Provider**	**Out-of-Network Provider**
	Contracted rate applies	Allowed Charge applies	For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies.	Contracted rate applies	Allowed Charge applies
Physician Services If performed by an in-network provider, some or all of the services listed below may be covered at 100% with no deductible under the Preventive Care benefits described on pages 98-103 of the SPD. For services covered under Wellness Benefits, see pages 107-108 of the SPD.					
Doctor's Office Visit	85%	60%	80%	70%	60%
Periodic Health Assessment	Covered under Wellness Benefits	Covered under Wellness Benefits	Covered under Wellness Benefits	Not covered	Not covered
Well Baby Care	85%	60%	80%	70%	60%
Childhood Wellness Visits including immunizations: • Through age 6: • Age 7 and older:	• 85% • Covered under Wellness Benefits	• 60% • Covered under Wellness Benefits	• 80% • Covered under Wellness Benefits	• 70% • Not covered	• 60% • Not covered
Adult Immunizations	Covered under Wellness Benefits	Covered under Wellness Benefits	Covered under Wellness Benefits	Not covered	Not covered
Maternity Care Includes prenatal care, delivery, and postnatal care of a physician-delivered baby	85%	60%	80%	70%	60%

Summary of Benefits

Inpatient/ Outpatient Physician Services	85%	60%	80%	70%	60%
Inpatient Routine Nursery Visits and Room and Board Inpatient hospital copay applies to the facility fees associated with the baby's facility charges	85%	60%	80%	70%	60%
Other Physician Services	85%	60%	80%	70%	60%
Surgery	85%	60%	80%	70%	60%

IMPORTANT NOTES:

- Out-of-network anesthesiologists, radiologists, and pathologists are payable at 85% of the Allowed Charge under the PPO Plan or 70% of the Allowed Charge under the Low Option Plan, if services are rendered at an in-network facility by an in-network physician. Does not apply to out-of-area (OOA) care.
- Assistant surgeons will be considered at a reduced benefit level that is equal to 20% of the surgeon's contract or the Allowed Charge.

Summary of Benefits

HOSPITAL SERVICES

MEDICAL					
	PPO PLAN			**LOW OPTION PLAN (COBRA and Extended Coverage Participants only)**	
	In-Network Provider	**Out-of-Network Provider**	**Out-of-Area**	**In-Network Provider**	**Out-of-Network**
	Contracted rate applies	Allowed Charge applies	For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies.	Contracted rate applies	Allowed Charge applies
Hospital Services If performed by an in-network provider, some or all of the services listed below may be covered at 100% with no deductible under the Preventive Care benefits described on pages 98-103 of the SPD. For services covered under Wellness Benefits, see pages 107-108 of the SPD. You must obtain preauthorization, or prior approval, for inpatient and outpatient treatment facilities.					
Emergency Room[1]	85% after $50 copay (copay is waived if admitted; hospital admission copay applies)	60% after $50 copay (copay is waived if admitted; hospital admission copay applies)	80% after $50 copay (copay is waived if admitted; hospital admission copay applies)	70% after $50 copay (copay is waived if admitted; hospital admission copay applies)	60% after $50 copay (copay is waived if admitted; hospital admission copay applies)
Inpatient Services Includes prenatal care, delivery, and postnatal care of a physician-delivered baby	85% after $100 copay/ admission	60% after $100 copay/ admission	80% after $100 copay/ admission	70% after $100 copay/ admission	60% after $100 copay/ admission
Outpatient Services	85%	60%	80%	70%	60%
Outpatient Lab Work and X-rays	85%	60%	80%	70%	60%
Skilled Nursing Facility Ask your provider to contact Anthem Blue Cross to facilitate your care through Case Management	85% after $100 copay/ admission	60% after $100 copay/ admission	80% after $100 copay/ admission	70% after $100 copay/ admission	60% after $100 copay/ admission

IMPORTANT NOTES:

- Inpatient services include semi-private room within Plan limits and ancillary services.
- If you fail to obtain the required preauthorization, the Trustees may, at their discretion, authorize a post-service Medical Necessity review (which does NOT waive the preauthorization requirement under the Plan). See pages 183-185 of the SPD for complete information.

[1] Emergency room services may qualify for in-network coinsurance if the condition meets the definition of emergency care on page 71 of the SPD.

OTHER MEDICAL SERVICES

MEDICAL					
	PPO PLAN			**LOW OPTION PLAN (COBRA and Extended Coverage Participants only)**	
	In-Network Provider	**Out-of-Network Provider**	**Out-of-Area**	**In-Network Provider**	**Out-of-Network Provider**
	Contracted rate applies	Allowed Charge applies	For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies.	Contracted rate applies	Allowed Charge applies
Alternative Medicine • Acupuncture[2] • Biofeedback[3] • Chiropractic[4] • Hydrotherapy/ Aquatic Therapy[3] • Lymphedema Therapy[3] • Outpatient Occupational Therapy[3] • Osteopathic Manipulative Treatment • Outpatient Physical Therapy[3] • Orthoptic Training	85% after $60 allowable per visit (one re-exam every 30 days to evaluate and monitor progress)	60% after $60 allowable per visit (one re-exam every 30 days to evaluate and monitor progress)	80% after $60 allowable per visit (one re-exam every 30 days to evaluate and monitor progress)	70% after $60 allowable per visit (one re-exam every 30 days to evaluate and monitor progress)	60% after $60 allowable per visit (one re-exam every 30 days to evaluate and monitor progress)
Alternative Medicine (effective Jan. 1, 2019) Outpatient Occupational Therapy[3] and Outpatient Physical Therapy[3]	85% after $90 allowable per visit, with one re-exam every 30 days to evaluate and monitor progress	60% after $90 allowable per visit, with one re-exam every 30 days to evaluate and monitor progress	80% after $90 allowable per visit, with one re-exam every 30 days to evaluate and monitor progress	70% after $90 allowable per visit, with one re-exam every 30 days to evaluate and monitor progress	60% after $90 allowable per visit, with one re-exam every 30 days to evaluate and monitor progress
Ambulance	80% (emergency only)	80% (emergency only)	80% (emergency only)	70% (emergency only)	60%[1] (emergency only)
Air or Sea Ambulance	85% (emergency only)	60% (emergency only)	80% (emergency only)	70% (emergency only)	60% (emergency only)
Ambulatory Surgery Center	85%	60% $1,500/ incident maximum	80% $1,500/ incident maximum	70%	60% $1,500/ incident maximum
Electro-Convulsive Therapy (ECT) See SPD page 87 for details.	85%	60%	80%	70%	60%
Enhanced External Counterpulsation Therapy (EECP) See SPD page 87 for details	85%	60%	80%	70%	60%
Hearing Aids[5]	50%	50%	50%	50%	50%
Home Health[6] Care and Home Infusion Therapy	Preauthorization Required - 85%	Preauthorization Required - 60%	Preauthorization Required - 80%	Preauthorization Required - 70%	Preauthorization Required - 60%

[2] For chronic pain only.
[3] A referral is required from a doctor of medicine (MD).
[4] Manipulation of the musculoskeletal system.
[5] Covers up to a maximum allowable charge of $2,000 per device. A prescription from a doctor of medicine (MD) is required. Benefit does not accumulate to the coinsurance or the out-of-pocket maximums.
[6] Please have your provider contact the Fund's Utilization Administrator (Anthem Blue Cross) to facilitate your care through Case Management Intervention. On the back of your Medical ID card, you will find the phone number for preauthorization, or pre-service, review.

Summary of Benefits

OTHER MEDICAL SERVICES

MEDICAL					
	PPO PLAN			**LOW OPTION PLAN (COBRA and Extended Coverage Participants only)**	
	In-Network Provider	**Out-of-Network Provider**	**Out-of-Area**	**In-Network Provider**	**Out-of-Network Provider**
	Contracted rate applies	Allowed Charge applies	For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies.	Contracted rate applies	Allowed Charge applies
Hospice Care[6]	Preauthorization Required - 85%	Preauthorization Required - 60%	Preauthorization Required - 80%	Preauthorization Required - 70%	Preauthorization Required - 60%
Infertility Treatment	Not covered	Not covered	Not covered	Not covered	Not covered
Preventive Care Benefits For services covered under Wellness Benefits, see SPD pages 107-108.	100% of certain preventive charges as identified by federal law	Not available	Not available	100% of certain preventive charges as identified by federal law	Not available
Routine Mammograms ● Under 35 ● Ages 35-39 ● Age 40 & Over	Covered under Preventive Care at 100% with no deductible (see SPD pages 98-103) ● Not covered ● One every 5 years ● One every year	Covered under Wellness Benefits (see SPD pages 107-108) ● Not covered ● One every 5 years ● One every year	Covered under Wellness Benefits (see SPD pages 107-108) ● Not covered ● One every 5 years ● One every year	Covered under Preventive Care at 100% with no deductible (see SPD pages 98-103) ● Not covered ● One every 5 years ● One every year	60% ● Not covered ● One every 5 years ● One every year
Speech Therapy[3] Subject to Plan restrictions and coordinated with speech therapy benefits provided through child's school. Any sessions covered through school program will reduce visits, on a one-for-one basis.	85% 100 visits/ calendar year	60% 100 visits/ calendar year	80% 100 visits/ calendar year	70% 100 visits/ calendar year	60% 100 visits/ calendar year

[3] Ibid
[6] Ibid

Summary of Benefits

MEDICAL Inpatient, outpatient facility, home health, hospice, home infusion therapy, skilled nursing facility, and transplant services must be preauthorized through Anthem Blue Cross. If you fail to obtain the required preauthorization, the Trustees may, at their discretion, authorize a post-service Medical Necessity review (which does NOT waive the preauthorization requirement under the Plan). See pages 183-185 of the SPD.					
	PPO PLAN			**LOW OPTION PLAN (COBRA and Extended Coverage Participants only)**	
	In-Network Provider	**Out-of-Network Provider**	**Out-of-Area**	**In-Network Provider**	**Out-of-Network Provider**
	Contracted rate applies	Allowed Charge applies	For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies.	Contracted rate applies	Allowed Charge applies
Telemedicine – LiveHealth Online (LHO) Medical	100% after $20 copay with no deductible	Not covered	Not covered	100% after $20 copay with no deductible	Not covered
Telemedicine – LiveHealth Online Psychology/ Psychiatry[7, 8]	100% after $10 copay with no deductible	Not covered	Not covered	100% after $10 copay with no deductible	Not covered
Transplant Services[9]	Preauthorization Required - 85%	Preauthorization Required - 60%	Preauthorization Required - 80%	Preauthorization Required - 70%	Preauthorization Required - 60%
Treatment of TMJ Dysfunction	85% for X-rays and 6 physiotherapy visits	60% for X-rays and 6 physiotherapy visits	80% for X-rays and 6 physiotherapy visits	70% for X-rays and 6 physiotherapy visits	60% for X-rays and 6 physiotherapy visits
Wellness Benefits[10] Ages 7 and older; refer to SPD pages 107-108 for covered wellness services.	$500/person or $1,500/family/ calendar year for specific wellness care expenses covered at 100% up to this limit	$500/person or $1,500/family/ calendar year for specific wellness care expenses covered at 100% up to this limit	$500/person or $1,500/family/ calendar year for specific wellness care expenses covered at 100% up to this limit	Not covered (May be covered at 100% with no deductible under Preventive Care benefits described on pages 98-103 of the SPD).	Not covered

IMPORTANT NOTES:

- Telemedicine services are offered through Anthem Blue Cross only, available in all 50 states and the District of Columbia. Visit *livehealthonline.com*.
- Services under the Wellness and Preventive Care benefits are not subject to a copay or annual deductible.
- All services are subject to review for Medical Necessity at the time of payment.
- In-network services that are considered preventive care services (including women's preventive care) as identified by the federal law are not subject to a copay or annual deductible. For additional details, see pages 98-103 of the SPD or visit *healthcare.gov/coverage/preventive-care-benefits*.

[7] Treats patients 10-17 and/or 18 years of age or older. For 18 years of age and older, the patient must have his/her own LHO account.

[8] The patient must be 18 years of age or older and must have his/her own LHO account. Prescriptions determined to be a controlled substance (as defined by the Controlled Substances Act under federal law) cannot be prescribed using LiveHealth Online. Psychiatrists on LHO will not offer counseling or talk therapy.

[9] Please have your provider contact the Fund's Utilization Administrator (Anthem Blue Cross) to facilitate your care through Case Management Intervention. On the back of your Medical ID card, you will find the phone number for preauthorization, or pre-service, review.

[10] If the wellness benefit maximum is met, services will be considered under the Plan's medical benefits, subject to the annual deductible and Plan limitations. (This doesn't apply to the Low Option Plan, which does not have wellness benefits.) Preventive services defined as preventive benefits under the ACA (e.g., routine mammogram and pap smear for women of certain ages) are not subject to the deductible.

Summary of Benefits

PRESCRIPTION DRUGS

MEDICAL					
	PPO PLAN			**LOW OPTION PLAN (COBRA and Extended Coverage Participants only)**	
	In-Network Provider	**Out-of-Network Provider**	**Out-of-Area**	**In-Network Provider**	**Out-of-Network Provider**
	Contracted rate applies	Allowed Charge applies	For Participants 25+ miles from two in-network providers — contact Plan office to confirm eligibility. Allowed Charge applies.	Contracted rate applies	Allowed Charge applies
Participants and covered dependents will automatically be enrolled in the Pharmacy Program if you are enrolled in the PPO Plan only. The benefits are administered by Express Scripts.					
Prescription Drugs (subject to coordination of benefits provision)					
Retail (up to a 30-day supply only)					
• Generic • Preferred Brand • Non-Preferred Brand[11]	$10 copay $25 copay[12] $50 copay[12]	$10 copay[13] $25 copay[13] $50 copay[13]	$10 copay $25 copay $50 copay	Not covered[12]	Not covered
Mail Order (up to a 90-day supply) Important: Using the mail-order service or Smart90 is mandatory for maintenance medications.					
• Generic • Preferred Brand • Non-Preferred Brand[9]	$20 copay[12] $50 copay[12] $100 copay[12]	$20 copay[13] $50 copay[13] $100 copay[13]	$20 copay $50 copay $100 copay	Not covered[12]	Not covered

IMPORTANT NOTES:

- Compounded medications will be subject to the preauthorization requirements. If any ingredient in a compounded medication is on Express Scripts' list of excluded ingredients, it will not be covered. However, ESI will work closely with the compounding pharmacy to replace or remove the non-covered ingredient.
- Hepatitis C Medications will be subject to the preauthorization requirements.
- There are medications that are excluded from the Express Scripts formulary. These medications are not covered by the Plan.

[11] Brand-name copay applies only when a licensed health care provider acting within the scope of his/her license specifies "Dispense as Written" (DAW) on the prescription and no generic equivalent is available. If a generic equivalent is available, the patient pays the generic copay plus the cost difference between generic drug and brand-name drug even if a licensed health care provider acting within the scope of his/her license specifies DAW on the prescription. For non-covered drugs, visit Express Scripts' website *express-scripts.com*.

[12] Preventive care drugs allowed under the Affordable Care Act are administered by Express Scripts. See list of eligible preventive care benefits on pages 98-103 of the SPD.

[13] You must pay the full cost of the drug at the point of purchase. You will be reimbursed according to the Plan's schedule of benefits when you submit your claim to Express Scripts.

THE INDUSTRY HEALTH NETWORK

Participants can take advantage of significant savings available to them when they use The UCLA Health/Motion Picture & Television Fund (MPTF) Health Centers (TIHN - The Industry Health Network), available only in Southern California. Initially, you must choose a primary care physician (PCP). Then, your TIHN PCP will treat you directly, coordinate your care, and, if necessary, refer you to a TIHN specialist. Without a PCP's referral, your standard Health Plan benefits will apply, including your deductible and coinsurance. No enrollment is required to use this benefit. You may change your PCP at any time, and you may choose other health care providers within The Industry Health Network.

All TIHN benefits are subject to the maximums and limitations listed in this Summary of Benefits and your Summary Plan Description. All claims from a TIHN specialist must be submitted with the referral number assigned by MPTF. The Preventive Care services rendered under TIHN are not subject to a $10 copay and will not be applied towards your wellness benefit maximum.

If the Health Center doctor treating you determines that a behavioral health provider should treat your condition, he/she will provide you with a medical order (a recommendation that requires self-referral to a behavioral health care provider) rather than a referral. At this time, behavioral health services will not be part of the TIHN referral program.

Referral from a primary care physician to a TIHN specialist does not guarantee payment. All services are subject to Medical Necessity and the maximums, and the limitations of the Plan.

PLAN BENEFITS	WHEN YOU USE THE INDUSTRY HEALTH NETWORK
If performed by an in-network provider, some or all of the services listed below may be covered at 100% with no deductible under the Preventive Care benefits described on pages 98-103 of the SPD. All specialist charges require a referral from your primary care physician.	
PCP Office Visit	$10 copay
Specialist Office Visit (requires a written referral from your PCP)	$10 copay (Referrals to specialists who will provide alternative medicine services, such as physical/occupational therapy, are subject to the Plan's alternative medicine $60 allowable per visit limitation. Outside services, such as specialty care, always requires a written referral authorization from your PCP. You and your dependents must obtain a referral for all services outside of the Health Centers, even if ordered by your specialist. Note: Effective Jan. 1, 2019 and thereafter, under the alternative medicine benefit, the Fund allows up to $90 per day, per provider for occupational and physical therapy services only.)
Periodic Physical Exam[14]	No copay
Well Child Care/ Pediatric Visit[15]	$10 copay
Lab Works/X-rays	100%
Physical Therapy	$10 copay (Subject to the Plan's alternative medicine $60 allowable per visit limitation. Effective Jan. 1, 2019 and dates of services thereafter, the Fund will allow $90 per visit limitation.)
Hospitalization	100% after $100 copay/admission
Surgery	100% after $100 copay
Anesthesiology	100%

IMPORTANT NOTE:

- A medical order is a treatment recommendation that requires self-referral to a behavioral physician.

[14] Comprehensive Physical Exam (CPE) charges will be applied to your Wellness Benefit. Wellness Benefits are only available to those over age 7.

[15] Children 13 years and older may utilize pediatric services at any of the five TIHN Health Centers (see page 17). For children under 13 contact TIHN customer service at (800) 876-8320 for a list of pediatricians.

Summary of Benefits

You have the right to designate any primary care provider who participates in the TIHN network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the in-network primary care providers, contact (800) 876-8320. Children 13 years and older may utilize services at any of the five Health Centers. For children under 13 years of age, you may designate a pediatrician as the primary care provider. You do not need prior authorization from TIHN or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the TIHN network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of TIHN health care professionals who specialize in obstetrics or gynecology, contact (800) 876-8320.

DENTAL PLAN BENEFITS

If Participants (and their dependents) are enrolled in the PPO Plan, they will automatically be enrolled in the Delta Preferred Option (DPO). Participants who live in California may choose to enroll in the DeltaCare USA Dental HMO (DHMO), a managed dental plan, instead. Participants also have the option of enrolling their eligible dependent(s) in the DHMO.

DELTA PREFERRED OPTION (DPO)			**DELTACARE**	
	DPO Provider	**Delta Dental Provider** (not part of DPO network)	**Out-of-Network Provider**	**DHMO**[14] (California only)
Plan Features				
Calendar-Year Deductible	$75/person or $150/family (doesn't apply to diagnostic and preventive services)	$75/person or $150/family (doesn't apply to diagnostic and preventive services)	$75/person or $150/family (doesn't apply to diagnostic and preventive services	None
Plan Maximums Important: All orthodontia benefits are limited to the lifetime maximum of $2,000				
Diagnostic, Preventive, Basic, and Major Services	$2,500/ calendar year	$2,500/ calendar year	$2,500/ calendar year	Unlimited
Orthodontia	Coverage for children up to the age 19 $2,000 Lifetime maximum	Coverage for children up to the age 19 $2,000 Lifetime maximum	Coverage for children up to the age 19 $2,000 Lifetime maximum	See Delta Dental's Evidence of Coverage (EOC) Schedule A for a description of benefits and copayments.
Plan Benefits				
Diagnostic and Preventive	100% of DPO-approved fee (no deductible applies)	80% of Delta-approved fee (no deductible applies)	80% of Delta-approved fee; you pay remaining 20% plus fees above approved amount	See Delta Dental's Evidence of Coverage[17] (EOC) Schedule A for a description of benefits and copayments
Basic and Major Services	80% of DPO-approved fee	70% of Delta-approved fee	70% of Delta-approved fee	See Delta Dental's Evidence of Coverage[16] (EOC) Schedule A for a description of benefits and copayments

[14] Ibid

[16] Services received from out-of-network dentists are not covered, except in an emergency, and if your DeltaCare dentist is unavailable or cannot see you within 24 hours of making contact, or if you believe your condition makes it medically inappropriate to travel to your contracted dentist to receive emergency services. The Plan will reimburse up to $100 of out-of-network emergency dental care per emergency, per enrollee, less any applicable copayment.

