

Writers' Guild-Industry Health Fund Health Benefit Changes

Summary of Material Modification

Addendum – November 1, 2011

A Message From The Board of Trustees

This document is a Summary of Material Modification (“SMM”) intended to notify you of important changes to certain benefits as well as to the claim and appeal procedures under the Writers' Guild-Industry Health Fund (“Plan”). Generally speaking, these changes were made to comply with the applicable requirements under the Patient Protection and Affordable Care Act of 2010 (“PPACA”) and the Mental Health Parity Act of 2008 (“MHPA”), and are effective as of January 1, 2012, unless otherwise noted below.

Changes Regarding Mental Health And Chemical Dependency Benefits

Overview of Benefit Changes to Comply with the MHPA

To comply with the Mental Health Parity and Addiction Equity Act of 2008, Plan coverage for mental health and chemical dependency benefits will be provided at the same benefit levels as the medical coverage. Effective January 1, 2012, mental health and chemical dependency benefits will have the same deductibles, copays, coinsurance and out-of-pocket maximums as medical benefits.

- Calculation of deductibles and out-of-pocket expenses will *combine* mental health and chemical dependency treatment costs with other medical costs; co-insurance rules will apply to all such services.
- The OptumHealth provider network will no longer be available and, instead, the *Blue Cross/BlueCard*® provider network will be the approved network for both medical and mental health care.
- Claims processing for such benefits will be transferred from OptumHealth to the Fund Office.

Transition of Care Policy

Recognizing that some providers may not belong to both OptumHealth's and *Blue Cross/BlueCard*® respective networks, we have arranged for “transition of care” benefits that will allow patients to continue to receive services at in-network benefit levels for a defined period if their participating OptumHealth provider is not contracted with the *Blue Cross/BlueCard*® as of January 1, 2012.

In-Patient Policy

If you are receiving ongoing in-patient services at a facility in the OptumHealth network for continuous dates beginning before January 1, 2012 and ending on or after January 1, 2012, you may continue to receive such services at the current in-network benefit levels until the end of your confinement.

Out-Patient Policy

If you are receiving ongoing out-patient services from an OptumHealth network provider prior to January 1, 2012, you may continue to use that provider and receive benefits at the in-network level until March 2, 2012. If, however, you continue to receive ongoing outpatient treatment from your OptumHealth network provider *after* March 2, 2012 and that provider *does not join* the *Blue Cross/BlueCard*® network, you will be subject to out-of-network benefit reimbursement rules for such treatment.



Plan Benefits

Calculation of deductibles and out-of-pocket expenses will *combine* mental health and chemical dependency treatment costs with other medical costs; co-insurance rules will apply to all such services.

The current visit limitations for treatment of mental health and chemical dependency benefits will be eliminated. Coverage for such treatments will still be subject to medical necessity considerations and reasonable and customary industry practice.

Medical and Mental Health and Chemical Dependency Benefits

| | PPO PLAN | PPO PLAN | LOW OPTION PLAN | LOW OPTION PLAN | OUT-OF-AREA PLAN |
|------------------------------|----------------------|--------------------------|----------------------|--------------------------|---|
| | In-Network Providers | Out-of-Network Providers | In-Network Providers | Out-of-Network Providers | (For participants who live over 25 miles outside the PPO service area of 2 providers) |
| Inpatient Services* | | | | | |
| -Deductible | \$300/\$900 | \$300/\$900 | \$750/\$2,250 | \$750/\$2,250 | \$300/\$900 |
| -Copay per admit | \$100 copay | \$100 copay | \$100 copay | \$100 copay | \$100 copay |
| -Coinsurance | 85% | 70% | 70% | 60% | 80% |
| -Out-of-Pocket Max | \$1,000 | \$2,500 | \$4,500 | \$6,000 | \$1,000 |
| Outpatient Services** | | | | | |
| -Deductible | \$300/\$900 | \$300/\$900 | \$750/\$2,250 | \$750/\$2,250 | \$300/\$900 |
| -Coinsurance | 85% | 70 % | 70% | 60% | 80% |
| -Out-of-Pocket Max | \$1,000 | \$2,500 | \$4,500 | \$6,000 | \$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

Under the current mental health and chemical dependency benefits, you are required to have all treatment pre-authorized by OptumHealth. As of January 1, 2012, this requirement is being eliminated for services provided by a behavioral health provider for outpatient therapy. However, all in-patient and outpatient facility¹ 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



Referrals From “The Industry Health Network” (“TIHN”)

If the health center doctor treating you determines a behavioral health provider should treat your condition, they will provide you with a medical order² rather than a referral. At this time, behavioral health services will not be a part of the TIHN referral program.

