2027 Health Plan Changes – Frequently Asked Questions (Version 2) September 18, 2026

INTRODUCTION

WHY DO WE HAVE TO MAKE CHANGES IN THE WGA HEALTH PLAN?

In the 2026 MBA negotiations, the WGA and the companies agreed to increased funding for the health plan and to implement a number of cost-saving measures. As an alternative to the Anthem PPO, starting in 2027 the Health Fund will also offer a new plan option for active participants and pre-Medicare retirees (as well as participants who are Medicare eligible, but still working) through a network called Centivo.

These changes are intended to make the Fund more sustainable, generating savings while preserving member choice and access to high-quality benefits, and limiting out-of-pocket costs as much as possible.

PLAN CHANGES

WHAT IS CHANGING ABOUT HEALTH COVERAGE REQUIREMENTS?

Beginning July 1, 2027, the earnings threshold to qualify for coverage will increase to 110% of the one-hour network primetime story and teleplay minimum, or $53,773, and thereafter will continue to increase with MBA minimums.

WHAT IS CHANGING IN THE ANTHEM PPO PLAN?

Participants will pay increased amounts in out-of-pocket expenses related to premiums, deductibles, co-insurance, and their out-of-pocket maximums in the Anthem PPO plan. To address rising out-of-network expenses, the Plan will be adjusting its reimbursement of out-of-network behavioral health care to match the reimbursement rates for all other out-of-network care.

Changes to the Anthem PPO		
	Current	**Beginning Jan. 1, 2027**
Member Premiums (Monthly)	Active and Pre-65 Certified Retirees: Single participant: $0 Any number of dependents: $50	Active and Pre-65 Certified Retirees: Single Participant: $75 Participant + 1 Dependent: $150 Participant + multiple dependents: $200 Increases 3% annually Medicare-primary post-65 Certified Retirees: Single participant: $0 Any number of dependents: $0
Deductible (Individual / Family)	In-Network: $400 / $1,200 Out of Network: $400 / $1,200	In-Network: $500 / $1,500 Out-of-Network: $500 / $1,500 Increases 3% annually
Out-of-Pocket Maximum (In-Network)	$1,000 per person	$2,500 per person Increases 3% annually
Coinsurance	Plan covers 85% in-network / 60% out-of-network	Plan covers 80% in-network / 60% out-of-network
Out-of-Network Reimbursement	Out-of-network Behavioral Health (BH) is reimbursed at a different rate than non-BH care	All BH and non-BH care out-of-network to be reimbursed at the same rate (150% of Medicare)

Changes to the Anthem PPO		
	Current	**Beginning Jan. 1, 2027**
The Industry Health Network	Members pay discounted rates at The Industry Health Network clinics and associated referrals	Discontinue the Industry Health Network; the clinics remain available at the same cost-sharing as other providers. (They are also available through Centivo.)

With these changes, the Anthem PPO plan will continue to provide access to a broad national network of providers with low participant cost-sharing compared to most plans in the U.S. For comparison, the Mercer Benchmark estimates that typical premiums for employer-sponsored healthcare are $185 per month for single coverage and $682 per month for a family.

ARE PREMIUMS STILL QUARTERLY AS THEY ARE NOW?

Yes, the cost of the premiums is listed monthly but premiums will continue to be paid quarterly.

	2026	**2027**			**2028**		
Anthem PPO	$0 participant, $50 for dependent coverage	**Participant**	**Participant +1**	**Family**	**Participant**	**Participant +1**	**Family**
		$75	$150	$200	$78	$155	$206
Centivo	N/A	$25	$50	$75	$26	$52	$78
*Keep in mind that for future years, premiums for both options automatically increase 3% per year.							

I AM A RETIREE, WHAT WILL CHANGE FOR ME?

Pre-65 Certified Retirees will have the same changes as Active participants.

Medicare-primary post-65 Certified Retirees will see the same increased deductibles, out-of-pocket maximums, and coinsurance changes as Active participants, but will not pay any participant or dependent premiums as long as they are not on active coverage. The Plan will also make changes to the drug benefit that will cause minimal disruption while saving the Plan and many participants money on their prescriptions.