[17] The Delta Dental EOC was distributed at the time of enrollment. If you need another copy, contact DeltaCare USA Customer Relations at (800) 422-4234 or visit *pwga.org*.

Summary of Benefits

Orthodontia Benefits	70% of DPO-approved fee (coverage for children up to age 19 with a $25 deductible) Benefits are limited to a $2,000 lifetime maximum. 50% is payable at the time of banding and the remaining 50% 12 months later.	70% of Delta-approved fee (coverage for children up to age 19 with a $25 deductible) Benefits are limited to a $2,000 lifetime maximum. 50% is payable at the time of banding and the remaining 50% 12 months later.	70% of Delta-approved fee (coverage for children up to age 19 with a $25 deductible) Benefits are limited to a $2,000 lifetime maximum. 50% is payable at the time of banding and the remaining 50% 12 months later.	• Up to age 19: 100% after $350 start-up fee; $1,600 copay (for 24 months of standard orthodontia treatment; additional fee may apply after 24 months) • Adults and dependents 19-26 years of age: 100% after $350 start-up fee; $1,800 copay (for 24 months of standard orthodontia treatment; additional fee may apply after 24 months)
Dental Work Performed by a Pedodontist (a dentist who specializes in the growth and development of children's teeth)				• Pedodontic referrals must be pre-authorized by DeltaCare. • Up to age 7: 100% less applicable copayments following an attempt by the assigned contracted dentist to treat the child and upon prior authorization by DeltaCare USA. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

IMPORTANT NOTE:

- Plan maximum annual dollar limit does not apply to dependent children under the age of 19. However, orthodontia benefits will be limited to the lifetime maximum of $2,000.

VISION PLAN BENEFITS

All eligible Participants (excluding Participants covered under the Low Option Plan) will automatically be enrolled in vision coverage administered through VSP Vision Care (VSP).

VSP IN-NETWORK BENEFITS			
Benefit	**Description**	**Copay**	**Frequency**
Well Vision Exam	Regular vision wellness exam	$30	Once every calendar year
Prescription Glasses		**$30** (materials copay)	**See frame and lenses**
Frames	• $150 allowance for a wide selection of frames • $200 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco frame allowance	No additional copay required (included in prescription glasses)	Once every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for adults • Polycarbonate lenses for dependent children	Included with prescription glasses $31 for single vision; $35 for multifocal Included with prescription glasses	Once every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$0 $95 – $105 $150 – $175	Once every calendar year
Contacts (elective; instead of glasses) **Contact lenses** (Medically Necessary)[18]	• $150 allowance for elective contacts; copay does not apply • Materials covered in full with prior approval (less a $30 materials copay)	Up to $60 for exam, fitting, and evaluation $30 (for materials)	Once every calendar year
Sun care	$150 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contacts	$30	Once every other calendar year
Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible Participants with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed

[18] When VSP benefit criteria is met and verified by an in-network doctor for eye conditions that would prohibit the use of glasses, contact lenses are considered Medically Necessary. Covered conditions include aphakia, aniridia, anisometropia, corneal transplant, high ametropia, nystagmus, keratoconus, heredity corneal dystrophies, and other eye conditions that make contact lenses necessary.

Summary of Benefits

OUT-OF-NETWORK BENEFITS

A Participant may receive vision care services from an out-of-network health care provider. If a Participant chooses an out-of-network provider, he/she must pay the provider directly for all charges and then submit a claim for reimbursement to:

VSP
PO Box 385018
Birmingham, Ala. 35238-5018

You can obtain a copy of the VSP Vision Claim Form at: *pwga.org* or online at: *vsp.com*.

Claims for out-of-network vision care must be filed with VSP no later than 12 months after the date of service.

The chart below outlines the VSP out-of-network benefit.

OUT-OF-NETWORK BENEFITS (Visit *vsp.com* for details if you plan to see a provider that is not in the VSP network.)	
Description	**Benefit**
Exam	Up to $76
Frames	Up to $70
Single Vision Lenses	Up to $33
Lined Bifocal Lenses	Up to $50
Lined Trifocal Lenses	Up to $65
Progressive Lenses	Up to $50
Contacts (instead of glasses) Contacts (Medically Necessary)	Up to $115 for elective contacts Up to $327 for Medically Necessary contacts
VSP will reimburse the patient according to each benefit's out-of-network schedule of allowances, not to exceed the actual exam fee and the cost of corrective eyewear.	

IMPORTANT TELEPHONE NUMBERS AND WEBSITES

IMPORTANT TELEPHONE NUMBERS AND WEBSITES			
For Questions Related To	**Contact**	**Phone Number**	**Website Information**
Eligibility, Claims, General Benefits, and Life and AD&D Insurance	Writers' Guild-Industry Health Fund 2900 W. Alameda Ave. Suite 1100 Burbank, CA 91505-4220	(818) 846-1015 or (800) 227-7863	*pwga.org*
PPO Plan and Low Option Plan Providers	Physician and Hospital Network in California: Anthem Blue Cross of California Physician and Hospital Network Outside California: BlueCard®	(800) 810-BLUE (2583)	*pwga.org*
Prescription Drug Benefits	Prescription Drug Network Nationwide: Express Scripts	(800) 987-6551	*express-scripts.com*
The Industry Health Network	Motion Picture & Television Fund Customer Service (available in Southern California only)	(855) 760-6783	*mptf.com*
DPO Dental Plan	Delta Preferred (DPO) Customer Relations	(800) 765-6003	*deltadentalca.com/deltacareusa*
DeltaCare Dental HMO	DeltaCare USA Customer Relations (available in Southern California only)	(800) 422-4234	*deltadentalca.com/deltacareusa*
Vision Plan	VSP	(800) 877-7195	*vsp.com*

TIHN Health Centers	Location	Phone Number
Bob Hope Health Center	Los Angeles, Hollywood, Mid-City	(323) 634-3850
Jack H. Skirball Health Center	Woodland Hills	(818) 876-1050
Santa Clarita Health Center	Valencia	(661) 284-3100
Toluca Lake Health Center	Toluca Lake	(818) 556-2700
Westside Health Center	Los Angeles, West Los Angeles	(310) 996-9355

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please contact the Fund Office at 1-818-846-1015 or 1-800-227-7863 or through our website, www.pwga.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-227-7863 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400** person / **$1,200** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Preventive Care, LiveHealth online visit, In-network prescription drugs and primary care services through "The Industry Health Network" (TIHN, Southern California only) are covered before you meet your deductible.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network Providers: $1,000/individual (coinsurance only) Non-Network Providers: $20,000/individual (coinsurance only) ACA Network Providers: **$9,100**/individual; **$18,200**/family (includes deductibles, coinsurance, copayments)	The out-of-pocket limit is the most you could pay in a year for covered services. In addition to having a Plan out-of-pocket limit for coinsurance, the Fund complies with the Affordable Care Act (ACA) annual out-of-pocket limit on in-network cost sharing for Plan Participants.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, provider discounts and health care expenses this Plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	**Yes**. For The Industry Health Network (TIHN, Southern California only), call 1-800- 876-8320. For the Blue Cross/Blue Card network at 1-800-810-BLUE (2583).	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**Yes.** If you obtain services through TIHN (in Southern California only), you need a referral when seeing a specialist.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Area Provider	Non-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance ($10 copay/visit through TIHN, deductible does not apply). LiveHealth online: $20 copay/visit, deductible does not apply.	20% coinsurance	40% coinsurance	Copay for LiveHealth online visit will be waived if the online doctor refers the patient to the emergency room.
	Specialist visit	15% coinsurance ($10 copay/visit through TIHN, deductible does not apply)	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% coinsurance	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance (0% coinsurance through TIHN)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance (0% coinsurance through TIHN)	20% coinsurance	40% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.pwga.org.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Area Provider	Non-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Retail $10 copay/Rx; Mail order $20 copay/Rx	You pay the pharmacy the full amount of your prescription and must submit a claim to Express Scripts. You'll receive a reimbursement of the highest dollar amount according to the plan formula.		• Retail covers up to a 30-day supply • Mail order covers up to a 90-day supply • Deductible does not apply • * See SPD for list of over-the-counter generic drugs available at no cost at an In-Network pharmacy with a prescription • Drugs on the ESI's drug exclusion list will not be covered by the Plan without an advanced exception • Retail Hepatitis C drugs and Compound drugs require preauthorization to avoid non-payment • No charge for ACA-required generic (or brand if the generic is medically inappropriate) preventive care drugs (such as contraceptives). • Mail order service is mandatory for maintenance medications through ESI or Smart90 program (Walgreens, Duane Reade, Happy Harry's)
	Preferred brand drugs	Retail $25 copay/Rx; Mail order $50 copay/Rx			
	Non-preferred brand drugs	Retail $50 copay/Rx; Mail order $100 copay/Rx			
	Specialty drugs	$0 copay for specialty drugs if you enroll in SaveonSP program For specialty drugs not covered by SaveonSP, same copays as generic, preferred brand or non-preferred brand drugs.	Not covered. Specialty drugs must be ordered through Express Scripts Accredo.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance (0% coinsurance through TIHN)	20% coinsurance	40% coinsurance	• Non-Network and Out-of-Area ambulatory surgery centers are limited to maximum payment of $1,500 • Some surgery services may require preauthorization review
	Physician/surgeon fees	15% coinsurance (No charge after $100 copay/procedure through TIHN)	20% coinsurance	40% coinsurance	• Some surgery services may require preauthorization review. • Assistant surgeon fees are payable at 20% coinsurance of the surgeon's contracted or Allowed Charge.
If you need immediate medical attention	Emergency room care	15% coinsurance after $50 ER copay/visit	15% coinsurance after $50 ER copay/visit	15% coinsurance after $50 ER copay/visit	• Copay is waived if admitted; hospital admission copay applies • Professional/physician charges may be billed separately.
	Emergency medical transportation	Ground: 20% coinsurance Air or Sea:15% coinsurance	Ground or Sea: 20% coinsurance Air: 15% coinsurance	Ground or Sea: 20% coinsurance Air: 15% coinsurance	Air or Sea ambulance is subject to medical necessity review and covered if the transport is to the nearest equipped facility.

* For more information about limitations and exceptions, see the plan or policy document at www.pwga.org.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Area Provider	Non-Network (You will pay the most)	
	Urgent care	15% coinsurance	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance after $100 copay/admission (No charge after $100 copay/admission through TIHN)	20% coinsurance after $100 copay/admission	40% coinsurance after $100 copay/admission	Requires preauthorization review. Private room payable only if medically necessary or the hospital only has private rooms (payable at semi-private room rate).
	Physician/surgeon fees	15% coinsurance (No charge after $100 copay/admission through TIHN)	20% coinsurance	40% coinsurance	$100 copay applies to surgeon fees through TIHN.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and other outpatient services: 15% coinsurance LiveHealth online: $10 copay/visit, deductible does not apply.	Office visits and other outpatient services: 20% coinsurance	Office visits and other outpatient services: 40% coinsurance	Facility requires preauthorization review (includes Intensive Outpatient Programs and Partial Hospitalization).
	Inpatient services	15% coinsurance after $100 copay/admission	20% coinsurance after $100 copay/admission	40% coinsurance after $100 copay/admission	Requires preauthorization review. Private room payable only if medically necessary or the hospital only has private rooms (payable at semi-private room rate).
If you are pregnant	Office visits	Prenatal care: No charge Office visits: 15% coinsurance	20% coinsurance	40% coinsurance	• Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound)
	Childbirth/delivery professional services	15% coinsurance (No charge after $100 copay/admission through TIHN)	20% coinsurance	40% coinsurance	• Delivery expenses are not covered for dependent children • Preauthorization is required if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section • Private room payable only if medically necessary or the hospital only has private rooms (payable at semi-private room rate)
	Childbirth/delivery facility services	15% coinsurance after $100 copay/admission (No charge after $100 copay/admission through TIHN)	20% coinsurance after $100 copay/admission	40% coinsurance after $100 copay/admission	
If you need help	Home health care	15% coinsurance	20% coinsurance	40% coinsurance	Requires preauthorization review to avoid services not being covered.

* For more information about limitations and exceptions, see the plan or policy document at www.pwga.org.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Area Provider	Non-Network (You will pay the most)	
recovering or have other special health needs	Rehabilitation services	Inpatient: 15% coinsurance after $100 copay/admission (No charge after $100 copay/admission through TIHN) Outpatient: 15% coinsurance	Inpatient: 20% coinsurance after $100 copay/admission Outpatient: 20% coinsurance	Inpatient: 40% coinsurance after $100 copay/admission Outpatient: 40% coinsurance	Requires preauthorization review to avoid services not being covered.
	Habilitation services	15% coinsurance	20% coinsurance	40% coinsurance	• Some services may require preauthorization review • Outpatient physical therapy and occupational therapy are limited to maximum allowable charge of $90/visit
	Skilled nursing care	15% coinsurance after $100 copay/admission	20% coinsurance after $100 copay/admission	40% coinsurance after $100 copay/admission	Requires preauthorization review to avoid services not being covered.
	Durable medical equipment	15% coinsurance	20% coinsurance	40% coinsurance	Subject to medical necessity review.
	Hospice services	15% coinsurance	20% coinsurance	40% coinsurance	Requires preauthorization review to avoid services not being covered.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Area Provider	Non-Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Vision benefits available through VSP Vision Care.
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	Dental benefits available through Delta Dental.

* For more information about limitations and exceptions, see the plan or policy document at www.pwga.org.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (adult, child) under a separate dental plan
- Experimental or Investigational procedures
- Infertility treatment (adult) under a separate fertility plan
- Long-term care
- Private duty nursing
- Routine eye care (adult, child) under a separate vision plan

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (for chronic pain up to $60/visit)
- Chiropractic Care (up to $60/visit)
- Hearing Aids (up to $1,000 maximum/device)
- Non-emergency care when traveling outside the U.S.
- Routine foot care (for vascular impairment due to diabetes)
- Weight loss Programs (including bariatric surgery)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Writers' Guild-Industry Health Fund at 1-818-846-1015 or 1-800-227-7863.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-227-7863 (TTY: 1-818-526-3199).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-227-7863 (TTY: 1-818-526-3199).

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-227-7863 (TTY: 1-818-526-3199).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-227-7863 (TTY: 1-818-526-3199).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.pwga.org.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$400**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$110
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,530**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$400**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$880
Coinsurance	$80
What isn't covered	
Limits or exclusions	$160
The total Joe would pay is	**$1,510**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$400**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$60
Coinsurance	$380
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$840**

The plan would be responsible for the other costs of these EXAMPLE covered services.

PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

Writers' Guild-Industry Health Fund
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Writers' Guild-Industry Health Fund (the "Fund") is required by law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Standards for Privacy of Individually Identifiable Health Information, known as the "Privacy Rule," to maintain the privacy of protected health information ("PHI") maintained by the health care components of the Fund, and to notify affected individuals following a breach of unsecured PHI. All references to the "Fund" in this notice regarding privacy apply only to such health care components. The Fund must provide participants with notice of its legal duties and privacy practices with respect to PHI.

This Notice of Privacy Practices ("Notice") describes the Fund's privacy practices regarding PHI. Any insurers or HMOs that provide or fund benefits under the Fund should provide you with a separate description of their own privacy practices. Similarly, your personal doctor or any other health care provider may have different policies or notices regarding the use and disclosure of the PHI they create or receive.

This Notice describes how the Fund may use and disclose PHI about you and it explains your legal rights regarding PHI.

The term "PHI" means information created or received by the Fund that identifies you and relates to your past, present or future health, treatment or payment for health care services. This may include information regarding enrollment and eligibility.

This Notice is effective as revised as of March 1, 2013.

How the Fund May Use and Disclose PHI

In order to provide you with health coverage, the Fund needs PHI about you. The Fund obtains that information from many different sources. In administering your health benefits, the Fund may use and disclose PHI in various ways, as described in this Notice.

Uses and Disclosures for Treatment, Payment and Health Care Operations - Without Your Authorization

The Fund may use or disclose PHI for health care operations, payment functions, and treatment, without your authorization:

Health Care Operations: The Fund may use and disclose PHI as part of the general administrative or business functions that the Fund performs in order to function as a health plan. This includes that that the Fund may use PHI in connection with operational activities such as quality assessment and improvement; performance measurement and outcomes assessment; and preventive health, disease management, case management and care coordination. Also, for example, the Fund may use the PHI in the administration of detection and investigation of fraud; evaluating provider performance; enrollment, premium rating and similar activities; submitting claims for stop-loss (or excess loss) coverage; legal services, audit services, and other general administrative activities, including data and information systems management and participant services.

Payment: To help pay for your covered services, the Fund may use and disclose PHI in a number of ways – including conducting utilization and medical necessity reviews; coordination of benefits, subrogation; determining eligibility; collecting premiums; calculating cost sharing amounts; and responding to complaints, claims, and appeals. For example, the Fund may use your medical history and other PHI about you to decide whether a particular treatment is medically necessary and what the payment should be – and during the process, the Fund may disclose PHI to your provider. The Fund also mails Explanation of Benefits forms and other information to the address we have on record for the participant (i.e., the primary insured). The Fund may also disclose your PHI to another health plan or a health care provider for its payment activities.

Treatment: Although the Fund does not provide treatment, the Fund may use or disclose your PHI in connection with the provision, coordination or management of your health care treatment, including disclosing PHI to doctors, dentists, pharmacies, hospitals and other health care providers who take care of you. For example, doctors may request PHI from the Fund to supplement their own records, and the Fund may send certain information to doctors for patient safety or other treatment-related reasons.

Disclosure to Business Associates: In any circumstance where the Fund discloses PHI to a third party that performs a service on behalf of the Fund (for example, in connection with
Fund health care operations, payment activities or treatment-related activities), the Fund will have a written contract with that entity requiring the entity to protect the privacy of your PHI.

Disclosures to the Plan Sponsor

Without your authorization, the Fund may disclose PHI to the Fund's Board of Trustees as Plan Sponsor, but only for the purposes of activities performed by the Plan Sponsor on behalf of the Fund. The Plan Sponsor may not use such PHI for any other purpose and is required to safeguard the privacy of your PHI. In addition, the Fund may disclose "summary health information" to the Fund's Board of Trustees to obtain premium bids or to make changes to the Fund's benefits. Summary health information summarizes the claims history, claims expenses or type of claims experienced under a group health plan, and does not include information that would identify any individual.

Disclosure to Your Representatives

Individuals Involved in Your Care or Payment For Your Care: Unless you object in writing, the Fund may disclose PHI to a close friend or family member involved in or who helps pay for your health care, but only to the extent relevant to that friend or family member's involvement in your care or payment for your care. For example, if a family member or a caregiver calls the Fund with prior knowledge of a claim, the Fund may confirm whether the claim has been received and paid.

Personal Representatives: The Fund may disclose your PHI to your personal representative in accordance with applicable state law (e.g., to parents if you are an emancipated child under 18, to those with unlimited powers of attorney, etc.).

Other Permitted Uses and Disclosures of PHI

The Fund may also use or disclose your PHI without your authorization for any of the following purposes:

Required By Law: The Fund may use or disclose your PHI to the extent that the Fund is required to do so by federal, state or local law. For example, the Fund must respond to a request for disclosure of PHI if the Secretary of the U.S. Department of Health and Human Services is investigating or determining the Fund's compliance with the federal privacy rules.

Public Health: The Fund may disclose your PHI for public health and safety purposes to a public health authority that is permitted by law to collect or receive the information. For example, your PHI may be used or disclosed for the purpose of preventing or controlling disease (including communicable diseases), injury or disability, and, with your permission, may disclose certain immunization records to schools.