Claim Submission

The processing of your mental health and chemical dependency claims will be moved to the Fund Office. The filing process will generally follow the same process as the medical claims.

Where to file a claim

Where you submit your claim depends on where the provider is located.

- *Hospital and Outpatient Facility Claims must be submitted to the local Blue Cross/BlueCard® office. (Mailing addresses are listed on our website www.wgaplans.org, How to File a Medical Claim).*
- Claims from California providers must be submitted to the Fund Office.
- Claims from non-California providers must be submitted to the local Blue Cross/BlueCard® office for that provider. (Mailing addresses are listed on our website www.wgaplans.org, How to File a Medical Claim.)

What form to use

Whether you're submitting your claim to the Fund Office or to the local Blue Cross/BlueCard® office, you'll need to use a HCFA-1500 form for professional or ancillary services or UB-92/UB-94 for facility services. The HCFA-1500 form is available in the forms section of our website. If the HCFA-1500 form is not completed by the provider of service, the provider's *super bill* or itemized bill must be attached. An itemized bill (evidence of loss) submission should include —

- Your name and ID number
- Your provider's name, address and taxpayer ID number
- Patient's name and date of birth
- Procedure code(s) and diagnosis code
- Amount paid and proof of payment

Claims Incurred Prior to January 1, 2012

OptumHealth will continue to process all claims incurred before January 1, 2012, including claim appeals for services rendered during this period and such claims should be submitted directly to OptumHealth. Claims will be honored through the Plan's filing period of 2 years or December 31, 2013.

² Treatment recommendation that requires self-referral to a behavioral physician.



QUESTIONS– Mental Health And Chemical Dependency Benefits

What if my current OptumHealth provider is not in the Blue Cross/BlueCard® network?

You will need to switch to a provider who is in the *Blue Cross/BlueCard®* network to continue to receive the higher network benefits. If your Optum provider is interested in joining the *Blue Cross/BlueCard®* network, he or she should contact their local *Blue Cross/BlueCard®* office or call (800) 810-BLUE (2583). See the Transition of Care Policy noted on Page 1.

What if I need to see a doctor prior to January 1, 2012?

The January 1st effective date applies to services rendered by a provider after December 31, 2011. Therefore, you must use Optum network providers through December 31, 2011 to receive the higher network benefits.

How do I get a list of Blue Cross/BlueCard® contracted providers in my area?

You can call (800) 810-BLUE (2583). Be sure to tell the Customer Service Representative that your 3-character alpha prefix is WRX. You can also visit the Health Fund's Web site (www.wgaplans.org) and use the link for the *Blue Cross/BlueCard®* Doctor and Hospital Finder.

Will my prescription drug coverage remain the same?

Yes. Medco Health Solutions remains the nationwide provider for prescription drug benefits.

Is the Plan issuing new ID cards to all participants?

Yes, new ID cards are being issued to all Health Fund participants. The new ID card has specific claim submission information for providers located in and outside California.

Who do I call for claim status or questions regarding my EOB for services rendered?

For services rendered **prior** to January 1, 2012, call OptumHealth customer service at (800) 301-0056.

For services rendered **on or after** January 1, 2012, call the Fund Office at (818-846-1015 or (800) 227-7863 (outside the Los Angeles Area).

Who do I call for eligibility and benefits?

For services rendered **prior** to January 1, 2012, call OptumHealth customer service at (800) 301-0056.

For services rendered **on or after** January 1, 2012, call the Fund Office at (818) 846-1015 or (800) 227-7863 (outside the Los Angeles Area).



Changes To Comply With PPACA

As a result of the above-discussed changes with regard to the mental health and chemical dependency benefits, the Trustees believe that the Plan will no longer be grandfathered under PPACA when these changes go into effect on January 1, 2012. Accordingly, the Trustees have decided to implement the necessary changes (as described below) under the healthcare reform law that apply to non-grandfathered group health plans. These changes are effective as of January 1, 2012.

Coverage for Hospital Emergency Room Services

Effective January 1, 2012, the Plan will charge you the same copayment or coinsurance for hospital emergency room services whether you obtain those services from a participating in-network hospital or from a non-participating out-of-network hospital. Accordingly, emergency care provided in an emergency room by an out-of-network provider will be considered at the network coinsurance level or 85% for the PPO Plan and 70% for the Low Option Plan, subject to the Plan's \$50 copayment³ and annual deductible.