Changes for Post-65 Medicare-Primary Certified Retirees		
	Current	Beginning Jan. 1, 2027
Deductible (Individual / Family)	In-Network: $400 / $1,200 Out of Network: $400 / $1,200	In-Network: $500 / $1,500 Out-of-Network: $500 / $1,500 Increases 3% annually
Out-of-Pocket Maximum (In-Network)	$1,000 per person	$2,500 per person Increases 3% annually
Coinsurance	Plan covers 85% in-network / 60% out-of-network	Plan covers 80% in-network / 60% out-of-network
Out-of-Network Reimbursement	Out-of-network Behavioral Health (BH) is reimbursed at a different rate than non-BH care	All BH and non-BH care out-of-network to be reimbursed at the same rate (150% of Medicare)
The Industry Health Network	Members pay discounted rates at The Industry Health Network clinics and associated referrals	Discontinue The Industry Health Network; the clinics remain available at the same cost-sharing as other providers.
Retiree Drug Coverage	"Retiree Drug Subsidy" program with limited federal reimbursements	Switching to the "Employer Group Waiver Plan" (EGWP) moves Medicare retirees onto a Medicare drug formulary with a more generous federal rebate. Under EGWP, a small number of prescribed drugs will be reviewed for possible generic alternatives, and high-income Medicare retirees will pay a small additional premium for drug coverage. Express Scripts will continue to administer the program.

WHAT DOES THE CHANGE FOR OUT-OF-NETWORK BEHAVIORAL HEALTH REIMBURSEMENT MEAN?

The Plan will treat out-of-network behavioral health the same way it does the rest of out-of-network care: the Plan will pay 60% of 150% of the Medicare rate. This will be consistent for both Anthem and Centivo (more below) participants when they go out-of-network.

WHAT'S CHANGING ABOUT THE OUT OF NETWORK BEHAVIORAL HEALTH ALLOWED CHARGE REIMBURSEMENT RATE?

When you see an out-of-network provider, the Fund determines your cost-sharing based on the "Allowed Charge" for the service, which is defined in the SPD under "Allowed Charge (Out-of-Network Services)".

Starting January 1, 2027, the Fund will determine the Allowed Charge for out-of-network behavioral health services based on 150% of the Medicare rate for the services, which is the same benchmark the Fund uses for other out-of-network covered services.

> If you currently use out-of-network providers for behavioral health care, you will likely see your out-of-pocket costs increase in connection with this change.

Example: John Smith sees an out-of-network therapist once a month. The therapist charges $260 per visit. Prior to 2027, the Fund's Allowed Charge for John's visit was $240. After meeting his deductible for the calendar year, John would pay 40% of the Allowed Charge plus the balance of the provider's bill ($96 (40% of $240) + $20 ($260 - $240)), making him responsible for $116 for each visit. The Health Fund would pay the remaining $144.

John continues seeing the same provider after January 1, 2027. The Fund's Allowed Charge for his visits is now $165 (Medicare 150% rate). After meeting his deductible for the calendar year, John will pay 40% of the Allowed Charge plus the balance of the provider's bill ($66 (40% of $165) + $95 ($260 - $165)), making him responsible for $161 for each visit. The Health Fund pays the remaining $99.