Health Oversight: The Fund may disclose your PHI 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.

Abuse or Neglect: The Fund may disclose your PHI to any public health authority authorized by law to receive information about abuse, neglect or domestic violence if the Fund reasonably believes that you have been a victim of abuse, neglect or domestic violence. In this case, the Fund will inform you that such a disclosure has been or will be made unless that notice will cause a risk of serious harm.

To Avert a Serious Threat to Health or Safety: The Fund may use or disclose your PHI when reasonably necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure,

however, would only be to someone reasonably able to help prevent or lessen the threat.

Legal Proceedings: The Fund may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal. In addition, the Fund may disclose your PHI under certain conditions in response to a subpoena, court-ordered discovery request or other lawful process, in which case reasonable efforts must be undertaken by the party seeking the PHI to notify you and give you an opportunity to object to the disclosure.

Law Enforcement: The Fund may disclose your PHI if requested by a law enforcement official as part of certain law enforcement activities.

Deceased Individuals: The Fund may disclose your PHI to a coroner or medical examiner for identification purposes, or other duties authorized by law. The Fund may also disclose your PHI to a funeral director, as authorized by law, and in order to permit the funeral director to carry out his/her duties. The Fund may disclose such information in reasonable anticipation of death. The Fund may also disclose PHI for cadaveric organ, eye or tissue donation purposes, if you are an organ donor. The Fund may PHI is protected for 50 years after death.

Research: The Fund is permitted to disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has established protocols to ensure the privacy of your PHI.

Military Activity and National Security: When the appropriate conditions apply, the Fund may use or disclose PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by military command authorities; or (2) to a foreign military authority if you are a member of that foreign military service. The Fund may also disclose your PHI to authorized federal officials conducting national security and intelligence activities.

Workers' Compensation: The Fund may disclose your PHI to comply with workers' compensation laws and other similar legally established programs.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Fund may disclose your PHI to the institution or official if the PHI is necessary for the institution to provide you with health care; to protect the health and safety of you or others; or for the security of the correctional institution.

Uses and Disclosures of PHI That Require Your Written Authorization:

The Fund will not use or disclosure your PHI for the following purposes without your prior written authorization:

Psychotherapy Notes: Except for certain narrow exceptions permitted by law (such as legal defense in a proceeding you bring against us), the Fund will not use or disclose any mental health professional's psychotherapy notes (discrete notes that document the contents of conversation during counseling sessions) without your prior authorization.

Marketing or Sales: The Fund will not use or disclose your PHI for any paid marketing activities or sell your PHI without your prior authorization.

Uses and Disclosures Not Described in This Notice:

Other uses and disclosures of PHI not described in this Notice will be made only with your written authorization before using or disclosing your PHI. If you have given the Fund an authorization, you may revoke it at any time, if the Fund has not already acted on it. The Fund is unable to take back any disclosures already made with your authorization. If you have questions regarding authorizations, please contact the Fund's Privacy Official.

No Use or Disclosure of Genetic Information for Underwriting:

The Fund is prohibited by law from using or disclosing PHI that is genetic information of an individual for underwriting purposes. Generally, genetic information involves information about differences in a person's DNA that could increase or decrease his or her chance of getting a disease (for example, diabetes, heart disease, cancer or Alzheimer's disease).

Additional Special Protections:

Additional special privacy protections, under federal or state law, may apply to certain sensitive information, such as genetic information, HIV-related information, alcohol and substance abuse treatment information, and mental health information. If you have questions please contact the Fund's Privacy Official.

Your Legal Rights

The Privacy Rule gives you the right to make certain requests regarding PHI about you. You may ask the Fund to:

- Communicate with you in a certain way or at a certain location. The Fund will honor reasonable requests if the communication could endanger you.

- Restrict the way the Fund uses or discloses PHI about you in connection with health care operations, payment and treatment. You also have the right to ask the Fund to restrict disclosures to persons involved in your health care. While the Fund will consider reasonable requests, the Fund is (except as set forth below) not required to agree to your request. Except as otherwise required by law (and excluding disclosures for treatment purposes), the Fund is obligated, upon your request, to refrain from sharing your PHI with another health plan for purposes of payment or carrying out health care operations if the PHI pertains solely to a health care item or service for which you or someone on your behalf (other than the Fund), has fully paid the health care provider "out- of-pocket."

- Provide you with access to or a copy of PHI that is contained in a "designated record set" – records used in making enrollment, payment, claims adjudication, medical management and other decisions. If the Fund uses or maintains an electronic health record with respect to your PHI, you may request such PHI in an electronic format, and direct that such PHI be sent to another person or entity. The Fund may ask you to make your request in writing, may charge a reasonable fee for producing and mailing the copies and, in certain cases, may deny the request.

- Amend PHI that is in a "designated record set." Your request must be in writing and must include the reason for the request. If the Fund denies the request, you may file a written statement of disagreement. If your doctor or another person created the PHI that you want to change, you should ask that person to amend the information.

- Provide you with a list (an "accounting") of certain non-routine disclosures of your PHI maintained by the Fund made within six years (or less) of the date on which the accounting is requested. In general, the list will not include disclosures made (a) in connection with your receiving treatment, payment for such treatment, and for the Fund's health care operations; (b) to you regarding your own PHI; (c) pursuant to your written authorization; (d) to a person involved in your care; or other similar

authorized person; or (e) for national security. If you request such an accounting more than once in a 12-month period, the Fund may charge a reasonable fee.

You may make any of the requests described above, or may request a paper copy of this Notice, by contacting the Fund's Privacy Official.

You also have the right to file a complaint if you think your privacy rights have been violated. To do so, please contact the Fund's Privacy Official. You also may write to the Secretary of the U.S. Department of Health and Human Services. The Fund will not retaliate against you for making a complaint.

The Fund's Legal Obligations

The Fund is required by law to keep PHI about you private (to the extent provided by the Privacy Rule and other applicable laws), to give you notice of its legal duties and privacy practices with respect to your PHI, and to follow the terms of the Notice currently in effect. This Notice is provided to you based solely on the Privacy Rule requirements and serves no purpose under the Employee Retirement Income Security Act of 1974 ("ERISA"), and accordingly is not a document governing the Fund under ERISA.

This Notice is Subject to Change

The Fund may change the terms of this Notice and its privacy policies at any time. If the Fund does, the new terms and policies may then be applied to all PHI previously received and then maintained by the Fund, as well as PHI created or received in the future. If the Fund makes any material changes to this Notice, the Fund will distribute a new notice to its participants.

Contact Information

If you have questions, requests or complaints regarding this Notice, please write to the Fund's Privacy Official:

Writers' Guild-Industry Health Fund
Attn: Privacy Official
2900 W. Alameda Ave. Suite 1100
Burbank, California 91505
(818) 846-1015

PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

SUMMARY DESCRIPTION
OF THE
EXTENDED COVERAGE PROGRAM

Beginning April 1, 2000, Writers will be credited with a point for each year of regular, employer-paid eligibility commencing on and after January 1, 1990. Additional points may be credited for each earnings cycle in which a Writer earns *$100,000 or more in covered compensation. Once a Writer accumulates a sufficient number of points, the points will be applied to provide an extension of Health Fund coverage should the Writer not have sufficient earnings to qualify for regular employer-paid coverage. The extension of coverage will be provided without cost to the Writer and will precede any COBRA coverage the Writer may be entitled to purchase. A brief description of the Program and how it works is provided below.

HOW THE PROGRAM WORKS

If the Writer loses eligibility under the Health Fund due to failure to earn sufficient compensation within his or her earnings cycle, and has accumulated at least 10 points at any time, the Writer will be advised of extended coverage available under the program and asked to select the benefit plan desired.

- ❑ Full Plan – Ten Points for one year of coverage
- ❑ Low Option Plan – Six Points for one year of coverage

For each quarter that a participant receives benefits under this program, the applicable number of points will be deducted. This process will continue until: 1) the participant regains eligibility based upon satisfaction of the earnings requirement within the appropriate earnings cycle; or 2) the participant retires under the Producer-Writers Guild of America Pension Plan as a Certified Retiree; or 3) there is an insufficient number of points available for continuation in the program.

Note: As long as a participant has at least 1 ½ points on the Full Plan or 1 point on the Low Option Plan remaining, he or she will be granted one last quarter of coverage in the plan then in effect.

Once all points are exhausted and eligibility is not regained based upon covered employment or Certified Retiree status, the participant and all eligible dependents will be offered participation in the COBRA continuation coverage program.

Under this new program, the Health Fund will award points for Writers' past and future participation, as follows:

One (1) point will be awarded for each four-quarter earnings cycle, which resulted in Health Fund eligibility

One (1) additional point will be awarded for each four-quarter earnings cycle during which the writer earned at least $125,000 in covered compensation as reported to the Health

Fund

One (1) additional point will be awarded for each four-quarter earnings cycle during which the writer earned at least $250,000 or more in covered compensation as reported to the Health Fund

Thus, a Writer may earn up to three points for a four-quarter earnings cycle in which the Writer earned Health Fund eligibility. For example, if a Writer earned eligibility during an earnings cycle, he or she would be credited with one point for the four quarters of eligibility. If he or she earned $125,000, there would be an additional point credited for a total of two points for that earnings cycle. If the writer earned $250,000 or more during that earnings cycle, one additional point would be credited for a total of three points for that earnings cycle. Once a Writer has accumulated at least ten (10) points at any time, he or she will be eligible for an extension of coverage should regular, employer-paid eligibility lapse.

For all extended coverage point threshold minimums, please refer to the point chart on the last page.

ADDITIONAL RULES RELATED TO THE PROGRAM

Writers will be able to accumulate up to a maximum of fifty - (50) points.

Participants **must** use points if employer-paid eligibility is lost and points are available to 'purchase' coverage.

Points will be determined on an "earnings cycle" basis and awarded as of the beginning of each writer's "eligibility cycle". Writers will receive a statement from the Health Fund that will indicate the number of points previously accumulated, the number of points earned during the most recent earnings cycle, the number of points used during the most recent eligibility cycle and the number of points currently available.

Eligibility will be extended in minimum increments of one calendar quarter and points will be deducted at the beginning of each such quarter.

Only full points will be awarded, but fractional points may be used for extending eligibility.
Ten points will 'purchase' four calendar quarters of eligibility for full benefits, including regular Medical, Hospital, Dental, Prescription Drug, Vision, Life Insurance, Accidental Death & Dismemberment and Wellness benefits and will be charged at the rate of 2 ½ points per quarter.

Six points will 'purchase' four calendar quarters of eligibility for the Low-Cost Plan which includes regular Medical and Hospital benefits only but with higher annual deductibles, co-payments and annual out-of-pocket maximums, and will be charged at the rate of 1 ½ points per quarter.

Extended eligibility will be provided on a composite, full-family basis only. No individual or tiered coverage will be allowed.

A Participant's points will be forfeited upon election of Certified Retiree Health Fund Coverage or the death of the Participant. However, extended coverage will be provided to the surviving spouse

and eligible dependent children of a deceased Participant using the remaining points credited to the deceased Participant.

Each Writer of a *bona fide* writing team must earn his or her own entitlement to points under this Program in the same manner as for individual writers.

This Program is **not** available to the staff of the Health Fund or Pension Plan Administrative Offices, the Writers Guild of America, East, the Writers Guild of America, West and certain others, such as permanent staff news writers of ABC, CBS, and NBC. (Temporary staff news writers will be eligible to participate, however.)

Eligibility extended through this program does not count toward satisfaction of the earned coverage requirement for the Certified Retiree Health Fund program, nor does any such extended coverage generate points under this Program.

Accumulation of points under this Program will be coordinated with the "High Earners" or "$250,000 extension" of eligibility in gross compensation in one earnings cycle but who would otherwise lose coverage because they did not earn enough compensation in the next earnings cycle to be eligible. Extension of eligibility will be first granted on the basis of the 'High Earners" extension and then, if necessary and available, based upon points accumulated as described.

COMMENTS

As with all benefits provided under the Writer's Guild-Industry Health Fund, this Program may be modified, amended or terminated at any time by the sole discretion of the Board of Trustees, if deemed necessary and in the best interest of the Fund.

If you should have any questions about this program or your entitlement to coverage, please contact the Eligibility Department at the phone number below and select option "1" then options "2" from the Main Menu.

Sincerely,
Board of Trustees

EXTENDED COVERAGE PROGRAM POINT THRESHOLD CHART

Earnings Minimum for Second Point	Earnings Minimum for Third Point	Earnings Cycle Effective Date	Earnings Cycle Effective Date	Earnings Cycle Effective Date	Earnings Cycle Effective Date
$100,000	$200,000		04/01/00	07/01/00	10/01/00
103,252	200,000	01/01/01	04/01/01	07/01/01	10/01/01
106,089	200,000	01/01/02	04/01/02	07/01/02	10/01/02
108,741	200,000	01/01/03	04/01/03	07/01/03	10/01/03
111,460	200,000	01/01/04	04/01/04	07/01/04	10/01/04
113,968	204,500	01/01/05	04/01/05	07/01/05	10/01/05
116,534	209,101	01/01/06	04/01/06	07/01/06	10/01/06
119,156	213,806	01/01/07	04/01/07	07/01/07	10/01/07
122,731	220,220	04/01/08	07/01/08	10/01/08	01/01/09
126,413	226,827	07/01/09	10/01/09	01/01/10	04/01/10
130,205	233,631	07/01/10	10/01/10	01/01/11	04/01/11
132,809	238,304	07/01/11	10/01/11	01/01/12	04/01/12
135,133	242,474	07/01/12	10/01/12	01/01/13	04/01/13
137,498	246,717	07/01/13	10/01/13	01/01/14	04/01/14
125,000	250,000	And Beyond….			

PWGA
Pension & Health Plans
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COBRA Continuation Coverage General Notice of Rights

April 25, 2018

COBRA CONTINUATION COVERAGE
GENERAL NOTICE OF RIGHTS

This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

If you are considering COBRA for yourself or your family, you may want take a look at some of the Affordable Care Act offerings which are often high in quality and substantially lower in cost.

INTRODUCTION You are receiving this notice because you have recently become covered under the Writers' Guild-Industry Health Fund. This notice contains important information about your right to COBRA continuation coverage, which is a self-paid temporary extension of coverage under the Fund.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

For additional information, we suggest you review the Fund's Summary Plan Description or contact us at the Health Fund office so that we can answer any questions you might have.

YOU MAY HAVE OTHER OPTIONS AVAILABLE TO YOU WHEN YOU LOSE GROUP HEALTH COVERAGE COBRA continuation coverage can be very expensive. There are high quality, far less costly options available to you. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs.

In addition to the Health Insurance Marketplace, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE? COBRA continuation coverage is a continuation of Health Fund coverage when coverage would otherwise end because of a life

event known as a "qualifying event." Specific qualifying events are listed later in this notice.

After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Health Fund is lost because of the qualifying event. Under the Fund, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are a covered plan participant, you will become a qualified beneficiary if you lose your coverage under the Fund because of the following qualifying event:

- Loss of coverage due to reduction of qualified earnings.
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a covered plan participant, you will become a qualified beneficiary if you lose your coverage under the Fund because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse loses coverage due to reduction of qualified earnings; or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Fund if any of the following qualifying events occur:

- The parent/plan participant dies;
- The parent/plan participant loses coverage due to reduction of qualified earnings;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Fund as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed and that bankruptcy results in the loss of coverage of any retired plan participant covered under the Health Fund, the retired plan participant may become a qualified beneficiary with respect to the bankruptcy. The retired plan participant's spouse, surviving spouse, and dependent children may also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Fund.

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE? The Health Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Health Fund determines that one of the following qualifying events has occurred:

- Termination of coverage due to reduction of qualified earnings,
- Death of the plan participant, or
- For retired plan participants covered by the Fund, commencement of a proceeding in bankruptcy, if applicable.

For all other qualifying events you must notify the Administrative Office of a divorce, legal separation or a child's loss of dependent status within 60 days after the date of the qualifying event. If you do not, the time limit to elect COBRA Continuation Coverage will be exhausted and your qualified dependent(s) will lose their right to elect COBRA Continuation Coverage.

HOW IS COBRA COVERAGE PROVIDED? Once the Health Fund Administrator determines or receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage.

- Covered plan participants may elect COBRA continuation coverage on behalf of their spouses

- Parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. 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.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

DISABILITY EXTENSION OF 18-MONTH PERIOD (OR 24-MONTH PERIOD, IF APPLICABLE) OF CONTINUATION COVERAGE If you or anyone in your family covered under the Fund is determined by the Social Security Administration to be disabled and you notify the Health Fund Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months (or 5 months if the initial 24-month period applies) of COBRA continuation coverage, for a total maximum of 29 months.

The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 or 24-month period. You are required to provide written proof of a disability determination by the Social Security Administration within 60 days of such determination. You are also required to provide written notification of a determination that the qualified beneficiary is no longer disabled within 30 days of such determination. This information must be provided to the Eligibility Department of the Fund by mail to 2900 W Alameda Ave Suite 1100, Burbank, CA 91505 or by fax to 818-566-8445.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD (OR 24-MONTH PERIOD, IF APPLICABLE) OF CONTINUATION COVERAGE If your family experiences another qualifying event while receiving the first 18 or 24 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months (or 12 additional months if the initial 24-month period applies) of COBRA continuation coverage, for a maximum of 36 months – *if notice of the second qualifying event is properly given to the Fund*.

This extension may be available to the spouse and any dependent children receiving continuation coverage if the plan participant or former plan participant dies, enrolls in Medicare (under Part A, Part B, or both), gets divorced or legally separated, or if the dependent child stops being eligible under the Fund as 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.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at: www.healthcare.gov

IF YOU HAVE QUESTIONS Questions concerning your Fund or our COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Care Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health Funds, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website) For more information about the Marketplace, visit: www.HealthCare.gov

KEEP YOUR FUND INFORMED OF ADDRESS CHANGES In order to protect your family's rights, you should keep the Fund informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund.

FUND CONTACT INFORMATION:

Eligibility Department
Writers' Guild-Industry Health Fund
2900 Alameda Ave
Suite 1100
Burbank, California 91505
(818) 846-1015 or (800) 227-7863
www.wgaplans.org

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Pension & Health Plans
YOUR TRUSTED GUIDE

Important Forms And Information

This folder contains important forms that must be completed to update our records, as well as information about the Health Fund coverage.

Please complete:

- New Participant Registration Form
- The Dependent Enrollment form, if applicable (You must prepay a $150 quarterly dependent premium in order for dependents to be eligible for coverage, family must be added by 30 days of your coverage start date.)
- Health Authorization for Release of Information form (Complete this form ONLY if you want to designate someone other than yourself to call on your behalf and receive personal information about you, i.e., a business manager or spouse)
- Pension Authorization Release Form
- The Designation of Life Insurance Beneficiary form
- The Coordination of Benefits form

Also enclosed are documents for your review:

- Paid Parental Leave Guide

Please take a moment to fill out the forms and send them directly to the Fund Office at the following address. Enclosed is a self-addressed envelope for your convenience.

Writers' Guild – Industry Health Fund
2900 W Alameda Ave Suite 1100
Burbank CA 91505

Please take a moment to review the attached information. If you have any questions, feel free to contact the Eligibility Department at the Fund Office, (818) 846-1015, or visit our website at www.wgaplans.org.

PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

NEW PARTICIPANT REGISTRATION FORM

Congratulations! We have received contributions on your behalf from your Guild signatory employer(s). To ensure that we have all your correct information for claims processing and PWGA correspondence, please complete the registration form below and return it to the Administrative Office.

		WRXA
PARTICIPANT NAME		HEALTH FUND ID NUMBER
Is the name listed above used when filing your Federal Tax return? YES ☐ NO ☐ If NO, please provide the name submitted with your Tax Return on the line below.		
Name Listed on Tax Return:		
STREET ADDRESS		SOCIAL SECURITY NUMBER
STREET ADDRESS 2		DATE OF BIRTH
CITY	STATE	ZIP CODE
HOME PHONE NUMBER	WORK PHONE NUMBER	
MOBILE PHONE NUMBER	EMAIL ADDRESS	
2ND EMAIL ADDRESS (optional)		

Signature

Please submit this completed form using one of the below methods:

Mail: 2900 W Alameda Ave, Suite 1100 Burbank, CA 91505

Fax: 818-526-3180

Email: Send an email to the Eligibility Department at emailbox@wgaplans.org. In the subject line type: **SECURE LINK;** in the message area type: **Participant Registration Form**. However, **DO NOT** attach your completed form with this email. We will respond to your email with a **Zix** secure email. You must register, and then you may upload your form to our secure email, and send it back to our office.