However, if you obtain those services from a non-participating out-of-network hospital, that hospital may bill you separately if the hospital's charges exceed the Plan's allowances for the services.

No Cost Sharing for Preventive Care Services

Effective January 1, 2012, the Plan will cover certain preventive services at 100% with no deductible or co-payment if they are rendered by an in-network provider⁴.

The preventive services to which this new rule applies is generally defined to include the following, as may be amended from time to time:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventative Services Task Force ("Task Force") with respect to the individual involved. (For a complete list of "A" and "B" Recommendations of the Task Force see <http://www.healthcare.gov/center/regulations/prevention/taskforce.html>.)
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force).

³ Copay is waived if admitted; hospital admission copay applies.

⁴ PPO and Low Option Plan.



Pages 7-8 contain a list of preventive care services that are currently covered at this level under the Plan, but this will change automatically as the above guidelines/recommendations change.⁵ Additional detail regarding these preventive care services may be found online at www.healthcare.gov/center/regulations/prevention/taskforce.html.

We also note that many of these tests and screenings are already covered under the Plan's wellness benefits. With that in mind, please note that there are certain wellness benefit services that are not deemed to be preventive care services and, therefore, will continue to be covered under the Plan's wellness benefit program⁶. Accordingly, the Plan will apply the preventive care benefits first and any remaining wellness benefits (that do not constitute preventive care services) will be applied toward the Plan's \$500/person or \$1500/family annual wellness benefits.

Note: Cost Sharing When Preventive Health Services Are Provided as Part of an Office Visit:

Generally speaking, the imposition of a cost-sharing requirement for office visits during which recommended preventive health care services are rendered, either in whole or in part, depends upon how the preventive health service is billed and the primary nature of the office visit. Cost sharing for office visits will be applied if: (1) a preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit where the primary purpose of the visit was for preventive services; or (2) the primary purpose of the office visit was not to provide a preventive service or item, regardless of whether preventive services are billed separately (or are tracked as individual encounter data) from an office visit.

Cost sharing for office visits will not be applied if recommended preventive services are not billed separately (or are tracked as individual encounter data) from an office visit and the primary purpose of the visit was the delivery of a preventive service or item.

Also, there may be times when you are seen by your doctor for your annual physical examination, but your doctor may order several tests. Some of those tests may be considered preventive care. These tests will be paid at 100% of the network contract allowance only if in-network. Some of the tests ordered by your doctor might not be for preventive services and may be subject to any applicable deductibles, co-pays, or co-insurance. For example, if you go to a network provider for a sore throat and while there it is recommended that you have your cholesterol checked, the office visit is subject to the deductible/co-pay/coinsurance, and the cholesterol test is paid at 100%. Additionally, if you are diagnosed with a condition such as hyperlipidemia (high cholesterol) and your doctor performs a cholesterol test, then that test is subject to cost sharing as it is in connection with a medical condition and not preventive services. Please also note that the Plan will only pay for preventive services which are considered medically necessary. For example, a routine colonoscopy for an individual under the age of 50 would not be a covered expense as this test is performed routinely only for individuals age 50 and over.

⁵ Any additional recommendations provided in the future will be covered as of the first plan year beginning on or after the first anniversary of when the recommendations are updated.

⁶ Wellness Benefits are not available under the Low Option Plan.



List of Covered Preventive Care Services NETWORK ONLY

Children and Adolescents

Newborns

- ◆ Screening all newborns for
 - Hearing loss
 - Hypothyroidism
 - Phenylketonuria (PKU)
 - Sickle cell disease
- ◆ Gonorrhea preventive medication for eyes of all newborns

Childhood/Adolescent Immunizations

- ◆ Diphtheria, Tetanus, Pertussis
- ◆ Haemophilus influenzae type B
- ◆ Hepatitis A and B
- ◆ Human Papillomavirus (HPV)
- ◆ Influenza (Flu)
- ◆ Measles, Mumps, Rubella
- ◆ Meningococcal
- ◆ Pneumococcal (pneumonia)
- ◆ Inactivated Poliovirus
- ◆ Rotavirus
- ◆ Varicella (chickenpox)

