Jim Hedges, Chief Executive Officer

November 1, 2013

TO: All Covered Plan Participants

FROM: The Writers' Guild-Industry Health Fund Trustees

SUMMARY OF MATERIAL MODIFICATION ("SMM")

This document is a Summary of Material Modification ("SMM") intended to notify you of important changes to certain benefits under the Writers' Guild-Industry Health Fund ("Plan").

Out of Pocket (OOP) Limits – 2014

As part of the Patient Protection Affordable Care Act (ACA), for the plan year starting in 2014, all non-grandfathered plans, including self-insured plans and insured plans in the large group market, must comply with the addition of a new annual out-of-pocket limit on cost-sharing for plan participants. In general, for the purposes of this rule, cost-sharing refers to deductibles, copayments and coinsurance that a plan participant must pay for *in-network covered services*. The out-of-pocket (OOP) limits in 2014 can be no higher than $6,350 for an individual and $12,700 for a family. After this OOP limit is reached the Plan must pay 100% of the cost of in-network covered services.

Effective January 1, 2014, the current $1,000 PPO and $4,500 Low Option in-network OOP limit as a maximum that applies only to coinsurance payments remains the same. In addition, a new *in-network* OOP limit for cost-sharing (that accumulates in-network deductibles, copayments and coinsurance, including the current OOP maximum *for in-network* coinsurance*) of $6,350 per person/year and $12,700 per family/year will be added.

For example, a single PPO plan participant would still pay the $300 deductible as well as up to $1,000 in coinsurance and applicable co-pays until the sum of the three types of cost-sharing reaches $6,350. Then the Plan begins to pay covered *in-network* benefits at 100%. Of course, if you reach the $1000 PPO or $4500 Low Option in-network out of pocket maximum (which, unlike the new maximum, only counts your coinsurance) sooner, then the Plan would already be paying at 100% of the R&C allowances or contracted rate (as applicable).

Note: Out of Network's OOP limit remains the same, $2500 PPO or $6000 Low Option.

**Dental and Prescription drug co-pays, coinsurance and deductible will not apply at this time.*

Air or Sea Ambulance Benefits

(Change to the Air or Sea Ambulance benefits, located on page 9, within your Summary of Benefits section of your 2013 Summary Plan Description Booklet.)

The PPO and Low Option Plan currently covers emergency Air or Sea Ambulance services with a

maximum plan benefit limit of $5000 payable at the Plan's network or non-network benefit level. This benefit limit has changed. All Air or Sea Ambulance claims will be *subject to medical necessity review*. When medically necessary, all *eligible* emergency Air or Sea Ambulance service to the nearest facility, equipped to treat the condition, will no longer have a benefit maximum. The PPO, Out-of Area and Low Option Plan's deductible and coinsurance, out-of-pocket limits will still apply. This change will take effect in 60 days from the date of this SMM and will be retroactive to September 1, 2012.

Clinical Trials Coverage

Effective January 1, 2014, to the extent required by the Patient Protection and Affordable Care Act ("PPACA"), the Plan will not deny (or impose additional conditions on) the coverage of "routine patient costs" for items and services furnished to "qualified individuals" in connection with their participation in "approved clinical trials." For example, where a covered individual requires temporary hospitalization or monitoring in connection with a clinical trial and there is a separate charge for those related services. Additionally, a covered individual can participate in approved trials conducted outside of the state in which the covered individual lives. Please note, the Plan does not cover treatments that fall outside the designated class of approved clinical trials.

What is a "qualified individual"?
Generally, a "qualified individual" is someone who is eligible to participate in an "approved clinical trial" according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either (1) the covered individual's doctor is a participating provider and has concluded that participation in the clinical trial would be appropriate; or (2) the covered individual provides medical and scientific information establishing that his or her participation in the clinical trial would be appropriate.

What is an "approved clinical trial"?
An "approved clinical trial" is a Phase I, II, III or IV clinical trial that is: (1) conducted for the prevention, detection, or treatment of cancer or other life-threatening disease or condition; and (2) is (a) federally funded (as described in PPACA), (b) conducted under an investigational new drug application (IND) reviewed by the Food and Drug Administration, or (c) a drug trial that is exempt from the IND application requirements. A life-threatening condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

What are "routine patient costs"?
"Routine patient costs" include all items and services consistent with the coverage provided in the Plan that is typically covered for a covered member who is not enrolled in a clinical trial. Routine patient costs do not include 1) the clinical trial investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

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.