If you have any questions regarding this information, please feel free to contact us at:
818-846-1015 or 800-227-7863 select 1, and then 2 at the menu prompt.

We are here to be your Trusted Guide.

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Dependent Enrollment and Reinstatement Form

To add or reinstate your dependent(s) to your insurance policy, complete this form and make sure to circle the appropriate relationship code below. If more room is necessary use the back of this sheet. **Dependents must be added within 30 days** of the qualifying event. Regarding required documents, a **hospital birth record or marriage license** can be submitted, however, a photocopy of the certified document will be required within 120 days. You must pay a quarterly dependent premium of **$150.00 ($600 per year)** to cover all of your dependents. **Once your dependent(s) have been enrolled,** you may pay your quarterly premium online through our website, www.wgaplans.org. After paying your current premium due, you may enroll in Autopay. Once enrolled, all future premium payments will be automatically charged to the card on file. You may also pay by check, **make check payable to PWGA, include member ID number on the check and mail it to the address listed below.**

Online payment:
www.pwga.org
Sign in/Register
My Plans

E-mail Documents:
Emailbox@wgaplans.org PWGA

Mail documents:
PWGA
2900 W Alameda Ave
Suite 1100
Burbank CA 91505

Mail payments:
WGA Health Fund Participant
Dept LA 25118
Pasadena CA 91185-5118

Relationship Documents and Codes:

SPOUSE-SP:	A photocopy of the certified marriage certificate.
CHILD-CH/SC:	A photocopy of the certified birth certificate.
ADOPTION-AC, FOSTER CARE-KC, GUARDIANSHIP-KC:	A photocopy of the adoption/release or guardianship placement documents.

Dependent Codes: SP (Spouse) **CH** (Child) **AC** (Adopted Child) **SC** (Step Child) **KC** (Legal Ward Child)

Name of Participant _____ Address _____ Participant ID. # _____ DOB _____

E-Mail Address_____ Phone Number_____

PLEASE LIST EACH DEPENDENT'S LEGAL NAME ☐ Check this box if more dependents are listed on the back

First Name MI Last Name	SP CH SC KC	Soc. Sec. #	DOB	Sex
First Name MI Last Name	SP CH SC KC	Soc. Sec. #	DOB	Sex
First Name MI Last Name	SP CH SC KC	Soc. Sec. #	DOB	Sex
First Name MI Last Name	SP CH SC KC	Soc. Sec. #	DOB	Sex

PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

Authorization for Use/Disclosure Protected Health Information (PHI)

The Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") under federal law requires certain protection and limitations on the disclosure of protected health information (PHI). PHI means information created or received by the Fund that identifies an individual and relates to the individual's past, present or future health, treatment or payment for health care services. PHI may include information regarding enrollment and eligibility.

In many cases, the Privacy Rule limits the Fund's ability to disclose PHI without appropriate authorization. While you are not required to grant an authorization, in certain circumstances, if you do not grant an authorization the Fund cannot disclose your PHI. In order to be valid, the authorization must include the beginning and end dates for the authorization. The authorization must also name the receiving individual/organization and provide a specific description of the information to be disclosed. You may name more than one individual or entity on this agreement only if they may all receive the same information. If each has authority to receive different information, separate authorizations are required.

The Plan will not use or disclose your protected health information without your Authorization except as described in the Plan's Notice of Privacy Practices. If you want the Plan to use or disclose your protected health information in a way that requires your Authorization, complete this Authorization form and submit it as instructed below.

This Authorization is not valid without your dated signature.

THIS AUTHORIZATION MUST BE COMPLETED IN FULL FOR IT TO BE VALID

Information about the Use or Disclosure

Participant Name:_____ Participant ID#_____

If the person/entity being authorized is not the Participant, please fill out the below:

Authorized party is: Participant____ Spouse___ Domestic Partner___ Child____ Other___

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Authorization for Use/Disclosure of Protected Health Information (PHI)

I hereby authorize the Fund to disclose certain individually identifiable health information to the following person below for the purposes described below:

Name & Organization *(if applicable)* (If organization, attach a listing of personnel authorized to receive disclosed information)	
Relationship or Title	
Address	
City, State & Zip	
Phone Number	
Last Four Digits of Social Security Number	

Information to be used or disclosed:

All information related to: Claim Status_____ Eligibility_____ Contribution_____

OR

Release only the following specific information (fill out all that apply)

All of my health information from: _____ through _____
(month/day/year) (month/day/year)

All of my health information relating to my treatment for _____
(condition)
from _____ through _____
(month/day/year) (month/day/year)

All of my health information related to my treatments provided by _____
(provider of service)
from _____ through _____
(month/day/year) (month/day/year)

Other (be as specific as possible)_____

_____

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Authorization for Use/Disclosure of Protected Health Information (PHI)

This Authorization will begin on_____ (effective date) and will remain in effect until_____ (expiration date or event)

This Authorization shall expire no later than two years from the date of execution. You may revoke this Authorization at any time earlier than the expiration date or event by writing to the Plan at the following address:

Writers' Guild-Industry Health Fund
Attention: Privacy Official
2900 W Alameda Ave Suite 1100
Burbank, CA 91505

Revocation forms are available upon request from the above address. If you revoke your Authorization, the Plan will no longer disclose your protected health information except as described in the Plan's Notice of Privacy Practices or as permitted under your remaining Authorizations, if any. I understand that the revocation will not be effective until I receive written confirmation from the Fund.

Important Information About Your Rights

I hereby authorize the Plan to use and disclose my protected health information in accordance with this Authorization. I understand that protected health information disclosed in accordance with this Authorization may be re-disclosed by the recipients listed in this Authorization and, as a result, may no longer be protected under applicable health privacy laws or under the Plan's privacy practices. I understand that, without my Authorization, the Plan may use my protected health information only as described in the Plan's Notice of Privacy Practices or as permitted under my remaining non-revoked Authorizations, if any. I understand that I am not required to sign this form to receive my health care benefits.

This Authorization is made at my request. I understand that payment of my Plan claims and eligibility for my Plan benefits are not affected by my decision to complete this Authorization form.

I understand that this Authorization is valid until the revocation date indicated above, or until I revoke this Authorization in writing (but no longer than two years). I understand that I have the right to revoke this Authorization at any time, except to the extent that the Plan has already used or disclosed my protected health information in reliance on the Authorization.

Signature _____ Date _____

Copy of this Authorization

You are entitled to a copy of this authorization. If you do not want the Fund to send you a copy, please check this box: ☐

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Authorization for Use/Disclosure of Protected Health Information (PHI)

Authorization to Release Information

The Participant should complete this form, only if the Participant would like to authorize a person or entity to receive Pension information on his/her behalf. *Unless this form is returned (signed and dated by the Participant), information will not be released to any unauthorized third party*. This authorization will remain in effect until such time that the Participant notifies the Administrative Office in writing. A photocopy of this form will be treated as an original, with the full force and power of said original.

SECTION 1	**PARTICIPANT INFORMATION**
Please print or type the information below for the Participant.	
NAME	SOCIAL SECURITY NUMBER OR UNIQUE IDENTIFIER

SECTION 2	**AUTHORIZED THIRD PARTY INFORMATION**	
Please print or type the information below for the third party authorized to receive Pension information on behalf of the Participant.		
NAME OF INDIVIDUAL OR ENTITY	ALL INDIVIDUALS REPRESENTING ENTITY OR INDIVIDUAL NAMES (CHECK ONLY ONE AND LIST, IF APPLICABLE)	
	❑ ALL INDIVIDUALS REPRESENTING ENTITY, OR ❑ ONLY THE FOLLOWING INDIVIDUALS:	
STREET ADDRESS		
CITY	STATE	POSTAL CODE
TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS
ADDRESS INFORMATION RELATIVE TO PARTICIPANT (PLEASE CHECK THE BOX BELOW TO INDICATE THAT THE ADDRESS ON RECORD FOR THE PARTICIPANT SHOULD BE UPDATED. IF THE BOX IS NOT CHECKED, THEN THE PARTICIPANT'S ADDRESS WILL NOT BE UPDATED.)		
❑ UPDATE THE PARTICIPANT'S ADDRESS ON RECORD FOR PENSION PURPOSES TO THE ADDRESS IN THIS SECTION (2).		

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Authorization for Use/Disclosure of Protected Health Information (PHI)

SECTION 3	PARTICIPANT'S ACKNOWLEDGEMENT

I, the Participant, authorize the individual or entity in Section 2 to receive Pension information from the Producer-Writers Guild of America Pension Plan (the "Plan") and that the Plan may act under this authorization upon receipt. I agree to hold the Plan harmless from any claims that may arise against the Plan because of the Plan's reliance on this authorization. I understand that this authorization will remain in effect unless and until I notify the Administrative Office in writing.

NAME	DATE	SOCIAL SECURITY NUMBER OR UNIQUE IDENTIFIER

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of _____)
County of _____)

On _____, before me, _____(insert name and title of the officer), personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity, and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____
Notary Public Signature (Seal)

IMPORTANT

Authorization to Release Information

Due to enhanced security measures, Authorization to Release Information forms require either:

1) Notarization* of the PWGA Authorization to Release Information form

OR

2) Completion of a video call with a Plan representative in order to validate the identification of the Participant.

(*The Plan office will accept traditionally notarized forms (signed in person with a notary public) via US mail to the address below. Remote online notarized forms are only accepted via email at Emailbox@wgaplans.org.)

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Authorization to Release Information

The Participant/Beneficiary should complete this form, only if the Participant/Beneficiary would like to authorize a person or entity to receive Pension information on his/her behalf. *Unless this form is returned (signed and dated by the Participant/Beneficiary), information will not be released to any unauthorized third party.* This authorization will remain in effect until such time that the Participant/Beneficiary notifies the Administrative Office in writing. A photocopy of this form will be treated as an original, with the full force and power of said original.

SECTION 1 PARTICIPANT/BENEFICIARY INFORMATION

Please print or type the information below for the Participant or Beneficiary

NAME	SOCIAL SECURITY NUMBER OR UNIQUE IDENTIFIER

TELEPHONE NUMBER (REQUIRED)	E-MAIL ADDRESS (REQUIRED)

SECTION 2 AUTHORIZED THIRD PARTY INFORMATION

Please print or type the information below for the third party authorized to receive Pension information on behalf of the Participant or Beneficiary.

NAME OF INDIVIDUAL OR ENTITY	ALL INDIVIDUALS REPRESENTING ENTITY OR INDIVIDUAL NAMES (CHECK ONLY ONE AND LIST, IF APPLICABLE)
	❑ ALL INDIVIDUALS REPRESENTING ENTITY, OR ❑ ONLY THE FOLLOWING INDIVIDUALS:

STREET ADDRESS

CITY	STATE	POSTAL CODE

TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS

ADDRESS INFORMATION RELATIVE TO PARTICIPANT/BENEFICIARY (PLEASE CHECK THE BOX BELOW TO INDICATE THAT THE ADDRESS ON RECORD FOR THE PARTICIPANT/BENEFICIARY SHOULD BE UPDATED. IF THE BOX IS NOT CHECKED, THEN THE PARTICIPANT/BENEFICIARY'S ADDRESS WILL NOT BE UPDATED.)

❑ UPDATE THE PARTICIPANT/BENEFICIARY'S ADDRESS ON RECORD FOR PENSION PURPOSES TO THE ADDRESS IN THIS SECTION 2.

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SECTION 3 PARTICIPANT/BENEFICIARY'S ACKNOWLEDGEMENT

I authorize the individual or entity in Section 2 to receive Pension information from the Producer-Writers Guild of America Pension Plan (the "Plan") and that the Plan may act under this authorization upon receipt. I agree to hold the Plan harmless from any claims that may arise against the Plan because of the Plan's reliance on this authorization. I understand that this authorization will remain in effect unless and until I notify the Administrative Office in writing.

SIGNATURE	DATE
SIGN HERE	

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of _____)
County of _____)

On _____, before me, _____(insert name and title of the officer), personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity, and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____
Notary Public Signature (Seal)

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DESIGNATION OF BENEFICIARY FOR LIFE INSURANCE

The Fund provides you with a life insurance benefit of $5,000.00 when you die from any cause, either on or off the job when you are covered with the Health Fund. The Fund pays the entire cost of coverage under the Life Insurance Plan. Your dependents aren't eligible for coverage under the plan.

You may choose anyone you wish to be your beneficiary, and you may change your designation at any time. Use this form to designate primary and contingent beneficiaries.

YOU MUST SIGN AND DATE THIS FORM FOR IT TO BE VALID. ALL INFORMATION IN EACH SECTION MUST BE COMPLETED TO AVOID A DELAY IN PROCESSING.

Participant Information

First Name	Middle Name	Last Name
Address	City	State ZIP
Sex	Birth date	Social Security Number
Male ☐ Female ☐		
Email Address		Phone Number

Primary Beneficiary-if this is your spouse, please provide date of Marriage _____.

First Name	Middle Name	Last Name
Address	City	State ZIP
Sex	Birth date	Social Security Number
Male ☐ Female ☐		
Phone Number	Relationship	

Contingent Beneficiary

First Name	Middle Name	Last Name
Address	City	State ZIP
Sex	Birth date	Social Security Number
Male ☐ Female ☐		
Phone Number	Relationship	

Participant Signature **Date Signed**

2900 W. Alameda Avenue ● Suite 1100 ● Burbank, CA 91505-4220 ● 818.846.1015 ● 800.227.7863 ● FAX 818.526.3180
www.wgaplans.org

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Writers' Guild Industry-Health Fund
Coordination of Benefits Form

Please submit this form with all supporting documentation to The Fund

Mailing Address: 2900 West Alameda Ave., Suite 1100, Burbank, CA 91505 or access this form on our website at: www.wgaplans.org

SUBSCRIBER INFORMATION (Please Print Clearly or Type)

Participant's Name: _____ Participant ID # WRXA _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employer Address/Phone Number _____

_____

COVERAGE INFORMATION

Please note: If you, your spouse or dependent(s) have: (check applicable box)

- ☐ No other group health insurance coverage, then sign and date the form in Part D
- ☐ Other coverage, please complete Part A1, then sign and date the form in Part D
- ☐ Been Divorced/legally separated, please complete Part A and Part B, then sign and date the form in Part D
- ☐ Medicare coverage, please complete Part C, then sign and date the form in Part D

Part A

If you, your spouse or dependent(s) have other coverage, list each separately

Carrier Name: _____

Carrier Address: _____ Telephone #: _____

Subscriber's Name: _____ Policy/Group #: _____ Subscriber's ID #: _____

Policy Effective Dates: Start: _____ End: _____ Covered Dependents _____

_____

_____

Coverage Type:
(Check applicable) ☐ Medical ☐ Mental Health ☐ Prescription ☐ Dental

Type of Plan:
☐ Retiree ☐ COBRA ☐ Individual ☐ Self Pay ☐ Active

Carrier Name: _____

Carrier Address: _____ Telephone #: _____

Subscriber's Name: _____ Policy/Group #: _____ Subscriber's ID #: _____

Policy Effective Dates: Start: _____ End: _____ Covered Dependents _____

_____

_____

Coverage Type:
(Check applicable) ☐ Medical ☐ Mental Health ☐ Prescription ☐ Dental

Type of Plan:
☐ Retiree ☐ COBRA ☐ Individual ☐ Self Pay ☐ Active

If previous coverage terminated within the last two years, you must enclose documentation from the former carrier indicating the date the policy was terminated.

See back

COVERAGE INFORMATION (Continued)

Part B

Please complete this section if you are divorced or legally separated, and you have dependent children covered under this plan.

1. Does the other custodial parent of your dependent children provide health benefits? ☐ Yes ☐ No

Name of other custodial parent:_____ Birth date:_____

If yes, please provide the following information:

Name of other health plan: _____

Policy/Group #:_____

Subscriber ID #:_____

Which children are covered?_____

2. If divorced, check one of the following: Date of divorce/separation:_____

☐ Divorce decree stipulates other parent must provide health benefits

☐ Divorce decree stipulates joint custody

☐ Divorce decree does not stipulate any special provisions

☐ Other, please explain:_____

_____

** A copy of the section of the court decree pertaining to health coverage or other documents must be provided to support your response.*

*** IMPORTANT NOTE: If you are over age 65, you must enroll in Medicare part A & B ***

Part C

You should complete this section if you, your spouse, and/or your dependents are eligible for Medicare. Please enclose a copy of the Medicare ID card for each eligible member of your family.

Name of **Participant** eligible for Medicare:

_____

Effective Dates of Medicare:

Part A:_____ Part B:_____

Name of **Dependent** eligible for Medicare:

_____

Effective Dates of Medicare:

Part A:_____ Part B:_____

If you are under age 65 are you enrolled in Medicare due to a disability? ☐ Yes ☐ No

Part D

PARTICIPANT SIGNATURE

Signature and date is required

I certify that the above information is correct and understand that I am obligated to provide this information to the Writers' Guild Health Fund with the Certificate of Coverage. If other coverage is added or terminated for any individuals covered under my Writers' Guild-Industry Health Fund Plan, I must notify the Fund immediately. Failure to provide complete and accurate information may result in a delay in the payment of benefits and/or can result in the incorrect handling of your claim.

Print Your Name: _____

Signature: _____ Date:_____

Participant ID Number: **WRXA**

WRITERS' GUILD-INDUSTRY HEALTH FUND
2900 W. Alameda Ave
Suite 1100
BURBANK, CA 91505
ATTN: CLAIMS DEPARTMENT
Phone Number: (818) 846-1015 or (800) 227-7863

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Paid Parental Leave Guide

OVERVIEW

A new child, whether birthed, adopted, or fostered is a wonderful and great change in a person's life, but a complicated one. In between the avalanche of diapers, feedings, sleep schedules, friends and family checking in, congratulatory phone calls, emails, and legal matters, there is a special bonding process that takes place. Work life often precludes spending much – if any – time to bond with this new addition to your family. Now there is a new resource available to help you during this period.

In the 2020 negotiations, the employers and the WGA agreed to a new benefit for writers: Paid Parental Leave (PPL). The purpose of this benefit is to provide income replacement for Participants who take leave from employment to bond with their newborn, newly adopted, or newly fostered child.

Beginning May 2, 2021, the Paid Parental Leave (PPL) benefit is available to all covered Health Fund Participants with qualifying coverage if a child is born, or if the Participant newly adopts or fosters (or has a child placed for adoption) after that date. The PPL benefit is available for a 24-month window from the date of birth, adoption, or fostership, and can be broken into non-concurrent weeks should you desire. The PPL benefit is $2,000 per week, for up to 8 weeks, and the weeks do not need to be taken sequentially.

You should receive a PPL enrollment package once you declare your new dependent. If this doesn't happen, or if you have any questions or concerns, please feel free to contact the Health Fund at (818) 846-1015 or toll-free (800) 227-7863 or via email at: Pmailbox@wgaplans.org.

ELIGIBILITY

In order to qualify for the Paid Parental Leave benefit, the Participant must have qualifying Writers' Guild-Industry Health Fund health coverage at the time of the birth, date of adoption of the child, or the date of formally fostering of a child. The Participant's qualifying health coverage only needs to be in place at that time – the coverage need not be maintained throughout the leave period.

For this purpose, adoption includes placement for adoption. Fostering of a child means that the child is placed with the Participant by an authorized placement agency or a court order. In all cases, the child must be new to the Participant. (Thus, for example, if the Participant adopts the child of a spouse or partner and the child has already lived with the Participant for an extended period of time, the Paid Parental Leave benefit would not be available.)

The qualifying Writers' Guild-Industry Health Fund health coverage may be Active Coverage, Extended Points Coverage, or COBRA Coverage (but not Total Disability Extension Coverage or Retiree Coverage). The qualifying health coverage must have been earned from contributions of employers that contribute for the Paid Parental Leave benefit.

A Participant can only take one Paid Parental Leave benefit in any 24-month period. However, if both parents are Participants with qualifying Writers' Guild-Industry Health Fund health coverage then each Participant is separately eligible for their own, individual Paid Parental Leave benefit, which can be taken concurrently or separately.