Childhood Screenings

- ◆ Medical history for all children throughout development
- ◆ Height, weight and Body Mass Index (BMI) measurements
- ◆ Developmental screening for children throughout childhood
- ◆ Autism screening for children at 18 and 24 months
- ◆ Behavioral assessment for children of all ages
- ◆ Vision screening
- ◆ Oral health risk assessment for young children
- ◆ Hematocrit or Hemoglobin screening
- ◆ Obesity screening and weight management counseling for children age 6 or older
- ◆ Iron supplements for children 6 to 12 months who are at higher risk for anemia
- ◆ Fluoride supplements for children without fluoride in their water
- ◆ Lead screening for children at risk of exposure
- ◆ Dyslipidemia screening for children at higher risk of lipid disorder
- ◆ Tuberculin testing for children at higher risk of tuberculosis

Additional Screenings for Adolescents

- ◆ Depression screening
- ◆ Alcohol and drug use assessment
- ◆ Cervical dysplasia screening for sexually active young women
- ◆ Counseling to prevent sexually transmitted infections (STIs) for sexually active adolescents
- ◆ HIV screening for adolescents at higher risk



Health Screenings for Adults

- ◆ Blood pressure screening for adults
- ◆ Cholesterol screening for men age 35 and older, women age 45 and older, and younger adults at higher risk
- ◆ Diabetes screening for type 2 diabetes for adults with high blood pressure
- ◆ HIV and sexually transmitted infections (STI) screenings for adults at higher risk

Cancer Screenings

- ◆ Breast cancer mammography every 1 to 2 years for women over age 40
- ◆ Breast cancer chemoprevention counseling for women at high risk for breast cancer
- ◆ Cervical cancer pap test for women
- ◆ Colorectal cancer screening including fecal occult blood testing, sigmoidoscopy or colonoscopy from age 50 to 75
- ◆ Prostate cancer (PSA) screening for men

Health Counseling

- ◆ Doctors are encouraged to counsel patients about these health issues and refer them to appropriate resources as needed
 - Healthy diet
 - Weight loss
 - Tobacco use
 - Alcohol misuse
 - Depression
 - Prevention of STIs
 - Use of aspirin to prevent cardiovascular disease

Adult Immunizations

- | | | |
|------------------------------|---------------------------|----------------------------------|
| ◆ Hepatitis A and B | ◆ Influenza (Flu) | ◆ Pneumococcal (pneumonia) |
| ◆ Herpes Zoster (Shingles) | ◆ Measles, Mumps, Rubella | ◆ Tetanus, Diphtheria, Pertussis |
| ◆ Human Papillomavirus (HPV) | ◆ Meningococcal | ◆ Varicella (chickenpox) |

Screenings for Men

- ◆ Abdominal aortic aneurysm one-time screening for men age 65 to 75 who have smoked

Screenings for Women

- ◆ Osteoporosis screening for women age 60 and older, depending on risk factors
- ◆ BRCA counseling about genetic testing for women at higher risk

Specifically for Pregnant Women

- | | |
|---|---|
| ◆ Folic acid supplements for women who may become pregnant | ◆ RH incompatibility blood type at first prenatal visit and 24-28 weeks |
| ◆ Anemia screening for iron deficiency | ◆ Bacteriuria urinary tract infection screening at 12 to 16 weeks |
| ◆ Tobacco cessation counseling for all pregnant women who smoke | ◆ Breastfeeding education to promote breastfeeding |
| ◆ Syphilis screening for all pregnant women | |
| ◆ Hepatitis B screening during the first prenatal visit | |



Changes to the Claims and Appeal Procedures

Overview of the “New” External Review Procedures

Effective for claims incurred on and after January 1, 2012, the Plan’s claims and appeals procedures have been changed pursuant to PPACA. Most notably, the Plan is implementing an external review appeal process. If, after exhausting the Plan’s internal appeals procedure, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- Clinical reasons,
- The exclusions for Experimental or Investigational Services or Unproven Services, or
- As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the Plan’s internal appeals process and receiving a final adverse benefit determination from the Plan on your internal appeal (your “internal appeal denial”). You may request an external review by an independent review organization (IRO) within four (4) months of the notice of the internal appeal denial.⁷

The Plan’s internal appeal denial notice will inform you of your right to request an external review appeal, your external review rights and your right to file suit in federal court under the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended. *See the SPD for details regarding the internal appeals process.*

The external review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a covered health service under the Plan. The IRO has been contracted by the Plan and has no material affiliation with or interest in the Plan. The Plan will choose the IRO based on a rotating list of approved IROs. In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO. Within applicable timeframes of the Plan’s receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- all relevant medical records;
- all other documents relied upon by the Plan in making a decision on the case; and
- all other information or evidence that you/or your Physician have already submitted to the Plan.