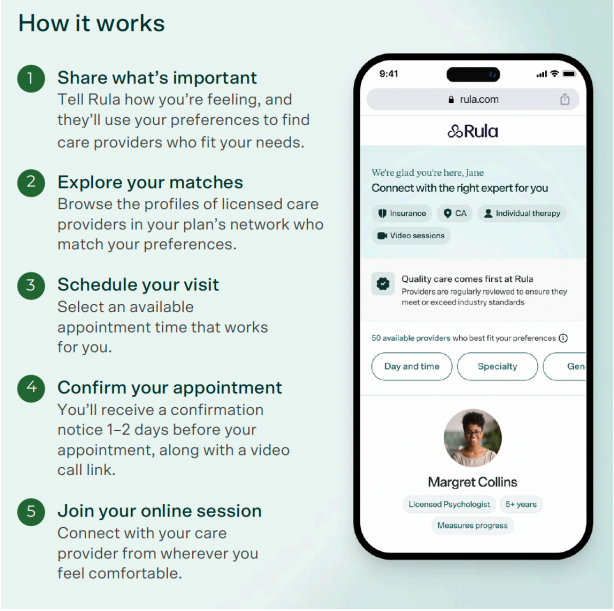
You will always have the lowest out-of-pocket costs by using in-network providers. Participants enrolled in either the Anthem or Centivo option can access in-network virtual mental health providers through Rula. For more information, visit www.wgaplans.org/rula. Should you choose to go out of network for services, we recommend against paying out-of-network providers up front. The Plan works to negotiate discounted payments with out-of-network providers where it can, but is unable to do so when a participant has already paid the provider.

HOW DOES RULA ASSIST PARTICIPANTS IN FINDING AN IN-NETWORK BEHAVIORAL HEALTH PROVIDER, WHETHER THEY ARE AN ANTHEM PPO PLAN OR CENTIVO PLAN PARTICIPANT?

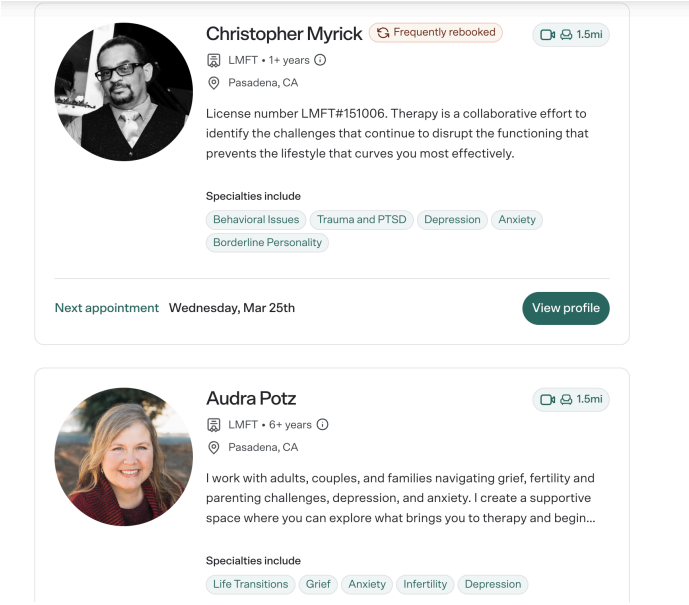
You will reach out to Rula through their website as you did before. The one difference – and it is a critical difference – you must use your Centivo ID # when searching for a

therapist if you are a Centivo Plan participant, OR you must use your WRXA ID # when searching for a therapist if you are an Anthem Blue Cross participant.

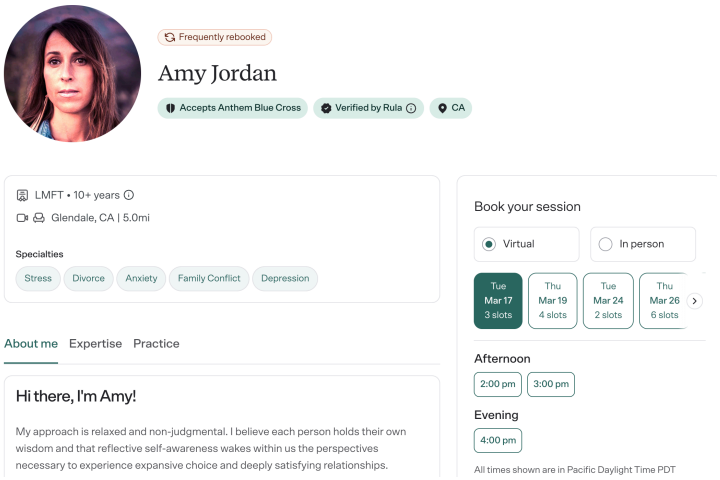
Getting started is easy. Go to the Rula website and answer a brief set of questions:



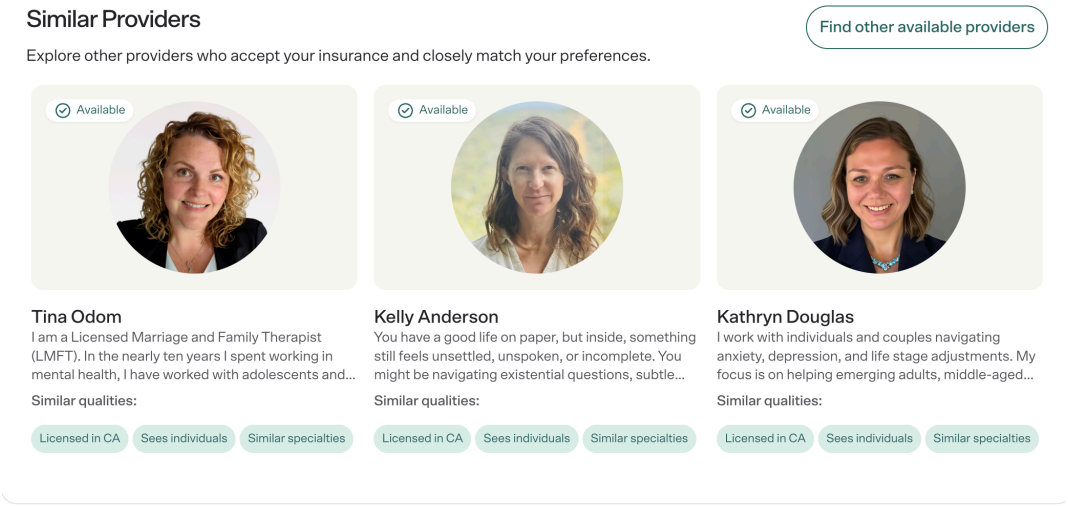
Once you've answered the questions about your needs and location, Rula will use your responses to find therapists that meet your needs in your local area. They have in-person and video sessions available, at your discretion.



You will see information about the therapists' professional accreditations and the type of work they do, as well as their next available appointment. If someone interests you, you can click to see a more detailed profile.



You will also get a list of similar providers.



You can call Rula at: (323) 205-7088 if you have any questions. If you have a problem with your therapist, you can contact Rula by phone at: (323) 205-7088 or you can reach out to Participant Services at the PWGA, either by phone: (818) 846-1015 x602, or via Contact Us on our website.

WHAT IS CHANGING ABOUT THE INDUSTRY HEALTH NETWORK CLINICS?

The Plan's Industry Health Network clinics, which have for years provided participants in the Southern California geographic area affordable access to UCLA Health, will terminate on December 31, 2026. One of the reasons for discontinuing TIHN is that they now charge rates above Anthem Blue Cross.

For Anthem PPO participants, TIHN clinics and associated referrals will no longer be discounted beyond the rest of in-network providers but will instead be reimbursed as regular in-network care. In the PPO, instead of the current $10 copay, participants will pay 20% of the negotiated rate for the services after the member meets their deductible. Participants should confirm that their TIHN providers are in the Anthem PPO Network; most are, but there may be exceptions.

Out of network TIHN providers will be reimbursed at the same rate as other out of network services. Also, see below for the description of Centivo, which offers a program similar to TIHN, that includes most of the UCLA Health providers.

HOW WILL EXTENDED COVERAGE POINTS CHANGE?

Writers who do not reach the eligibility threshold for coverage in a given year can continue their coverage through use of Extended Coverage Points they have banked from prior years. Extended coverage currently costs 2.5 points per quarter, and 1.5 points per quarter for low option coverage.

Since 2014, writers have been able to earn up to three Extended Coverage Points per year, with the first point accrued upon qualifying for coverage, the second point earned at $125,000 in covered compensation, and the third at $250,000.

Starting January 1, 2027, the first Extended Coverage Point will be earned at $200,000 in annual earnings, and the second point will be earned once earnings reach the compensation cap for screen, which will be $325,000 on January 1, 2027, and will increase along with the negotiated increases to screen caps.