If both parents are Participants with qualifying Health Fund coverage at the time of birth, adoption, or foster placement, then each can separately claim a PPL benefit. The PPL benefit can be used separately or concurrently – the decision is entirely up to the parents.

The Paid Parental Leave benefit is not available to employees of Named Employers. In addition, dependents of Participants are not eligible to receive the Paid Parental Leave benefit should they have a child, adopt a child, or foster a child.

If there are multiple births, adoptions, or foster placements at a time, there is only one Paid Parental Leave benefit.

ELECTING PAID PARENTAL LEAVE

Paid Parental Leave is intended as a replacement for income lost during a parental leave as a result of not working. In order to receive PPL benefits you must not work for an employer during, or be paid by an employer for, the period for which the Paid Parental Leave is taken.

To get started, you simply fill out an application provided by the Administrative Office. As part of this application, you must sign an attestation that you will not perform work for an employer during, or be paid by an employer for, the period for which you are receiving the Paid Parental Leave benefit.

If you lose your qualifying Health Fund coverage after a qualifying birth, adoption, or foster placement, the PPL benefit remains available to you.

You may also have to disclose whether you are receiving or will receive any state-mandated family leave benefits in connection with your newly-acquired child. Under the rules that apply to the PPL benefit, state-mandated family leave benefits are offset against the Paid Parental Leave benefit. This disclosure and offset requirement is temporarily waived until December 31, 2022.

You must advise the Fund Office immediately if, after applying for Paid Parental Leave, you decide to return to work for an employer during (or are going to be paid by an employer for) any portion of the period for which you applied for Paid Parental Leave.

PAYMENT DURATION AND AMOUNT

Once the Paid Parental Leave benefit is elected, and the attestation is signed, you will receive $2,000 per week for a period of up to 8 weeks, for a total of up to $16,000.

The Paid Parental Leave benefit may be taken sequentially or it can be broken into non-consecutive weekly increments, not to exceed the total number of sequential Paid Parental Leave benefit weeks (and, as described above, not to be paid beyond 24-months after birth/adoption/fostership). The minimum increment is one week. Payment will be made on a weekly basis. The child must be in the Participant's home for all weeks for which payment is made.

Make sure you use your PPL benefit within 24 months of the birth, adoption, or foster placement of a child. Once the 24-month window expires, no further PPL benefit is available.

Once twenty-four months have passed since the birth, adoption, or fostering of a child, you are no longer eligible to receive the Paid Parental Leave benefit, regardless of whether the full available amount has been used.

MISCELLANEOUS ISSUES

The monies distributed via the Paid Parental Leave benefit will not be counted toward pension benefits or vesting or toward health coverage eligibility.

All Paid Parental Leave benefits are subject to the applicable tax deductions and withholdings. This is a taxable benefit for which you will receive a W-2.

FAQs

How do I get started?

Once the child is born, adopted, or placed with you, contact the Health Fund and let them know you have a new dependent. A PPL benefit package should be sent to you which

includes an application for the benefit and an attestation that you will not work while receiving the PPL benefit.

If you don't receive your PPL benefit package, or if you have any questions or concerns about how to fill out the application you can contact the Fund at (818) 846-1015 or toll-free (800) 227-7863 or via email at: Pmailbox@wgaplans.org.

Do I have to use the PPL benefit immediately?

As long as you have qualifying Health Fund coverage when the child is born to, adopted by or placed/fostered with you, you have 24 months in which to use the PPL benefit. You can start right away, or at a time that is more convenient to you. Please keep in mind that the benefit is 8 weeks in length and ends at the close of the 24-month window, regardless of whether all of the weeks have been used, so you should plan accordingly.

What if I only want to use a few weeks of the benefit, can I do that?

Yes. You can use all 8 weeks, or as many as are convenient to you. Please keep in mind that there is a 24-month window in which to use some or all of the PPL benefit.

Both myself and the child's other parent are Participants with qualifying Health Fund coverage. Do we each get an individual PPL benefit?

If you both are Participants with qualifying Health Fund coverage on the date of the child's birth, adoption, or fostering, each of you will have your own individual PPL benefit. You can each take your leave payments as you see fit. If you want to have 8 consecutive weeks, then each of you will receive the $2,000 payment for 8 weeks. You can use the weeks concurrently or discretely. There can be gaps if you need to work, or find that this is better for your family. The PPL benefit is very flexible in this regard: how you use it is entirely up to you (subject to your getting the time off from your employer – see below).

Please note that dependents with Health Fund coverage are not eligible to receive the PPL benefit. If you are a Participant with qualifying Health Fund coverage and your spouse has dependent coverage under the Health Fund, your spouse is **not** eligible for the PPL benefit.

If I want to take the PPL benefit for a few weeks then go back to work and then take more weeks when my assignment is done can I do that?

You can use your 8 weeks of benefits in any order that best suits you. There are four caveats to keep in mind: 1) The PPL benefit begins with the birth, adoption or foster placement of a child. From that date, you have a 24-month window in which to use some or all of your PPL benefit, 2) If you do not use all your benefit within the 24-month period, you cannot reclaim the unused weeks at a later date, 3) Each time you seek to renew your PPL benefit payments during the 24-month window, you will have to fill out a new PPL benefit application and attestation form, and 4) The amount of time you can take for parental leave is between you and your employer (see below).

What if I get a residual or production payment or some other non-work payment while taking the PPL benefit?

As long as you are not working and the payment is not for the period for which you are taking leave, you may receive your PPL benefit. A residual, production bonus, or other similar payment will not interfere with this. If you're not sure about a situation, or have any questions, please feel free to contact the Fund at (818) 846-1015 or toll-free (800) 227-7863 or via email at: Pmailbox@wgaplans.org.

Is the PPL benefit taxable?

The PPL benefit is taxable. You will need to fill out a withholding form when you apply for the benefit. You will receive a W-2 and or all monies you receive and will have to fill out a W-4 form (or W-8BEN, if applicable).

What if I have a second child during the PPL benefit period, do I get a second PPL benefit?

There is only one PPL benefit available in any 24-month window. If a Participant has qualifying Health Fund coverage at the time of the second child's birth, adoption, or fostering during the first PPL benefit period, the Participant is eligible to apply for the second PPL benefit **after** the first PPL benefit period expires. The Participant will have 24 months from the date of the second child's birth, adoption, or fostering to utilize the second PPL benefit – regardless of when the Participant is eligible to apply for the second PPL benefit.

Does this new rule require my employer to give me time off if I have a child?

The Plan's PPL benefit provides a benefit that is available to you when you receive time off from your employer. However, it does not govern when you are entitled to that time off.

##

We hope this guide provides you the information you need about the Paid Parental Leave benefit. If you have any questions or concerns, please feel free to contact the Fund at (818) 846-1015 or toll-free (800) 227-7863 or via email at: Pmailbox@wgaplans.org and we will be happy to assist you.

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Paid Parental Leave Benefit Application

February 15, 2022

- Please complete the application form, the attestation form and the W-4 or W-8BEN form.
- Once completed, the forms may be returned to the Eligibility Department by mail or electronically
- If you have any questions or concerns, please feel free to contact the Eligibility Department (818) 846-1015 and then select Option #1, and then Option #2 or call toll-free (800) 227-7863 or via email at: emailbox@wgaplans.org

Dear Participant:

WRITERS' GUILD-INDUSTRY HEALTH FUND
APPLICATION FOR PAID PARENTAL LEAVE BENEFIT

You must complete Part I and Part II of this form.

Please return the completed form, along with all supporting documentation, including W-4 (or W-8BEN if applicable), to the Eligibility Department by email at emailbox@wgaplans.org or by sending the completed forms to the Fund Office, attn: Eligibility Department.

If you have any questions or concerns, please feel free to contact the Eligibility Department (818) 846-1015 and then select Option #1, and then Option #2 or call toll-free (800) 227-7863 or via email at: emailbox@wgaplans.org

PART I – PAYMENT REQUEST

To be completed by Participant (each question must be fully answered)

_____

Name

_____

Address (with apartment or unit number if relevant)

_____

City, State, and Zip Code

Federal Income Tax:

If we do not receive the Participant's completed election form, we will automatically begin to withhold Federal Income Tax from the Participant's benefit checks. As required by the law, we will determine the amount of the withholding based upon IRS tables for income tax withholding, and assume that the Participant is married and entitled to 3 exemptions. If the Participant wants us to withhold a different amount, the Participant must provide us with a completed IRS withholding certificate (IRS Form W-4P). If the Participant is a foreign-person, then the Participant must complete the IRS Form W-8BEN. If the Participant is a foreign-person and does not provide the Plan with the Participant's desired tax withholding, we will withhold at a rate of 30%.

CITIZENSHIP (THE PLAN IS REQUESTING THIS INFORMATION FOR PROPER TAX WITHHOLDING ONLY AND NOT FOR ANY OTHER PURPOSE)

☐ U.S. CITIZEN OR RESIDENT ALIEN

☐ NON-U.S. CITIZEN, NON-RESIDENT ALIEN NOR OTHER U.S. PERSON

COUNTRY OF CITIZENSHIP (NON-U.S.)

_____

Current (or most recent) employer

_____

Type of work being performed (feature, MOW, etc.)

_____

Start date (current employment)

_____

Stop date (if applicable)

_____

Current (or most recent) employer

_____

Type of work being performed (feature, MOW, etc.)

_____

Start date (current employment)

_____

Stop date (if applicable)

I newly acquired a child on:

_____

Date of birth/adoption/placement

If you have not done so previously, please submit the following items to the Fund Office along with this application:

- Birth certificate
- Adoption order
- Other verifying paperwork

I am requesting Paid Parental Leave for the following weeks listed below.

Please note that while you need not take all 8 weeks at once, the benefit request must be a minimum of one week (5 consecutive days).

	Benefit Begin Date (Monday)	Benefit End Date (Friday)
WEEK 1		
WEEK 2		
WEEK 3		
WEEK 4		
WEEK 5		
WEEK 6		
WEEK 7		
WEEK 8		

PART II - ATTESTATION

Writers' Guild-Industry Health Fund Paid Parental Leave Benefit Attestation

The Writers' Guild-Industry Health Fund has established a weekly Paid Parental Leave (PPL) benefit. The sole purpose of this benefit is to provide income replacement while a Participant takes unpaid time off from work to bond with a new child. The benefit is paid to eligible Participants weekly for up to 8 weeks in the 24-month period after a new child is acquired, but the weeks need not be taken concurrently.

For any work week for which I receive the Writers' Guild-Industry Health Fund Paid Parental Leave benefit, I attest that all of the following will remain true for the entire work week:

(1) I am one of my newly-acquired child's (or children's) caregivers, I will be actively engaged in bonding with and caring for my newly-acquired child (or children), and not more than twenty-four (24) months have passed since the birth, adoption, placement for adoption or fostership of my newly-acquired child (or children).

(2) I will not perform work for **any employer** for any portion of that work week (including both employers who are obligated to contribute to the Writers' Guild-Industry Health Fund and employers who are not).

(3) I will not be paid by **any employer** for any portion of that work week (including both employers who are obligated to contribute to the Writers' Guild-Industry Health Fund and employers who are not).

I understand that I must inform the Writers' Guild-Industry Health Fund if I return to work during, or am paid for, a week in which I have received or had applied to receive the Paid Parental Leave benefit. I understand that if I return to work during, or am paid for, a week in which I received the Paid Parental Leave benefit, I will be required to return or repay the Paid Parental Leave benefit I received.

The Writers' Guild-Industry Health Fund Paid Parental Leave Plan ("Paid Parental Leave Plan") is an income replacement benefit. Per California Unemployment Insurance Code 2656, your wages (including certain paid benefits) when added to your weekly California Paid Family Leave and California Disability Insurance cannot exceed 100 percent of your gross normal weekly salary immediately prior to the commencement of your disability or period of family care leave. New York state and other states with state-mandated family leave may have similar laws. By signing this form, you attest that your weekly benefit from the Paid Parental Leave Plan when added to your weekly state-mandated family leave or

disability benefits does not exceed 100 percent of your gross normal weekly salary. If your weekly Paid Parental Plan Leave benefit when added to your weekly state-mandated family leave or disability benefits will exceed 100 percent of your gross normal weekly salary, please notify the PWGA fund office so that the PWGA fund office can make necessary adjustments to your benefit.

I have enclosed my completed W-4 tax form (or W-8BEN, if applicable). I understand that this is a taxable benefit for which I will receive a W-2 tax form.

I understand that if I make a false statement on this attestation form, I will be required to return any Paid Parental Leave benefit payments I have received and I may be disqualified from receiving future Paid Parental Leave benefits.

Date: _____

Signature: _____

Name: _____

If you have any questions or concerns, please feel free to contact the Eligibility Department (818) 846-1015 and then select Option #1, and then Option #2 or call toll-free (800) 227-7863 or via email at: Emailbox@wgaplans.org

Yours truly,

Writers' Guild-Industry Health Fund

If you live in the U.S., you will need to submit a W-4 form. To obtain the latest version, click **HERE** and fill it out completely. Make sure you remember to sign it.

If you live outside the U.S., please fill out the W-8 BEN. To obtain the latest version, click **HERE**. As with the W-4 form, please remember to sign once you have filled out the form.

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PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

Medical and Vision Forms Plan Information

Medical

Your Medical plan is a Preferred Provider Organization (PPO) plan through the BlueCard® Nationwide Network. This means that benefits will be paid at a higher rate when you visit a network provider. See the back for instructions on finding a network provider.

As you know, the contracted rates or allowed rates are negotiated between Blue Cross and their network providers. These rates apply only to network services. When you use a network provider, you're not responsible for paying any amount over the contracted rate, even if the provider bills a higher amount. The allowed amount is payable at the higher network benefit rate.

Non-network providers are subject to the "Reasonable and Customary (R&C) limits". Any amount over R&C is not considered an eligible expense. The R&C amount is payable at the lower non-network benefit rate. If you use a non-network provider, you're responsible for paying any amount over the R&C limit.

For more information on coinsurance and Reasonable and Customary limits, please see the Summary Plan Description.

PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

Mental Health

Occasionally we find ourselves facing a situation that seems to be more than we can deal with on our own. At such times, it may be helpful to talk with a professional counselor, to assist you through a difficulty or simply to provide you with another point of view. As a plan participant, you are eligible for mental health and chemical dependency benefits.

Enclosed you will find information on the mental health and chemical dependency benefits available through the Writers' Guild-Industry Health Fund Plan ("Fund"). In reviewing the benefits chart, you will find that you will receive a higher level of benefits if you use a contracted provider.

Vision

VSP is a nationwide network of eye care and eyewear providers. All eligible participants will automatically be enrolled in the new VSP vision program. Make sure your vision provider uses your Health Fund ID number (WRXA), as we didn't provide VSP with any social security numbers.

The vision program offers:

- The broadest array of "paid-in-full" coverage
- Low member out-of-pocket cost
- The highest benefit allowances compared with other standard vision plans
- Total member flexibility to:
  - choose any frame at their provider's office
  - select the most popular lens options at significant savings
  - visit any of their network providers at more than 35,000 points of access (retail or private practice)
- The highest use of "covered-in-full" frame coverage

Please take a moment to review the attached information. If you have any questions, feel free to contact the Participant Services Department at the Fund Office (818) 846-1015, or visit our website at www.wgaplans.org.

PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

BlueCard®Network

How to Locate a BlueCard ® Provider

There are two ways you can find doctors and hospitals that participate in the PPO plan:

1. You may call (800) 810-BLUE (2583) for assistance in finding a PPO physician or hospital. Be sure to tell the Customer Service Representative that your three-digit alpha prefix is **WRX**.
2. You may also use our website, www.wgaplans.org, and click on the **Find Participating Provider** link to select a hospital network or physician in your area.

How to Locate a VSP Provider

There are two ways you can find a provider that participate in the VSP Vision plan:

1. You may call 1-800-877-7195 for assistance in finding a VSP Provider.
   - Be sure to tell the Customer Service Representative that your that your three-digit alpha prefix is **WRX** .
   - We have not provided VSP with social security number for your protection.
2. You may also use their website www.vsp.com and fill in the desired zip code in the section "**Find a VSP Doctor**".

Your ID# is 12 digits: a 3-digit alpha prefix (WRX) is followed by your unique ID# (A12345678). It is very important for your providers to use the entire 12 digit ID# on claims submission to all medical, mental health, vision and dental providers. Please be sure to follow the claim submission information that is located on the back of your new ID card.

An additional benefit for our Writers and their families!

MPTF
MOTION PICTURE & TELEVISION FUND

IMPORTANT NEWS FOR ALL PWGA PARTICIPANTS

As a PWGA participant, you can take advantage of UCLA HEALTH, Motion Picture Television Fund's high quality, integrated health care system and pay ***no annual deductible*** and only ***minimal co-payments***.

UCLA Health and Motion Picture & Television Fund gives you access to quality health care designed EXCLUSIVELY for PWGA members. The Network offers you:

- ☆ Board-Certified Primary Care Physicians
- ☆ A network of over 500 highly trained specialists.
- ☆ Pediatric services located near each Health Center.
- ☆ Affiliated, prestigious hospitals, including our own industry exclusive Motion Picture & Television Hospital, which provides a full range of medical services.
- ☆ Quality physicians available at convenient locations when and where you need them.
- ☆ Health Centers conveniently located throughout the greater Los Angeles area; most are full service, including physical therapy, pharmacy, lab and x-ray capabilities.
- ☆ Extended hours – evenings and weekends (hours vary by Health Center).

(See reverse side for Network Benefits)

NETWORK BENEFITS AND COPAYMENTS

	COVERED	YOU PAY ONLY
Hospitalization*	Yes	$ 0
Surgery*	Yes	$ 100
Anesthesiology*	Yes	$ 0
Primary Care Visits	Yes	$ 10
Specialists Visits*	Yes	$ 10
Lab/Radiology*	Yes	$ 0
Physical Therapy	Yes	$ 10
Periodic Physical Exam ($200 charged against your Wellness Allowance)	Yes	$ 0
Well Child Care/** Pediatric Visits (call your benefit plan for limitations)	Yes	$ 10

☆ ☆ ☆ **IMPORTANT** ☆ ☆ ☆

All Network Benefits are subject to standard Maximums and limitations as set forth in your WG-IHF Summary Plan Description.

* Benefits available when you receive a written referral from a Primary Care Physician.

** WGIHF participants can easily access pediatric services for children under the age of 13 by calling Customer Service at (800) 876-8320 or (855) 760-6783.

www.uclahealth.org/mptf

THE HEALTH CENTERS OF THE MOTION PICTURE & TELEVISION FUND

Bob Hope Health Center
335 N. La Brea Avenue
Los Angeles
(323) 634-3850

Calabasas Health Center
26585 W Agoura Rd Suite 330
Calabasas, CA 91302

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

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

Westside Health Center
1950 Sawtelle Blvd #130
Los Angeles
(310) 996-9355

MPTF
MOTION PICTURE & TELEVISION FUND

Getting Great Quality Care is Simple!

It starts by calling (800) 876-8320 or go online to www.mptvfund.org for your free copy of our Provider Directory, which provides information on all of our physicians as well as our services and locations. Then simply schedule an appointment with a Primary Care Physician at the MPTF Health Center most convenient to you. Your Primary Care Physician oversees all your care and provides referrals to specialists and additional services as needed.*

* **Without your Primary Care Physician's referral, your standard WGIHF benefits will apply, including your deductible and coinsurance.**

PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

Dear Participant:

Plan coverage for mental health and chemical dependency benefits will be provided at the same benefit levels as the medical coverage. Mental health and chemical dependency benefits will have the same deductibles, co-pays, coinsurance and out-of-pocket maximums as medical benefits.