⁷ If there is no corresponding date four (4) months after the date of your receipt of the internal appeal denial notice, then you must file the request for an external review by the first day of the fifth month following your receipt of such notice. For example, if the date of your receipt of the Plan’s internal appeal benefit denial notice is October 30, because there is no February 30, the request must be filed by March 1. In addition, if the last filing date would fall on a weekend or Federal holiday, the last filing date to request an external review is extended to the next day that is not a Saturday, Sunday or Federal holiday.



If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and the Plan will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

Preliminary Review by the Plan

Within five (5) business days following the date of the Plan's receipt of your request for an external review, the Claims Administrator will complete a preliminary review to determine whether your request is complete and eligible for an external review. Specifically, that preliminary review will determine whether:

- (i) you were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, provided;
- (ii) the final denial of your appeal relates to your failure to meet the Plan's eligibility requirements;
- (iii) you exhausted the Plan's internal appeal process (or are not required to exhaust the process); and
- (iv) you have provided all the information and forms required by the Plan to process an external review.

Within one (1) business day after the Claims Administrator completes its preliminary review, it will issue you a written notification of its determination. If your request is complete, but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If your request is not complete, the notification will describe the information or materials needed to make the request complete and you will be allowed to perfect your request for an external review within the original four-month filing period or, if later, the 48-hour period following your receipt of the notification.

Review by the IRO

If the Claims Administrator approves your request for an external review, the Plan will assign a qualified IRO to conduct it. Within five (5) business days after making the assignment, the Plan will provide the assigned IRO with the documents and information that the Claims Administrator considered in making its final adverse benefit determination.

The Plan will also notify you of this assignment. Upon receiving such notice, you will have ten (10) business days to submit additional information to the IRO. If you submit additional information, within one (1) day after receiving such information, the IRO will send such information to the Plan so that it may reconsider its determination. If the Plan decides to reverse its decision based on its review of this new information, it will provide a written notice of its decision to you and the IRO within one (1)



business day after reaching that favorable decision; and the IRO will terminate the external review upon receipt of the Plan's notice. If, however, the Plan does not reverse its determination, the IRO will conduct a *de novo* review of all of the information and documents that it received from the Plan or you, and will not be bound by any decisions or conclusions reached by the Claims Administrator during the Plan's internal claim and appeal process. The IRO, at its discretion, may also consider the following in reaching its decision: your medical records; the attending health care professional's recommendation; reports from the appropriate health care professionals and other documents submitted by the Claims Administrator, you or your treating provider; the terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan; appropriate practice guidelines; any applicable clinical review criteria developed and used by the Plan; and the opinion of the IRO's clinical reviewer(s).

The IRO will provide written notice to you and the Claims Administrator of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO's notice will contain, to the extent required by law, the following information:

- (i) a general description of the reason for the request for external review including, if applicable, information sufficient to identify the claim, the amount of the claim, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial;
- (ii) the date the IRO received the assignment from the Plan to conduct the external review and the date of the IRO's decision;
- (iii) references to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;
- (iv) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- (v) a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or you;
- (vi) a statement that judicial review may be available to you; and
- (vii) if applicable, the current contact information for any applicable office of health insurance consumer assistance or ombudsman.

Overview of the "New" Expedited External Review Procedures

Under the following circumstances, you may be eligible to file for an expedited external review:

- (i) If you receive an adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal with the Claims Administrator would seriously jeopardize your life or health, or that would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or



- (ii) If you receive a final adverse benefit determination from the Claims Administrator and
- you have a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or
 - if the final adverse benefit determination concerns an admission, availability of care, continued stay, or a health care item or service for which you have received emergency services but have not been discharged from a facility.

[Preliminary Review by the Plan](#)

Immediately upon receipt of the request for an expedited external review, the Claims Administrator will conduct a preliminary review of your request and determine whether you are eligible for such a review. Immediately after completion of this preliminary review, the Claims Administrator will issue you a written notification of its determination. If your request is complete but is not found to be eligible for an expedited external review, the notice will include the reasons for ineligibility. If your request is incomplete, the notice will describe the information or materials needed to perfect the request.

[Review by the IRO](#)

Upon a determination that a request is eligible for an expedited external review, the Claims Administrator will assign an IRO to review it and will transmit all necessary documents and information to the IRO in accordance with the above-discussed "standard" external review rules. The IRO will provide a written notice of its final decision to you and the Claims Administrator as expeditiously as possible, but in no event later than 72 hours (24 hours for reviews involving urgent claims) after the IRO receives the request for the expedited external review. If notice is not in writing, within 48 hours of providing that notice, the IRO shall provide written notice to you and the Claims Administrator of its final decision.