After January 1, 2027, Extended Coverage under the Anthem PPO plan will cost 4 points per quarter, while Extended Coverage under the new Centivo plan option will cost 2.5 points per quarter. Consistent with the current rule, these points can be used once a participant has accrued 10 points, but only one time during the course of a career.

> Note: The first quarter of 2027 will cost the extra points, since participants may elect to use points prior to the start of the quarter

Writers who do not have enough points for a final quarter of coverage will be provided with a point subsidy up to 1 point. If Anthem PPO is elected, you must have a minimum balance of 3 points to receive the subsidy. If Centivo is elected, you must have a minimum balance of 1.5 points to receive the subsidy. The maximum amount of ECP points that a participant can accrue is 50.

> Note: Participants using ECP points for coverage still need to pay their premium **per quarter**.

Extended Coverage Program (ECP)		
	Current	**Beginning January 1, 2027**
ECP Point Spending	2.5 points per quarter for Anthem PPO; 1.5 points for low option	4 points per quarter for Anthem PPO, 2.5 points per quarter for Centivo, 1.5 points for low option
ECP Point Accrual	1 point for earning the minimum compensation for coverage, $47,460 (as of July 1, 2026), 2nd point for $125K annual earnings, and 3rd point for $250K annual earnings	1 point for $200K annual earners, 2nd point at negotiated screen cap $325,000 as of Jan 1, 2027, $375,000 as of Jan 1, 2028, $400,000 as of Jan 1, 2029

HOW WILL CHANGES IN ECP POINTS ACCRUALS WORK?

The point accrual changes will take effect for eligibility cycles beginning on or after the effective date. If your eligibility cycle begins in 2026, you will accrue ECP points under the current accrual. For eligibility cycles starting between January 1, 2027 and December 31, 2027, a participant would accrue 1 point for covered earnings of at least $200,000 and 2 points for covered earnings of at least $325,000. For eligibility cycles starting between January 1, 2028 and December 31, 2028, a participant would accrue 1 point for covered earnings of at least $200,000 and 2 points for covered earnings of at least $375,000. For eligibility cycles starting between January 1, 2029 and December 31, 2029, a participant would accrue 1 point for covered earnings of at least $200,000 and 2 points for covered earnings of at least $400,000. More information can be found HERE.

IS THE "LOW OPTION" PLAN THAT CURRENTLY COSTS 1.5 ECP POINTS PER QUARTER CHANGING?

No. There will be no change to Low Option plan ECP rules regarding points per quarter needed in 2027, but the Low Option is only available for the Anthem Blue Cross PPO plan. The Low Option Plan is an option that covers only catastrophic needs and is only a relevant choice for a few participants. It has been retained so that those truly in need still have access to it.

HAS THE EXCESS EARNINGS RULE CHANGED?

No.

CENTIVO

WHAT IS CENTIVO?

Centivo is a new health plan option available to most current Health Plan participants in the U.S., effective January 1, 2027. Centivo is a narrow network plan with fewer in-network providers. All current Anthem PPO plan benefits are covered under Centivo, but at lower cost to participants than the Anthem PPO plan, which will also continue to exist.

WHAT DOES THE CENTIVO PLAN LOOK LIKE?

Plan Costs and Coverage	**Centivo Plan**	
Member Premiums (Monthly)	**Active/pre-65 Certified Retirees:** $25 for individual / $50 for Individual and 1 dependent / $75 for Individual and family (amounts will increase 3% annually starting January 2028)	
	In-Network Co-Pays	**Out-of-Network**
Deductible	$0	$500 / $1,500
Out-of-pocket maximum	$2,000 / $4,000	$20,000 per person (coins. only)
PCP Visit	$0	Plan pays 60%
Specialists	$25	Plan pays 60%
Lab Work/X-Rays	$10	Plan pays 60%
Surgeries (Outpatient/Inpatient)	$250 / $400	Plan pays 60%
Inpatient Stay	$600	Plan pays 60%
Urgent Care	$75	Plan pays 60%
Emergency Room	$300	
Rx (through Express Scripts same as Anthem PPO options)	$10 / $25 / $50 (x2 mail order)	
Network	Centivo Partners (incl. UCLA Health and Mount Sinai)	
OON Reimbursement	Medicare 150 (All Services)	
Physician referral requirement	Required for INN/not needed for OON	
Vision (same as Anthem PPO option)	VSP	
Dental (same as Anthem PPO plan)	Delta Dental	