Medical and Mental Health and Chemical Dependency Benefits

	PPO PLAN In-Network Providers	PPO PLAN Out-of-Network Providers	LOW OPTION PLAN In-Network Providers	LOW OPTION PLAN Out-of-Network Providers	OUT-OF-AREA PLAN (For participants who live over 25 miles outside the PPO service area of 2 providers)
Inpatient Services*					
-Deductible	$400/$1,200	$400/$1,200	$750/$2,250	$750/$2,250	$400/$1,200
-Co-pay per admit	$100 co-pay	$100 co-pay	$100 co-pay	$100 co-pay	$100 co-pay
-Coinsurance	85%	60%	70%	60%	80%
-Out-of-Pocket Max	$1,000	$20,000	$4,500	$20,000	$1,000
Outpatient Services**					
-Deductible	$400/$1,200	$400/$1,200	$750/$2,250	$750/$2,250	$400/$1,200
-Coinsurance	85%	60 %	70%	60%	80%
-Out-of-Pocket Max	$1,000	$20,000	$4,500	$20,000	$1,000

**Inpatient and outpatient facility charges require pre-authorization review through the Anthem Blue Cross Pre-Authorization department.*
***Outpatient professional charges are subject to medical necessity review.*

Treatment Authorization

All in-patient and outpatient facility[1] charges will continue to initiate the pre-authorization process as is currently required for medical benefits.

[1] Facility includes Residential, Partial hospitalization and Intensive Outpatient Programs

2900 W. Alameda Avenue Suite 1100 ● Burbank, CA 91505-4267 ● 818.846.1015 ● 800.227.7863 ● FAX 818.526.3180
www.wgaplans.org

Get the best in eye care and eyewear with Writers' Guild Industry Health Fund and VSP® Vision Care.

VSP® Vision care for life

At VSP, we invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness first.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP provider, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Create an account at vsp.com**. Once your plan is effective, review your benefit information.
- **Find an eye care provider who's right for you.** To find a VSP provider, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a Premier Program location that carries these brands. Prefer to shop online? Check out all of the brands at **Eyeconic.com**, VSP's online eyewear store.

See why we're consumers' #1 choice in vision care[2].

Contact us. **800.877.7195**
vsp.com

Your VSP Vision Benefits Summary

Writers' Guild Industry Health Fund and VSP provide you with an affordable eye care plan.

VSP Coverage Effective Date: 07/01/2017 **VSP Provider Network:** VSP Choice

Benefit	Description	Copay	Frequency
	Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness	$30	Every calendar year
Prescription Glasses		$30	See frame and lenses
Frame	• $150 allowance for a wide selection of frames • $200 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco® frame allowance	Included in Prescription Glasses	Every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$0 $95 - $105 $150 - $175	Every calendar year
Contacts (instead of glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
Suncare	• $150 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contacts	$30	Every other calendar year
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $50 to spend on featured frame brands. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Out-of-Network Providers

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider.

Exam ..... up to $76	Lined Bifocal Lenses ..... up to $50	Progressive Lenses ..... up to $50
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $65	Contacts ..... up to $115
Single Vision Lenses ..... up to $33		

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Contact us. **800.877.7195** | **vsp.com**

[1]Brands/Promotion subject to change.

[2]Blueocean Market Intelligence National Vision Plan Member Research, 2014

Request for Reimbursement

vsp vision care

Did you see an out-of-network doctor? We are here to help.
If you have out-of-network benefits, these are your options:

ONLINE

The way to go. It's secure, you can check claim status, get paid faster, and save on paper. Click the button below or go to **vsp.com** to log into your account and complete an internet form. You can also create an account there if you don't have one yet.

I Want To Get Paid Faster

OR

BY MAIL

Still want to mail the form in? Follow the form instructions on the next page.

TIPS TO SPEED CLAIMS PROCESSING:

Missing or incomplete information will slow down claims processing.
Be reimbursement ready by making sure the following are done:

Please attach a readable copy of itemized receipts, invoices or service statements that contain all of the following information:

- Name of provider (ex. doctor, office, website, or retailer)
- Name of patient
- Date service was received (ex. date of exam or date glasses were ordered)
- Complete description and amount paid for each service

- You typically have 12 months from the date of service to submit for reimbursement.
- Make sure all required fields have a value and dates are in the following format: Month/Day/Four-Digit Year.
- If you have Laser Vision coverage and are submitting for reimbursement:
  - The itemized receipt and/or letter from your provider must contain the following information:
    - Which eye(s) received the surgery
    - Surgeon Name
    - Facility Name
    - Surgery DOS
    - Type of procedure (e.g. PRK, LASIK, Custom LASIK and Custom PRK)
    - Cost of procedure
    - Member's name
    - Member's ID number (This may be the member's SSN or member's unique ID number)
    - Member's mailing address
    - Patient's name
    - Patient's DOB
    - Patient's relationship to the member (e.g. member, spouse, child, etc.)
    - Name of client who provides the VSP coverage (client name)
- Please note: Laser Vision warranty enhancements are not reimbursable under Laser Vision Care out-of-network. Claims may only be submitted for surgery (one or both eyes) and/or pre/post-operative care.
- Write the amount of the Laser Vision Care claim under "Exam" on the reimbursement form.

Form Instructions

vsp vision care

The form must be filled out by the member. All fields flagged with an asterisk (*) are required. The form is fillable, so you do not have to handwrite. Fill out on a computer, print, and mail in. If you decide to handwrite, use blue or black ink.

PATIENT SECTION:

1. Select the patient's relation to the member. Choose only one.
2. Enter the patient's date of birth in the following format: Month/Day/Four-Digit Year.
3. Select a gender. Choose only one.
4. Enter the patient's last name and first name.
5. Enter the address, city, state, and ZIP code.
6. The patient's middle initial and ZIP+4 are optional.

MEMBER SECTION:

1. Enter the last four digits of the member's SSN or member's unique ID number.
2. If the patient is the member, select "Member information below is the same as Patient."
3. Otherwise, enter the member's information:
    a. Enter the member's date of birth in the following format: Month/Day/Four-Digit Year.
    b. Select a gender. Choose only one.
    c. Enter the member's last name and first name.
    d. Enter the first address line, city, state, and ZIP code.
    e. The member's middle initial, second address line, and ZIP+4 are optional.

CLAIM SECTION:

1. Enter the date of service in the following format: Month/Day/Four-Digit Year.
2. Enter the amount charged for each applicable line item. Ensure they match the receipts.
3. Select a lens type.
4. If another insurance company is involved, check the box and attach a copy of the statement showing payment.

PROVIDER SECTION:

1. If the provider's name is known, enter the provider's last name and first name.
2. If the office name is known, enter the provider's office name.
3. Step #1 or #2 or both must contain a value.
4. Enter the first address line, city, state, and ZIP code.
5. The second address line and ZIP+4 are optional.

PRINT AND SIGN SECTION:

1. Review the completed form for accuracy.
2. Read the acknowledgment paragraph.
3. Print the form.
4. Sign the form.
5. Date the form in the following format: Month/Day/Four-Digit Year.
6. Only the form on the next page needs to be mailed in. All other pages are for reference.

VSP Member Reimbursement Form

To request reimbursement, complete and print this form, enclose a legible copy of your itemized receipt(s), and send them to the following address. Be sure to keep a copy for your records.

VSP
PO Box 495918
Cincinnati, OH 45249-5918

PATIENT

Relation to Member*: *(choose one)*

☐ Member ☐ Domestic Partner ☐ Dependent Parent ☐ Disabled Dependent
☐ Spouse ☐ Child ☐ Full-Time Student ☐ Other

Date of Birth*: *(mm/ddyyyy)* _____ Gender*: ☐ Male ☐ Female

Last Name*:_____ First Name*:_____ MI:____

Address*:_____

City*:_____ State*:_____ ZIP*:_____ ZIP+4:_____

MEMBER

Last Four Digits of SSN or Unique ID*: _____

☐ Member information below is the same as Patient

Date of Birth*: *(mm/dd/yyyy)* _____ Gender*: ☐ Male ☐ Female

Last Name*:_____ First Name*:_____ MI:____

Address 1*:_____ Address 2:_____

City*:_____ State*:_____ ZIP*:_____ ZIP+4:_____

CLAIM

Date of Service*: *(mm/dd/yyyy)* _____

☐ Another insurance company made payments to you, another insurer, or the doctor's office. If so, attach a copy of the statement showing payment.

Exam..... $
Frame..... $
Lens..... $
Lens Tints or Coatings..... $
Contact Lens Exam/Fitting Evaluation..... $
Contacts..... $

Lens Type*: *(choose one)*

☐ Single
☐ Bifocal
☐ Trifocal
☐ Progressive
☐ Lenticular

PROVIDER

Last Name:_____ First Name:_____

Office Name:_____

Address 1*:_____ Address 2:_____

City*:_____ State*:_____ ZIP*:_____ ZIP+4:_____

PRINT AND SIGN

I acknowledge that the above-named provider is not a VSP Preferred Provider and that VSP cannot guarantee eye care and/or eyewear satisfaction. By signing this claim form, I certify that I have read the applicable claim fraud warnings included with this form, and that all the information I have provided above is complete and accurate.

Claimant Signature:_____ Date:_____

Fraud Warnings

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly presents false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana, and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia, and Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim

Fraud Warnings (Cont.)

containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: Any person who knowingly presents a false or fraudulent claim for penalty of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Language Assistance Services

English: ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call **1.800.877.7195 (TTY: 1.800.428.4833)**.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.877.7195 (TTY: 1.800.428.4833)**.

Chinese: 注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 **1.800.877.7195 (TTY: 1.800.428.4833)**.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1.800.877.7195 (TTY: 1.800.428.4833)**.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1.800.877.7195 (TTY: 1.800.428.4833)** 번으로 전화해 주십시오.

Tagalog–Filipino: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1.800.877.7195 (TTY: 1.800.428.4833)**.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1.800.877.7195 (телетайп: 1.800.428.4833)**.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1.800.877.7195 (TTY (հեռատիպ)՝ 1.800.428.4833)**.

French: ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le **1.800-877-7195 (ATS : 1.800.428.4833)**.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1.800.877.7195 (TTY: 1.800.428.4833)**まで、お電話にてご連絡ください。

Tongan: FAKATOKANGA’I: Kapau ‘oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea ‘oku nau fai atu ha tokoni ta’etotongi, pea teke lava ‘o ma’u ia. Telefoni mai **1.800.877.7195 (TTY: 1.800.428.4833)**.

Serbo-Croatian: OBAVJEŠTENJE: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vambesplatno. Nazovite **1.800.877.7195 (TTY-Telefon za osobe sa oštećenim govorom ili sluhom: 1.800.428.4833).**

Cambodian: ប្រយ័ត្ន៖ បើ អ្នក ចេះ និយាយ ភាសា ខ្មែរ, បស់វាជំនួយខ្មែរ ឥតគិតថ្លៃ គឺមាន សម្រាប់ បម្រើ អ្នក។ ចូរ ទូរស័ព្ទ **1.800.877.7195 (TTY: 1.800.428.4833)**។

Punjabi: ਧਿਆਨ ਧਓ: ਜੇ ਤੁਸੀ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਧ ਵਿਚ ਸਹਾਇਤਾ ਸੇ ਾ ਤੁਹਾਡੇਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1.800.877.7195 (TTY: 1.800.428.4833)** ‘ਤੇ ਕਾਲ ਕਰੋ।

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche

Language Assistance Services (Cont.)

Hilfsdienstleistungen zur Verfügung. Rufnummer: **1.800.877.7195 (TTY: 1.800.428.4833)**.

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1.800.877.7195 (መስማት ለተሳናቸው: 1.800.428.4833)**.

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1.800.877.7195 (телетайп: 1.800.428.4833)**.

Nepali: ध्यान दिनुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् **1.800.877.7195 (टिटिवाइ: 1.800.428.4833)** ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1.800.877.7195 (TTY: 1.800.428.4833)**.

Sudan (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu **1.800.877.7195 (TTY: 1.800.428.4833)**.

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1.800.877.7195 (TTY: 1.800.428.4833)**.

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1.800.877.7195 (TTY: 1.800.428.4833)**.

Cushite/Oromo: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1.800.877.7195 (TTY: 1.800.428.4833)**.

Persian (Farsi):

Arabic: [illegible] (**[illegible]** [illegible] **TTY: 1.800.428.4833**) [illegible] **1.800.877.7195.**

Navajo: [illegible] **1.800.877.7195.** ([illegible] **1.800.428.4833:**).

हिंदी **(Hindi):**
ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1.800.877.7195 (TTY: 1.800.428.4833)** पर कॉल करें।

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

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PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

Prescription Benefits

When you need prescription drugs, you don't need hassles. An easy prescription drug plan is just what the doctor ordered. Express Scripts provides your prescription benefits. Enclosed are the following items for your review:

- Express Scripts pharmacy service mail order form
- Prescription Reimbursement Claim Form
- Your prescription drug plan benefit overview brochure
- Specialty Drugs and SavonSP program

All maintenance drugs are only received through Express Scripts Mail Order Service or a Walgreens or Duane Reed. The Plan's guidelines allow you to fill a prescription ***only twice*** *at your local pharmacy. After that, you must get a 90 day prescription with refills if needed, from your doctor and mail it to Express Scripts with the enclosed mail order form or at a local Walgreens, Duane Reade or Happy Harry's Pharmacy with a 90 day supply.*

Drug Class	Retail - 30 Day Supply	Mail - 90 Day Supply or Walgreen's Smart 90 Program
Generics	$10	$20
Preferred Brands	$25	$50
All Other Brands	$50	$100

Please take a moment to review the attached information. If you have any questions, feel free to contact the Eligibility Department at the Fund Office, at (818) 846-1015, or visit our website at www.wgaplans.org.

Medco Pharmacy®
MAIL-ORDER FORM

The **Medco Pharmacy** is now a part of the Express Scripts family of pharmacies

1 Member information: Please verify or provide Member information below.

Member ID: _____
Group: WGHIFRX _____
Name: _____
Street Address: _____
Street Address: _____
Street Address: _____
City, ST, ZIP: _____

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:
_____@_____.____

☐ New shipping address:
_____
_____
_____

(Express Scripts will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)

Daytime phone: ☐☐☐☐☐☐☐☐☐☐

Evening phone: ☐☐☐☐☐☐☐☐☐☐

FOLD HERE

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in the envelope provided.

First name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth date (MM/DD/YYYY) ☐☐☐☐☐☐☐☐

Sex ☐M ☐F

Patient's relationship to member ☐Self ☐Spouse ☐Dependent

Doctor's last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

1st initial ☐

Doctor's phone number ☐☐☐☐☐☐☐☐☐☐

First name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth date (MM/DD/YYYY) ☐☐☐☐☐☐☐☐

Sex ☐M ☐F

Patient's relationship to member ☐Self ☐Spouse ☐Dependent

Doctor's last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

1st initial ☐

Doctor's phone number ☐☐☐☐☐☐☐☐☐☐

FOLD HERE

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders **payable to Express Scripts,** and write your member ID number on the front. You can enroll for e-check payments and price medications at Express-Scripts.com, or call **800.987.6551.**

Number of prescriptions sent with this order: ☐

Payment options: ☐ e-check ☐ Payment enclosed ☐ Credit card ☐ Send bill

For credit card payments:
☐ Visa ☐ MC ☐ Discover ☐ Amex ☐ Diners

Credit card number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiration date ☐☐☐☐
M M Y Y

X _____
Cardholder signature

☐ I authorize Express Scripts to charge this card for all orders from any person in this membership.

☐ Rush the mailing of this shipment ($15, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

HG0293C

Mailing instructions are provided on the back of this form.

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex
☐ M ☐ F

Patient's relationship to member
☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex
☐ M ☐ F

Patient's relationship to member
☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

FOLD HERE

Important reminders and other information

Check that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

If you are a Medicare Part B beneficiary AND have private health insurance, check your prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at 800.987.6551. To verify Medicare Part B prescription coverage, call Medicare at 800.633.4227.

Express Scripts will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.

☐ Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise.

Check the box if you do not wish a less expensive brand or generic drug.

Please note that this applies only to new prescriptions and to any future refills of that prescription.

For additional information, log in to Express-Scripts.com or call Member Services at 800.987.6551. TTY/TDD users should call 800.759.1089.

Federal law prohibits the return of dispensed controlled substances.

FOLD HERE

Place your prescription(s), this form, and your payment in the envelope provided. Be sure the address shows through the window. Do not use staples or paper clips.

MEDCO HEALTH SOLUTIONS OF NETPARK, L.L.C.
PO BOX 30493
TAMPA, FL 33630-3493

Coordination of Benefits/Direct Claim Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

EXPRESS SCRIPTS®

Member/Subscriber Information *See your prescription drug ID card.*

Group No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member Name (First, Last)

Street Address

City State ☐☐ Zip ☐☐☐☐☐

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year) ☐☐ ☐☐ ☐☐☐☐

Sex
☐ Female
☐ Male

Relationship to Plan Member
☐ 1 Self
☐ 2 Spouse
☐ 3 Eligible Child
☐ 4 Dependent Student
☐ 5 Disabled Dependent
☐ 6 Dependent Parent
☐ 7 Nonspouse Partner
☐ 8 Other

Pharmacy Information

Name of Pharmacy

Street Address

City State ☐☐ Zip ☐☐☐☐☐

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

Is this an on-site nursing home pharmacy? ☐Yes ☐No

I hereby certify that the charge(s) shown for the medication(s) prescribed is correct and agree to provide Express Scripts or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

X _____ _____

Signature of Pharmacist or Representative **(Required)** **NABP Number Required**

Claim Receipts

Tape receipts or itemized bills on the back. **See back for details.**

Check the appropriate box if any receipts or bills are for a:

☐ **Compound prescription**
Make sure your pharmacist lists ALL the VALID 11-digit NDC numbers, ingredients, cost and quantities on the receipt or bill.

☐ **Medication purchased outside of the United States**
Please indicate:
Country_____
Currency used_____

☐ **Allergy medication**

Coordination of Benefits

(Another Health Plan has paid a portion) Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?
☐Yes ☐No

☐ 1 Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid.
☐ 3 Card Program
☐ 4 The **Medco Pharmacy**® (now a part of the Express Scripts family of pharmacies)

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment or denial of benefits.*

Please tape receipts on the back.

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me and that assignment of these benefits to a pharmacy or any other party is void.

X _____

Signature of Member

If allowed by law, you may assign the payment of this claim to your pharmacy. If your pharmacy is willing to accept assignment, do not complete this form. Please request that your pharmacy contact Pharmacy Services at 1 800 922-1557 for assistance.

Claim Receipts

Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on a separate piece of paper.

Tape receipt for prescription 1 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for prescription 2 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

Rx #		Date filled		Days' supply	

VALID 11-digit NDC #	Quantity	Price
Total quantity		
Total charge		

When To Use This Form

- Use this form to submit claims under Coordination of Benefit rules.
- You must complete a **separate** claim form for **each pharmacy** used and for **each patient.**
- You must submit claims within 1 year of date of purchase or as required by your plan.

Another Health Plan Paid

You must first submit the claim to the primary insurance carrier. Once the statement from the primary plan is received from the primary carrier, complete this form, tape the original prescription receipts in the spaces provided above, and attach the statement from the primary plan, which clearly indicates the cost of the prescription and what was paid by the primary plan.

Prescription Drug Programs or HMO Plans

Retail pharmacies: If the primary plan is one in which a co-payment or coinsurance is paid at the pharmacy, then no EOB is needed. Just complete this form and attach the prescription receipt(s) that shows the co-payment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the EOB.

The *Medco Pharmacy*: If the primary plan is mail order, complete this form and attach either the prescription receipt(s) that shows the co-payment or coinsurance amount paid to the mail-order pharmacy or the statement of benefits you receive from the mail-order pharmacy.

Instructions

Read carefully before completing this form.

1. **Be sure your receipts are complete.** In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
2. The plan member should read the acknowledgment carefully, and then sign and date this form.
3. Return the completed form and receipt(s) to:

Express Scripts
P.O. Box 14711
Lexington, KY 40512

* **California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Visit us online anytime at Express-Scripts.com

EXPRESS SCRIPTS®

PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

Express Scripts-
Your prescription benefit

Congratulations, you are eligible for Health Fund benefits. The Health Fund uses Express Scripts as your prescription provider. When you go to the pharmacy, all you have to do is present your Health Fund ID card and ask them to run your prescription through Express Scripts.

FILLING YOUR PRESCRIPTIONS

You have two ways to fill your prescriptions, depending on your medical needs:

- For **short-term prescriptions**, such as antibiotics or pain relievers for an injury, just go to the nearest participating pharmacy. You may fill the same prescription twice at a retail pharmacy; after that, the Health Fund no longer pay for the medication. That's because we have a heavily discounted mail-order program for long-term prescriptions.