[Overview of Changes to the Plan's Current Claims and Appeal Procedures](#)

In addition to the new standard and expedited external review procedures, the Plan's existing claims and appeal procedures are amended and/or clarified to reflect the following:

- The scope of an adverse benefit determination or claim will include rescissions (within the meaning of PPACA) of coverage whether or not there is an immediate adverse effect on any particular benefit. As a result, rescissions of coverage are subject to the Plan's claims and appeal rules.
- The Plan will notify you of its decision for urgent care claims as soon as possible but no later than 24 hours (instead of no later than 72 hours, the current rule) after the receipt of such claim, provided that you provide the Plan with sufficient information for it to determine whether and to what extent benefits are covered under the Plan under such circumstances. If the Plan requires additional information from you in order to make a determination for an urgent care claim, you will have no less than 48 hours to provide the Plan with the requested information.



Writers' Guild-Industry Health Fund
Summary of Material Modifications **January 2012**

- In connection with the Plan's review of a claim for benefits, it shall provide you (free of charge) with any new or additional evidence that was considered, relied upon, or generated by the Plan or the Claims Administrator in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for you to respond to such new evidence or rationale before the Plan makes a final determination of the claim on review or appeal.
- In addition to the existing notice standards required under the Plan's claims and appeals procedures, Plan notices of adverse benefit determinations in connection with a review of a claim or an appeal will include the following information to the extent required by law:
 - (i) information identifying the claim involved including the date of service, the health care provider, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
 - (ii) the reason(s) for the adverse benefit determination including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used to deny the claim at issue, and, in the case of final adverse benefit determinations, the description of the discussion of the decision;
 - (iii) a description of the available internal appeals and review processes, including information regarding how to initiate an appeal; and
 - (iv) the contact information and availability of any applicable offices of health insurance consumer assistance or ombudsman established under PPACA to assist you with the internal claims and appeals processes.

This summary is intended to satisfy the requirement for issuance of a SMM under ERISA. You should take the time to read this SMM carefully and keep it with the SPD that was previously provided to you. If you need another copy of the SPD or if you have any questions regarding this change to the Plan, please contact the Fund Office during normal business hours at: (818) 846-1015 or toll-free (800) 227-7863 or email your questions to Participantservices@wgaplans.org.



Summary of Material Modification Addendum - November 1, 2011

IMPORTANT UPDATE

No Cost Sharing for Preventive Care Services – Over the Counter Products

Under the Affordable Care Act (“ACA”), the U.S. Preventive Services Task Force (“USPSTF”) recommends the Writers’ Guild-Industry Health Fund (“Fund”) cover preventive services at a \$0 co-payment. The following drug products, including some over the counter drug products, are considered preventive care services *if they are ordered by your physician and the guidelines as described below are met.*

| Drug Product | USPSTF Recommendation | Fund’s Pharmacy Coverage Guideline |
|---|---|---|
| Aspirin | <p>Recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.</p> <p>Recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.</p> | Covered for persons age 45 years through 79 years |
| Folic Acid Supplements | Recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 ug) of folic acid. | Covered for females through the age of 50 years |
| Iron supplements for children | Recommends routine iron supplementation for asymptomatic children age 6 to 12 months who are at increased risk for iron deficiency anemia. | Covered for persons less than 1 year of age |
| Fluoride | Recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride. | Covered for persons through the age of 5 years |
| Tobacco cessation products (gum, lozenge, patch, inhaler and nasal spray, sustained release bupropion and varenline) | <p>Recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.</p> <p>Recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke.</p> | Covered for up to two courses of treatment (total up to 180 days) within a 1 year period for person’s age 18 years and older. |

Effective January 1, 2012, these specific preventive care drug products will be available under your pharmacy benefit, managed for Writers’ Guild-Industry Health Fund by Medco. In order to take advantage of this benefit you will need a valid prescription from your physician. Your prescription must be filled by a participating Medco Pharmacy. The participating retail pharmacy will fill the prescription and you will not be subject to any cost sharing. To find a pharmacy near you, you can visit www.medco.com and click on “Locate a pharmacy”. For long-term drugs, you can order your prescriptions through the mail by using the *Medco Pharmacy*.

If you have any questions regarding this change to the Plan, please contact the Plan Administrator at (818) 846-1015 or (800) 227-7863 or email your questions to Participantservices@wgaplans.org.