Plan Costs and Coverage	Centivo Plan
Infertility Benefit (same as Anthem PPO plan)	Carrot Infertility
Virtual Physical Therapy (same as Anthem PPO plan)	Hinge Health
Surgical Benefit Option (same as Anthem PPO plan)	Lantern

HOW DOES CENTIVO COMPARE TO THE INDUSTRY HEALTH NETWORK (TIHN)?

Centivo offers a similar lower cost fixed co-pay structure to The Industry Health Network (TIHN) which currently serves Southern California participants until December 31, 2026, at which time it terminates.

Centivo offers a far wider network than the expiring TIHN network, and offers participants similar low costs for services. The network is wider because it includes most UCLA Health primary care doctors (including the TIHN clinic physicians) but also includes doctors at other UCLA Health locations in the LA area, along with certain non-UCLA Health doctors. In total, Centivo covers 50 primary care locations in Southern California, rather than 5 available through TIHN. TIHN referrals included most UCLA Health specialists, and so does Centivo.

WHERE IS THE CENTIVO NETWORK AVAILABLE?

The Centivo network is available in the following markets. To check if you live within a Centivo market area, you can go to pwga.centivo.com.

California
- Los Angeles
- Orange County
- San Diego
- Inland Empire

Colorado
- Denver

Connecticut
- Hartford
- Bridgeport–Stamford–Norwalk
- New Haven

Florida
- Orlando

- Tampa–St. Petersburg–Clearwater

Iowa
- Des Moines

Kansas & Missouri
- Kansas City
- St. Louis

New York
- New York City
- Westchester
- Long Island

New Jersey
- Northern New Jersey
- Central New Jersey

North Carolina
- Greensboro–Winston-Salem–High Point

Pennsylvania
- Philadelphia

Texas
- Dallas Fort-Worth

Washington
- Spokane

Wisconsin
- Southeastern Wisconsin - examples include:
    - Milwaukee
    - Racine
    - Kenosha
    - Waukesha
    - Appleton
    - Sheboygan

HOW DOES CENTIVO DETERMINE WHERE THEIR NETWORK IS AVAILABLE?

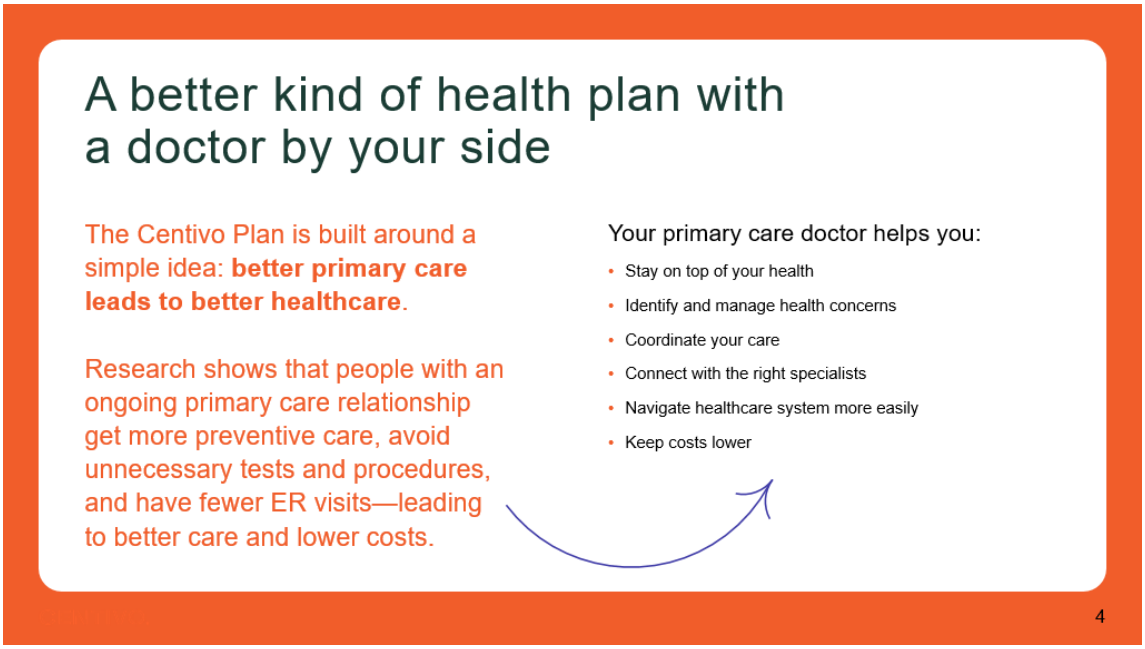
Centivo reviews their network of providers against national CMS standards based on provider type and mileage for different markets and geographies. For example, in Los Angeles within the Centivo network members will have access to hospitals on average within a 10-mile radius and primary care on average within a 5-mile radius. There will be certain areas where you may need to travel more or less, so we encourage you to research the Centivo network at pwga.centivo.com to understand the providers in the network and distance before enrolling. You can also reach out to Centivo with any questions on the network or the providers.