- For **long-term medication** needs – for example, drugs used to treat high-blood pressure or diabetes – mail-order delivery from the Express Scripts Pharmacy is mandatory and is the convenient, safe way to get your prescription.

- As of May 1, 2017, there is a third option for **long-term medication** needs. You can fill any or all of your long-term prescriptions through the Smart90 Walgreens Network (receiving the same cost savings as the current mail-order benefit). Duane Reade and Happy Harry's pharmacies are also participating in this program.

FOUR WAYS TO GET STARTED WITH HOME DELIVERY

An Express Scripts Pharmacy order form was included in your Welcome Kit with your member ID card. You can print additional forms if needed or start home delivery by visiting **Express Scripts.com** or by calling the number on your member ID card.

ONLINE

- Ask your doctor to write a prescription for up to a 30-day supply with one refill and fill it immediately at your local pharmacy.

- After you've filled your 30-day prescription, go to **Express-Scripts.com**, and follow the prompts to set up your account.

- When your registration is complete, you will be notified of an opportunity to save on your new prescription and any other savings opportunities you may have.

Follow the prompts and Express Scripts will contact your doctor to obtain a prescription for up to a 90-day supply of your medicine.

BY MAIL

- Ask your doctor to write two prescriptions: one for up to a 30-day supply that you can fill immediately at your local pharmacy; one for up to a 90-day supply of your medicine, plus refills for up to one year.

- Complete an order form for home delivery from the Express Scripts Pharmacy. You can print a form from **Express-Scripts.com**.

- Return the completed order form, your written prescription for your 90-day supply and payment to the Express Scripts Pharmacy.

- ****If you want to switch from mail order at Express Scripts to the ESI Smart90 program, you will have to call your physician and get a new 90-day prescription (and up to three refills), the same as you do with mail-order.

    a. Present your 90-day prescription(s) and your Health Fund ID Card at one of more than 8,000 participating Walgreen's pharmacies (or Duane Reade or Happy Harry's pharmacies)

        - Pay the same 90-day co-pay as you would filling your prescription using ESI's Mail Order Pharmacy.

        - **Note**: Participants who continue to fill 30-day supplies of maintenance medications (and do not obtain a 90-day prescription), or use a non-preferred pharmacy, will pay 100% of the prescription cost.

        - To find a Walgreens, or Duane Reade, or Happy Harry's pharmacy that participates in the ESI Smart90 program, all you need to do is log in or register at:

          www.express-scripts.com/90day

        - Once registered, select "Manage Prescriptions," and look for a link directing you to your nearest participating pharmacy.

**To help avoid delays in filling your prescription, be sure to include payment with your order.*

BY FAX FROM YOUR DOCTOR

- Ask your doctor to write two prescriptions: one for up to a 30-day supply that you can fill immediately at your local pharmacy; one for up to a 90-day supply of your medicine, plus refills for up to one year.

- Complete an order form for home delivery from the Express Scripts Pharmacy. You can print a form from **Express-Scripts.com**.

- Have your doctor or a member of your doctor's staff fax your completed order form to Express Scripts at **800.837.0959.** Faxes must be sent from your doctor's office. Faxes from other locations, such as your home or workplace, cannot be accepted.

ELECTRONICALLY

- Ask your doctor to send your prescription to the Express Scripts Pharmacy electronically.

USING THE EXPRESS SCRIPTS MOBILE APP TO MANAGE YOUR PRESCRIPTIONS

The Express Scripts mobile app helps you stay on track with taking your medicines as prescribed. It's available to anyone with an iPhone®, Windows Phone, Android™ or Blackberry®s. Go to your smartphone's app store, search for "Express Scripts" and download it free today. After downloading the app, log in with your online **Express-Scripts.com** user ID and password to open. Once the app is up and running, the app you can:

- Quickly and easily manage your home delivery prescriptions – refill and renew them.

- Track your home delivery prescription orders.

- Look up potential lower-cost prescription options available under your plan and discuss them with your doctor – even while you're still in the doctor's office.

- Review your personalized alerts to help ensure that you are following your treatment plan as prescribed by your doctor.

- View your medicines and set reminders for when to take them or notify you when you are running low.

- Get personalized alerts if there's a possible health risk related to your medicines.
- You can also add over-the-counter medicines, vitamins, and supplements to check for possible interactions with your prescriptions.

ACCREDO, YOUR SPECIALTY PHARMACY

Accredo, the full-service Express Scripts specialty pharmacy, provides personalized care to patients with chronic, complex health conditions. Accredo offers several comprehensive disease-specific patient-care management programs:

- **Patient counseling** – convenient access to highly trained specialty experts, including pharmacists, nurses and patient care coordinators who provide the support you need to manage your condition
- **Patient education** – clinicians and disease-specific educational materials available 24/7
- **Convenient medicine delivery** – coordinated delivery to your home, doctor's office or any other approved location
- **Refill reminders** – ongoing refill reminders from a patient care coordinator
- **Language assistance** – translation services are available for non-English speaking patients

(For additional information about the services available to you through Accredo, please call **800.922.8279**.)

Pharmacy co-pays effective 1/1/2018

	Retail 30 day supply	Mail order 90 day supply through Express Scripts	Retail 90 day supply through Walgreens, Duane Reade or Happy Harrys
Generic Drugs	$10.00	$20.00	$20.00
Preferred Brand-Name Drugs	$25.00	$50.00	$50.00
Non-Preferred Brand-Name Drugs	$50.00	$100.00	$100.00

GENERAL STATEMENT OF NONDISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)

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

a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)

b) Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters and information written in other languages

If you need these services, contact Joe Ficele, Director of Security & Risk Management at 1-800-227-7863.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Joe Ficele, Director of Security & Risk Management, 2900 W. Alameda Avenue, Suite 1100, Burbank CA 91505, Telephone: 1-818-846-1015, TTY: 1-818-526-3199, Fax: 1-818-526-6522, Email: jficele@wgaplans.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Joe Ficele, Director of Security & Risk Management is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHS Building, Washington, DC 20201, 1-800-868-1019, 1-800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
English	ATTENTION: Language assistance services are available to you free of charge. Call 1-800-227-7863 (TTY: 1-818-526-3199).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم - 1-800-227-7863 (رقم هاتف الصم والبكم: 1-818-526-3199).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-227-7863（TTY：1-818-526-3199）。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-227-7863 (ATS : 1-818-526-3199).
French Creole (Haitian)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-227-7863 (TTY: 1-818-526-3199).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-227-7863 (TTY: 1-818-526-3199).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-227-7863 (TTY: 1-818-526-3199).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-227-7863（TTY:1-818-526-3199）まで、お電話にてご連絡ください。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-227-7863 (TTY: 1-818-526-3199) 번으로 전화해 주십시오.
Persian	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-227-7863 (TTY: 1-818-526-3199) تماس بگیرید.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-227-7863 (TTY: 1-818-526-3199).
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-227-7863 (TTY: 1-818-526-3199).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-227-7863 (телетайп: 1-818-526-3199).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-227-7863 (TTY: 1-818-526-3199).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-227-7863 (TTY: 1-818-526-3199).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-227-7863 (TTY: 1-818-526-3199).

PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

New Drug Program – $0 Copay SaveOnSP

November 30, 2020

NEW DRUG PROGRAM WITH $0 COPAY: SaveOnSP

TO: Plan Participants using specialty drugs

FROM: The Writers' Guild-Industry Health Fund

♦♦

- Beginning February 1, 2021, the Writers Guild-Industry Health Fund is partnering with Express Scripts to implement a new specialty medication cost-saving program, SaveOnSP, to help you and the Health Fund save money on certain specialty medications.

  A list of the covered drugs can be found here: (www.saveonsp.com/wga).

- Once you are enrolled in the SaveOnSP program, you will have no out-of-pocket cost for certain specialty drugs.

Dear Participant Name,

Beginning February 1, 2021, the Writers Guild-Industry Health Fund is partnering with Express Scripts to implement a new specialty medication cost-saving program, SaveOnSP, to help you and the Health Fund save money on certain specialty medications.

Our priority is to make sure you can continue to access the medications you need at an affordable cost, while also managing costs for the Health Plan. That's why we're working with Express Scripts to offer SaveOnSP, a program that can save you money and reduce your out-of-pocket cost for eligible specialty medications to $0.

You may have already received an SMM detailing our new SaveOnSP from the Fund Office, and if not, you will receive it shortly.

Enrollment in the SaveOnSP program lowers your copay for certain specialty drugs to $0, effective February 1, 2021, and also saves the Health Fund money. An up-to-date list of the covered drugs can be found here: www.saveonsp.com/wga.

OVERVIEW

The new program requires a one-time, brief interview and enrollment process, after which you will not have to pay anything for these critical medications. However, it is critically important that you undertake the interview – and enroll in the program – because without it your copay will rise to $1,000 effective February 1, 2021.

The SaveOnSP program will save the Health Plan money as well as you. Each year, the Health Plan

spends almost 50% of its prescription-related costs on specialty drugs. This program will save you money and allow the Health Fund to continue to operate efficiently and effectively on your behalf.

Below is a typical example of how this will work:

Sue *ENROLLS* in SaveOnSP to save on her specialty medications.	
Current copay	$100
New Copay	none
Final Cost	$0
SaveOnSP will monitor Sue's account to make sure *she incurs no cost ($0)*.	

Sue *DOES NOT ENROLL* in SaveOnSP to save on her specialty medications.	
Current copay	$100
New Copay	$1,000
Final Cost	$1,000
SaveOnSP cannot monitor Sue's account. *She is responsible for the copay amount on the attached list.**	

*www.saveonsp.com/wga

WHAT TO EXPECT

Early in December, because you are prescribed one or more qualifying specialty medications, you will receive a letter from Express Scripts and the PWGA which officially introduces you to the SaveOnSP program.

Soon after you receive this letter, Express Scripts will begin making calls to each of you, to begin signing you up for the SaveOnSP program. The call is expected to take no more than a few minutes, and once the enrollment call is completed, you are officially signed up for the SaveOnSP program – there is nothing more you have to do. Your copay for the specialty drug will be $0.

For those who are not able to be reached by Express Scripts during their initial calls, you will be provided information on where to call to get signed up; however, if you are not able to call them back, Express Scripts will continue to reach out to you to get you signed up. Express Scripts has committed to making sure that 100% of our Participants will be contacted by them so that no one is inadvertently left with a large copay as we transition to this new program.

WHAT HAPPENS IF I AM NOT AVAILABLE FOR THE INITIAL INTERVIEW?

We recognize that our Participants are busy, sometimes on set, or working in various parts of the world. Eligible Participants who do not get signed up in the initial round of calls will

receive a follow up letter from Express Scripts on or about January 1, 2021. This will be followed by additional outreach calls again encouraging sign up for the program. The point of these calls is to make sure that none of our Participants miss out on enrollment.

Those Participants who have still not signed up as of January 20, will be contacted again by the PWGA. We want to ensure that all eligible Participants are signed up prior to our February 1, 2021 program start date.

If a Participant is not able to sign up initially, and they go to their preferred pharmacy to pick up their prescription, they will be given the opportunity to work with SaveOnSP and be instantly enrolled before filling their prescription. The SaveOnSP representative will explain the program to the impacted member and enroll them in the copay assistance program so they can benefit from a zero-dollar copay.

For those Participants who receive eligible specialty prescriptions by mail order through Accredo, there will be another opportunity to enroll. When the Participant renews their prescription, the Accredo representative will explain how to enroll and make the necessary arrangements with the Participant.

FINAL THOUGHTS

The Health Plan will work closely with you and Express Scripts to make sure this process goes as smoothly as possible. We are committed to working with Express Scripts to make sure all our eligible Participants can take advantage of the SaveOnSP program.

If you have any questions or concerns, you can contact us at: (818) 846-1015. You can also contact SaveOnSP at: 1-800-683-1074 Monday – Thursday 8:00 a.m. – 9:00 p.m. Eastern and Friday 8:00 a.m. – 7:00 p.m. Eastern.

Yours truly,

Jim Hedges
CEO

Writers Guild Industry Health Fund
2022 SaveOnSP Drug List

Please call 1-800-683-1074 to enroll. Once enrolled, your responsibility will be $0.

SaveOnSP

Effective January 1, 2022
The SaveOnSP Drug List is subject to change at any time. The inclusion of a particular specialty prescription drugs within the SaveOnSP Program is subject to SaveOnSP Program design, as well as applicable laws or regulations. Prescription benefit plan terms will take precedence and determine access to all specialty prescription drugs on SaveOnSP Drug List; medical benefit drugs are excluded from the SaveOnSP Program. The specialty medications included on this list will have a 30% coinsurance, but with participation SaveOnSP your final cost will be $0

A

Abraxane
Actemra
Acthar
Adakveo
Adcetris
Adcirca
Advate
Adynovate
Afinitor
Afstyla
Aldurazyme
Alecensa
AlphaNine
Alprolix
Alunbrig*
Ampyra
Arcalyst
Asceniv
Aubagio
Austedo
Avastin
Avonex
Avsola
Ayvakit*

B

Bafiertam
Balversa*
Benefix
Benlysta
Beovu
Berinert
Betaseron
Blenrep*
Bosulif
Braftovi*
Brukinsa*

C

Cablivi*
Cabometyx
Calquence*
Caprelsa*
Carbaglu
Cayston
Cerdelga
Cholbam*
Cimzia
Cinryze
Cometriq
Copaxone
Copiktra*
Cosentyx
Cotellic
Crysvita
Cuvitru
Cyramza
Cystadrops*

D

Darzalex
Darzalex Faspro
Daurismo
Dojolvi
Doptelet
Dupixent

E

Elaprase
Elelyso
Eloctate
Empliciti
Enbrel
Enhertu
Enspryng
Entyvio
Epclusa
Erbitux
Erivedge
Erleada
Esbriet
Esperoct
Evenity
Evkeeza*
Exjade
Exondys 51*
Extavia
Eylea

F

Fabrazyme
Farydak
Fasenra
Feiba NF
Ferriprox*
Fintepla*
Firazyr
Firdapse*
Folotyn
Forteo
Fotivda*
Fulphila

G

Galafold
Gamifant*
Gammagard
Gattex
Gavreto*
Gazyva
Gilenya
Gilotrif
Givlaari
Glatiramer Acetate
Glatopa
Gleevec
Gocovri*
Granix

H

Haegarda
Halaven
Harvoni
Hemlibra
Herceptin
Herceptin Hylecta
Herzuma
Hetlioz
Humate-P
Humira
Hyqvia

I

Ibrance
Iclusig*
Idelvion
Idhifa
Ilaris
Ilumya
Imbruvica*
Imcivree*
Imfinzi
Increlex
Inflectra
Ingrezza*
Inlyta
Inqovi
Inrebic
Iressa
Istodax
Ixempra
Ixinity

J

Jadenu
Jakafi
Jemperli
Jevtana
Jivi
Juxtapid
Jynarque*

K

Kadcyla
Kalbitor
Kalydeco
Kanjinti
Kanuma
Kesimpta
Keveyis*
Kevzara
Kisqali
Kisqali Femara Co-Pack
Kogenate FS
Koselugo*
Kovaltry
Krystexxa
Kuvan

L

Ledipasvir/Sofosbuvir
Lemtrada
Lenvima
Letairis
Leukine
Libtayo*
Lonsurf
Lorbrena
Lucentis
Lumakras
Lumizyme
Lumoxiti*
Lupkynis*
Luxturna
Lynparza

M

Makena
Margenza*
Mayzent

* Indicates drug not dispensed by Accredo Pharmacy. Continue to fill through approved pharmacy.

Mekinist
Mektovi*
Mvasi
Myalept

N

Nerlynx
Neulasta
Neupogen
Nexavar
Nexviazyme
Ninlaro
Nityr
Nivestym
Northera
Novoeight
Novoseven RT
Nplate
Nubeqa
Nucala
Nulibry*
Nuplazid
Nuwiq
Nyvepria

O

Ocaliva
Ocrevus
Odomzo
Ogivri
Olumiant
Ontruzant*
Onureg
Opdivo
Opsumit
Orencia
Orenitram
Orfadin*
Orgovyx*
Orkambi
Orladeyo*
Otezla
Oxbryta
Oxervate
Oxlumo*

P

Padcev
Palynziq
Pemazyre*
Perjeta
Phesgo
Piqray
Plegridy
Polivy
Poteligeo*
Procysbi
Promacta
Pulmozyme

Q

Qinlock*

R

Radicava*
Ravicti
Rebif
Rebinyn
Recombinate
Remicade
Renflexis
Retevmo
Revatio
Revcovi*
Riabni*
Rinvoq
Rituxan
Rituxan Hycela
Rixubis
Rozlytrek
Ruxience
Rybrevant
Rydapt

S

Sandostatin Lar Depot
Saphnelo*
Sapropterin
Sarclisa*
Serostim
Signifor*
Signifor LAR*
Siliq
Simponi
Skyrizi
Sofosbuvir/ Velpatasvir
Soliris
Somatuline Depot
Somavert
Sovaldi
Spinraza
Sprycel
Stelara
Stivarga
Strensiq*
Sublocade
Sutent
Sylvant*

T

Tabrecta
Tafinlar
Tagrisso
Takhzyro
Taltz
Talzenna
Tasigna
Tavalisse*
Tazverik*
Tecentriq
Tecfidera
Tegsedi
Tepezza
Thiola*
Tibsovo*
Tobi Podhaler
Tracleer
Trazimera
Tremfya
Treprostinil
Tretten
Trikafta
Triptodur*
Trodelvy*
Truseltiq*
Truxima
Tukysa*
Turalio*
Tykerb
Tysabri
Tyvaso

U

Udenyca
Ukoniq*
Ultomiris
Uptravi

V

Valchlor
Vectibix
Venclexta*
Verzenio
Viltepso*
Vistogard*
Vitrakvi
Vizimpro
Vonvendi
Vosevi
Votrient
Vumerity
Vyleesi*
Vyndamax
Vyndaqel
Vyondys 53*
Vyxeos*

W

Wakix
Wilate

X

Xalkori
Xeljanz
Xembify
Xenazine
Xermelo*
Xgeva
Xolair
Xospata*
Xpovio*
Xtandi
Xyntha
Xyrem*

Y

Yervoy

Z

Zarxio
Zejula*
Zelboraf
Zeposia
Ziextenzo
Zirabev
Zokinvy*
Zolgensma
Zydelig
Zykadia
Zytiga

* Indicates drug not dispensed by Accredo Pharmacy. Continue to fill through approved pharmacy.

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PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

Dental Plan Options

As a plan participant, Delta Dental provides your dental benefits under the Delta Preferred Option (DPO), a PPO Dental Plan. All Participants (and their dependents) are automatically enrolled under this plan.

If you live in California, you have a choice of dental plans; you may stay enrolled in the Delta Preferred Option (DPO) or you may elect the DeltaCare® USA (DHMO), a Dental HMO Plan. Enclosed you will find the following:

- Delta Preferred Option
  - Delta Dental flyers
  - Delta Dental claim form
    You are automatically placed in the Delta Preferred Option (DPO) Plan, therefore, **there are no forms required to enroll**.
- Delta Care® - You must complete a DeltaCare USA Enrollment/Change form that is located on our web site.

If you are interested in enrolling in the Delta Care Plan, please visit www.1deltadentalins.com to choose a DHMO dental provider.

- Click on Find a dentist
- Enter zip code
- Select DeltaCare® USA individual only (CA Only)
  *Note the 6-digit facility number, this will be asked on the Enrollment Form

PWGA
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YOUR TRUSTED GUIDE

IMPORTANT INFORMATION:

Enrollment is time sensitive for the DeltaCare Program, the enrollment form must be returned by the end of the month that your coverage starts.

"Dental coverage is provided by the Plan at no extra cost. Technically, however, you have the right under the Plan to elect not to receive any dental coverage (even though there is no financial advantage to opting out of the coverage). If, for some reason, you do not want to receive dental coverage, you should contact the Eligibility Department at the number below."

This material is time sensitive therefore please act quickly. If you have any questions, you may contact the Eligibility Department at the Fund Office (818) 846-1015, or visit our website at www.wgaplans.org.

1. PLEASE TYPE OR PRINT
2. DO NOT USE A HIGHLIGHTER
3. STAPLE X-RAYS TO TOP RIGHT CORNER
4. SEND PAGE 1 TO DELTA

DELTA DENTAL OF CALIFORNIA ENCOURAGES DENTAL OFFICES TO SUBMIT CLAIMS ELECTRONICALLY.

DELTA DENTAL®
Delta Dental of California

P.O. Box 997330
Sacramento, CA 95899-7330
Customer Service (888) 335-8227

DELTA USE ONLY

PLEASE MAKE SURE EMPLOYEE'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE: SELF SPOUSE CHILD OTHER
3. SEX: M F
4. **PATIENT BIRTHDATE** MO. DAY YEAR
5. IF FULL TIME STUDENT AND OVER AGE 18, INDICATE: SCHOOL CITY

6. EMPLOYEE/SUBSCRIBER NAME: FIRST MIDDLE LAST
7. **EMPLOYEE SOCIAL SECURITY NUMBER**
8. EMPLOYEE BIRTHDATE MO. DAY YEAR
9. EMPLOYER (COMPANY) NAME AND ADDRESS/UNION LOCAL
10. GROUP NUMBER

EMPLOYEE MAILING ADDRESS — APT. NO. — PHONE NO.
CITY, STATE, ZIP — **ZIP CODE**

11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? IF YES, COMPLETE ITEMS 12 THROUGH 15. YES _____ NO _____
12a. NAME AND ADDRESS OF DENTAL CARRIER(S), ITEM 11.
12b. GROUP NUMBER
13. NAME AND ADDRESS OF EMPLOYER, ITEM 11

14a. EMPLOYEE NAME, ITEM 11 (IF DIFFERENT FROM PATIENT'S)
14b. EMPLOYEE SOCIAL SECURITY NUMBER
14c. EMPLOYEE BIRTHDATE MO. DAY YEAR
15. RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER _____

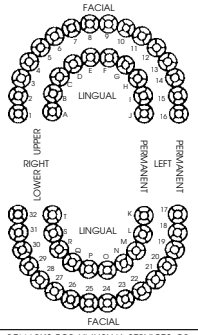
16. DENTIST NAME — **LICENSE NUMBER**
17. MAILING ADDRESS — PHONE NO.
CITY, STATE, ZIP — **ZIP CODE**

24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO YES
25. IS TREATMENT RESULT OF AUTO ACCIDENT? NO YES
26. OTHER ACCIDENT? NO YES
27. ARE ANY SERVICES COVERED BY A NON-DENTAL PLAN? NO YES
IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.

18. DENTIST SOC. SEC. NO. OR T.I.N.
19. DENTIST LICENSE NO.
20. DENTIST PHONE NO.
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT. NO YES
29. DATE OF PRIOR PLACEMENT

21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT: OFFICE HOSP. ECF OTHER
23. RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ HOW MANY?
30. IS TREATMENT FOR ORTHODONTICS? NO YES
IF SERVICES ALREADY COMMENCED ENTER → DATE APPLIANCES PLACED — MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



31. EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32, USE CHARTING SYSTEM SHOWN.

TOOTH NO. OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED M D Y		PROCEDURE NUMBER	FEE	
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

32. REMARKS FOR UNUSUAL SERVICES OR **AMOUNT PAID BY OTHER COVERAGE**

MY DENTIST MAY GIVE DELTA AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL CONDITION OR TREATMENT NEEDED TO DETERMINE BENEFITS FOR UP TO 5 YEARS FROM THIS DATE.

SIGNATURE OF PATIENT (OR PARENT OR GUARDIAN) _____ DATE _____

You may receive a copy of this authorization on request.

TOTAL FEE CHARGED	
PATIENT PAYS	
PLAN PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

PREDETERMINATION OF COST

THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST A PREDETERMINATION OF COST.

DENTIST SIGNATURE _____ DATE _____

TREATMENT COMPLETED - PAYMENT REQUESTED

THE TREATMENT LISTED WAS COMPLETED. I WILL CHARGE AND INTEND TO COLLECT THE ENTIRE PORTION OF THE FEES STATED ABOVE WHICH DELTA DETERMINES TO BE THE PATIENT'S RESPONSIBILITY, AND I WILL NOT WAIVE, REDUCE OR REBATE ANY OF THAT PORTION UNLESS I EXPRESSLY SO STATE ON THIS FORM.

DENTIST SIGNATURE _____ DATE _____

SEE DENTIST'S HANDBOOK FOR PARTICIPATION RULES.

1. SUBMIT PAGE 1 TO DELTA.
2. RETAIN PAGE 2 FOR YOUR FILES.

ATTENDING DENTIST'S STATEMENT
DELTA 105 Rev. 7/03

PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

DeltaCare Dental DHMO

This benefit is available for **California residents only**. If you would like to choose this plan instead of the PPO plan, please visit the website at www.pwga.org, click on forms, and then dental forms Eligibility department within 2 weeks of receipt of this packet to ensure timely enrollment.

- **There is no annual deductible and no cost for covered services except for co-payments for certain procedures.**
- **This is a DHMO. Enrollment is required and you must select a primary care dentist. No benefits are available when services are obtained from a non-DeltaCare provider.**

For a list of DeltaCare providers you may visit this website:
www.1deltadentalins.com

Delta Dental PPO℠ – Easy, Friendly, Accessible

We'll do **whatever it takes and then some.**

Greatest potential savings when you visit a Delta Dental PPO dentist

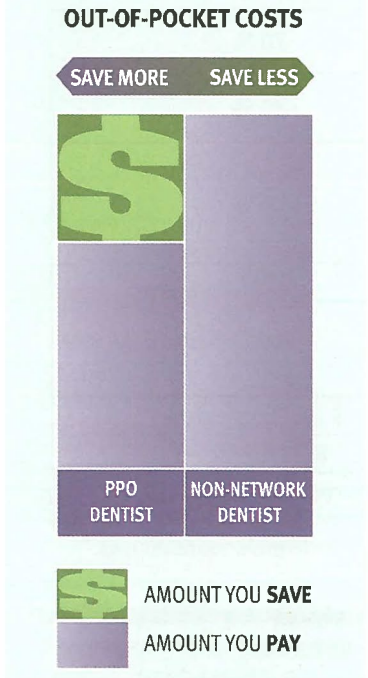


Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and by group contract.

We're pleased to be your partner in maintaining great oral health. The Delta Dental PPO* plan makes it easy for you to find a dentist, and easy to control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

- **Save money with a Delta Dental PPO dentist.** Our PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental PPO dentists won't balance bill you the difference between the contracted amount and their usual fee.
- **Visit the dentist of your choice.** Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest when you see a PPO dentist.
- **Many network dentists to choose from.** Since Delta Dental offers access to one of the largest dentist networks in the U.S., chances are there's a wide choice of network dentists near your home or office. Many dentists nationwide are contracted Delta Dental dentists, giving more enrollees convenient access to more dentists. Visit us at deltadentalins.com to search our dentist directory by location or specialty.
- **Easy to use your benefits.** When you visit a Delta Dental dentist, pay only your portion for services. Delta Dental dentists will file claim forms for you and receive payment directly from us. Many non-Delta Dental dentists ask that you pay the entire cost up front and wait for reimbursement.
- **Delta Dental's Online Services make getting information quick and easy.** Access your benefits and eligibility, print ID cards and get information about your claims. And check out Delta Dental's oral health resources for tips and information that can help keep your smile healthy.

** In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.*

DELTA DENTAL

WE KEEP YOU SMILING®

HL_PPO_2col #70708 (rev. 10/12)

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Plan Benefit Highlights for: WRITERS' GUILD - INDUSTRY HEALTH FUND

Group No: 00825 **Effective Date:** 1/1/2013

Eligibility	Primary enrollee, spouse (includes same-sex domestic partner only) and eligible dependent children to age 26			
Deductibles	$75 per person / $150 per family each calendar year			
Deductibles waived for D & P?	Yes			
Maximums	$2,500 per person each calendar year *(Waived for all dependent children to age 19 for D&P, Basic and Major Services)*			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Orthodontics None	Implants None

Benefits and Covered Services*	Delta Dental PPO dentists** In-PPO Network	Non-PPO dentists** Out-of-PPO Network
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays	100 %	80 %
Diagnostic & Preventive Services (D & P) Sealants to age 14	100 %	100 %
Basic Services Fillings, simple tooth extractions	80 %	70 %
Endodontics (root canals) Covered Under Basic Services	80 %	70 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	70 %
Oral Surgery Covered Under Basic Services	80 %	70 %
Major Services Crowns, inlays, onlays and cast restorations, bridges and dentures, occlusal guard	80 %	70 %
Implant Benefits	80 %	70 %
Orthodontic Benefits Adults to age 19 and Dependent children to age 19 only	70 %	70 %
Orthodontic Maximums	$ 2,000 Lifetime	$ 2,000 Lifetime
Orthodontic Deductibles	$ 25 Lifetime	$ 25 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California
100 First St.
San Francisco, CA 94105

Customer Service
800-765-6003

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Understanding coordination of benefits and dual coverage

We'll do **whatever it takes and then some.**

What is dual coverage?

If you have two jobs that both provide dental benefits or if you are covered by a second dental plan in addition to your own, you have what is called dual coverage. Dual coverage doesn't mean that your benefits are doubled. What it does mean is that you will likely enjoy lower out-of-pocket costs for your dental care.

Dual coverage saves money for you and your group by sharing the total cost of covered dental services between two carriers. Containing costs is an important part of Delta Dental's plan to keep you smiling.

How does dual coverage work?

Dual coverage works the same way whether you are covered by two Delta Dental plans or by Delta Dental and another carrier. We simply work with the other dental carrier and your dental office to coordinate your benefits and ensure that the combined amount paid by the plans does not exceed the total amount the dentist has agreed to accept from Delta Dental.

Suppose, for example, that both of your plans provide two cleanings a year, each with 80 percent coverage. You would not be entitled to four cleanings per year, but you would have some cost savings. The primary carrier pays up to 80 percent of its maximum plan allowance first, and the secondary carrier would cover up to the remaining 20 percent that you would have had to pay out-of-pocket if you were covered by only one plan.

Why not twice as many benefits?

Why don't you receive double the benefits when you have two dental plans, especially if your dentist recommends that you receive more than two cleanings per year?

Dual coverage limitations, like all other plan limitations, are built into your group's contract and into the rates your group pays for your coverage. These contracts are set up to provide affordable dental care to a maximum number of people. Given the choice between doubling an individual's benefits or providing a greater scope of benefits to more people in the group, most group purchasers choose to spread their benefit dollars more evenly.

What is "non-duplication of benefits"?

For groups with a non-duplication of benefits rule in their plan, the secondary carrier pays only the difference between what the primary carrier actually paid and what the secondary carrier would have paid if it had been the primary carrier.

For example, if the primary carrier paid 80 percent and the secondary carrier normally covers 80 percent as well, the secondary carrier would not make any additional payment. However, if the primary carrier had only paid 50 percent, the secondary carrier would pay up to the remaining 30 percent.

(Continued)

WE KEEP YOU SMILING®

Why do 60 million enrollees trust their smiles to Delta Dental?*

- More dentists
- Simpler process
- Less out-of-pocket

SmileWay® Wellness Program

Find all of our dental health resources, including risk assessment quizzes, articles, videos and a free e-newsletter subscription, at: **mysmileway.com**.

Connect with us!

facebook.com/deltadentalins
twitter.com/deltadentalins
youtube.com/deltadentalins

Product administration

Delta Dental includes these companies in these states: Delta Dental of California – CA • Delta Dental of Pennsylvania – PA & MD • Delta Dental of West Virginia – WV • Delta Dental of Delaware, Inc. – DE • Delta Dental of the District of Columbia, Inc. – DC • Delta Dental of New York, Inc. – NY • Delta Dental Insurance Company – AL, FL, GA, LA, MS, MT, NV, TX, UT

*Delta Dental of California, Delta Dental of Pennsylvania and Delta Dental Insurance Company, together with our affiliate companies and Delta Dental of New York Inc., are members, or affiliates of members, of the Delta Dental Plans Association, a network of 39 Delta Dental companies that together provide dental coverage to more than 60 million people in the U.S.

Who is the primary carrier?

The primary carrier is the one that covers you as the enrollee (e.g., through your employer rather than your spouse's employer). If you have two jobs, the plan that has covered you longer is considered primary.

For your children's coverage, the primary carrier is generally determined by the "birthday rule": coverage of the parent whose birthday (month and day, not year) comes first in the year is your children's primary coverage. For example, if the mother's birthday is in April and the father's birthday is in September, the mother's plan would be primary.*

Here are more dual coverage examples to help you determine the primary carrier.

Q. Whose plan is primary when a child's father and mother have the same month and day of birth?	**A.** The plan that has covered either parent longer is primary.*
Q. Whose plan is primary when a child's parents are legally separated or divorced?	**A.** The parent with legal custody usually provides primary coverage.* When children are covered through remarriages/ domestic partnerships, coverage is determined in this order: - Primary coverage: custodial parent - Secondary coverage: custodial parent's spouse/domestic partner - Third: non-custodial parent - Fourth: non-custodial parent's spouse/domestic partner
Q. Whose plan is primary when there is joint custody and both parents have dental coverage?	**A.** In joint custody cases, the parent whose birth date falls earlier in the year provides primary coverage.
Q. Which plan is primary for a person with two jobs, or if a person has coverage as an active employee of one company and as a laid-off or retired employee of another company?	**A.** In the case of two jobs, the plan that has covered the employee longer is primary. In the other case, the plan covering the person as an active employee is primary and the coverage resulting from retirement or being laid off is secondary.

Please review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

*These rules are superseded by a court order establishing the person responsible for the child's coverage.

DELTA DENTAL®

deltadentalins.com/enrollees

Pre-treatment estimate: Avoid surprises with a free estimate of your dental costs

We'll do **whatever it takes and then some.**

Reasons you might want a pre-treatment estimate:

- If you are having extensive dental work
- To ensure a procedure is covered
- To see if you will exceed your maximum
- If you need to plan your payment in advance

Make informed decisions about your dental care

If you are thinking about having extensive dental work, you should know about a free service Delta Dental provides to its enrollees called a *pre-treatment estimate* or a *predetermination of benefits*.

A pre-treatment estimate is particularly useful for more costly procedures such as crowns, wisdom tooth extractions, bridges, dentures or periodontal surgery. When your dentist requests a pre-treatment estimate from Delta Dental, you and your dentist will receive an estimate of your share of the cost and how much Delta Dental will pay — before treatment begins.

You can ask your dentist to get a pre-treatment estimate for any procedure, but this service is specifically designed to help estimate the costs of an extensive treatment plan, especially those that are expected to exceed $300.

Any service may be sent for a pre-treatment estimate if you would like an advance breakdown of the charges and coverage.

How does a pre-treatment estimate work?

Your dentist sends Delta Dental a proposed treatment plan, along with any necessary x-rays. We then check to be sure the services are covered by your dental plan. Some dental work may be limited or excluded by your plan, and you will want to know exactly what services are covered before you proceed with treatment. We also calculate how any deductibles, coinsurance and dollar maximum limits might affect your share of the cost. You and your dentist then receive an estimate of the amount we will pay for approved services and the amount you will be responsible for. Pre-treatment estimates usually take about two weeks.

Why are pre-treatment estimates useful?

Unless the need is urgent, it is worthwhile to find out how much of your treatment is covered, allowing you to plan in advance for your portion of the dental bill.

Please review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

DELTA DENTAL®

Socialize with us: deltadentalins.com/enrollees

WE KEEP YOU SMILING®

Why do 59 million enrollees trust their smiles to Delta Dental?*

- More dentists
- Simpler process
- Less out-of-pocket

SmileWay® Wellness Program

Find all of our dental health resources, including a risk assessment tool, articles, videos and a free e-newsletter subscription, at **mysmileway.com**.

Product administration

Delta Dental includes these companies in these states: Delta Dental of California – CA • Delta Dental of Pennsylvania – PA & MD • Delta Dental of West Virginia – WV • Delta Dental of Delaware, Inc. – DE • Delta Dental of the District of Columbia – DC • Delta Dental of New York, Inc. – NY • Delta Dental Insurance Company – AL, FL, GA, LA, MS, MT, NV, TX, UT

*Delta Dental of California, Delta Dental of Pennsylvania and Delta Dental Insurance Company, together with our affiliate companies and Delta Dental of New York, Inc., are members, or affiliates of members, of the Delta Dental Plans Association, a network of 39 Delta Dental companies that together provide dental coverage to more than 59 million people in the U.S.

DELTA DENTAL®

Check out our new wellness resource

SmileWay® Your smile. Your health. Your way.

The SmileWay Wellness Challenge provides recommendations for how to participate in the program by taking advantage of the extensive resources available on our SmileWay Wellness site.

1. Review your habits
Take one or both of our interactive quizzes to see if you are at risk for cavities or gum (periodontal) disease. When you receive your quiz results, you can sign up to receive customized emails based on your risk level.

2. Get educated
Read any of the 100+ articles on dental health-related topics — everything from acid reflux to x-rays. We also have a variety of short videos on specific topics.

3. Stay informed
Receive regular dental health tips and information from us by:

a. signing up for the *Grin!* newsletter (emailed quarterly)
b. connecting with us on Facebook
c. following us on Twitter

All of this is accessible from our SmileWay Wellness site at **mysmileway.com**. Bookmark the page so you can refer to it frequently.

Questions about oral health?

If you've got questions about oral health, be sure to check out our **SmileWay Wellness site** for answers. We've compiled an extensive library of articles on oral health topics from amalgam fillings to x-rays and just about every oral health topic in between.

Mouth-body connection
- Diabetes and oral health
- Heart disease and oral health
- Men's and women's oral health
- Stress and oral health

Preventive care
- Brushing and flossing
- Choosing a toothbrush
- Fighting bad breath
- Fluoride

Emergency care
- Dental care when traveling
- Handling dental emergencies

Kids & teens
- Baby bottle tooth decay
- Children's oral health
- Teens' oral health

Seniors
- Dentures
- Seniors' oral health

Dental treatments
- Amalgam and resin fillings
- Braces
- Dental implants
- Sealants

Conditions
- Dry mouth
- Mouth sores
- Sensitive teeth
- TMJ

Nutrition
- Diet and diabetes
- Snacking on the go
- Vegetarian diet
- What to eat to keep your teeth

deltadentalins.com/enrollees

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GENERAL STATEMENT OF NONDISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)

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

a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)

b) Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters and information written in other languages

If you need these services, contact Linda Abruzzo, Program and Compliance Manager, at 1-800-227-7863.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Linda Abruzzo, Program and Compliance Manager, 2900 W. Alameda Avenue, Suite 1100, Burbank CA 91505, Telephone: 1-818-846-1015, TTY: 1-818-526-3199, Fax: 1-818-526-6522, Email: Compliance@wgaplans.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Linda Abruzzo, Program and Compliance Manager is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHS Building, Washington, DC 20201, 1-800-868-1019, 1-800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

ATTENTION: FREE LANGUAGE ASSISTANCE

This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.

Language	Message About Language Assistance
English	ATTENTION: Language assistance services are available to you free of charge. Call 1-800-227-7863 (TTY: 1-818-526-3199).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-227-7863 (رقم هاتف الصم والبكم: 1-818-526-3199).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-227-7863（TTY：1-818-526-3199）。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-227-7863 (ATS : 1-818-526-3199).
French Creole (Haitian)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-227-7863 (TTY: 1-818-526-3199).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-227-7863 (TTY: 1-818-526-3199).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-227-7863 (TTY: 1-818-526-3199).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-227-7863（TTY:1-818-526-3199）まで、お電話にてご連絡ください。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-227-7863 (TTY: 1-818-526-3199) 번으로 전화해 주십시오.
Persian	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-227-7863 (TTY: 1-818-526-3199) تماس بگیرید.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-227-7863 (TTY: 1-818-526-3199).
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-227-7863 (TTY: 1-818-526-3199).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-227-7863 (телетайп: 1-818-526-3199).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-227-7863 (TTY: 1-818-526-3199).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-227-7863 (TTY: 1-818-526-3199).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-227-7863 (TTY: 1-818-526-3199).

PWGA

Pension & Health Plans

YOUR TRUSTED GUIDE

PWGA PENSION & HEALTH PLANS
2900 W. Alameda Avenue, Suite 1100
Burbank, CA 91505-4267
(818) 846-1015 • (800) 227-7863
wgaplans.org