Virtual care is offered nationwide.

In the case of rare illnesses requiring specific treatments that are not offered in the Centivo network, Centivo can do single-case agreements where they negotiate with the specialty provider for the care. Virtual care is also available nationwide. Primary care visits are free. There are fixed co-pays for referrals, no deductible, and no percentage co-insurance in-network.

WHAT IS CENTIVO'S STRATEGY?

Centivo observed that traditional health networks, such as Anthem, often don't negotiate lower prices with the big providers. Centivo creates leverage by choosing certain partners. It picks a large provider group in areas where it operates and excludes other big provider groups. That exclusivity allows Centivo to negotiate lower prices.



WHY ARE WE ADDING CENTIVO?

Centivo's objective is to offer significant savings to the Health Fund when compared to Anthem. With Centivo, the Fund will no longer pay the premium above the Anthem rates that UCLA Health has been charging for TIHN. Additionally, Centivo is available to most participants across the country, whereas TIHN was only available within the Southern California area. The participants residing outside of Southern California could not access TIHN and their only option was Anthem, with its higher deductibles and co-insurance payments.

More broadly, the most important factor in selecting Centivo as an alternative for PWGA participants is that Centivo has a strategy that seeks to limit the inexorable rise in healthcare costs to about half of the overall industry rate.

WHY ARE WE REPLACING TIHN?

The TIHN clinics, operated as part of UCLA Health, and the TIHN referrals, are discounted for members, but are more expensive for the Health Fund than the PPO rates negotiated through Anthem. In effect, the Health Fund has been creating an incentive for participants to use an insurance option that costs the Fund more. In addition, TIHN was only ever available to participants in Southern California.

HOW DOES CENTIVO COMPARE TO TIHN FOR PRIMARY CARE?

Centivo includes the primary care physicians in the current TIHN clinics for a zero-dollar co-pay. Participants with a TIHN primary care physician can continue seeing their doctor without interruption after signing up with Centivo, and without the $10 co-pay. In addition, most other UCLA Health primary care physicians are part of the Centivo network and referrals are available to most UCLA Health specialists.

DOES CENTIVO INCLUDE UCLA HEALTH PEDIATRICS?

Yes. UCLA Health Pediatrics are included in the Centivo network.

HOW WILL ENROLLMENT WORK?

To enroll as a Centivo plan participant, participants select Centivo as their plan option during the fall annual open enrollment period, which this year will be from November 11, 2026 through December 15, 2026. Coverage on the Centivo plan will be effective January 1, 2027. At that time, you will be asked to select a primary care physician from the Centivo Partners Network.

IF I SELECT CENTIVO DURING OPEN ENROLLMENT, WHEN WOULD I BE ABLE TO SWITCH BACK TO ANTHEM BLUE CROSS IF I DESIRE TO DO SO?

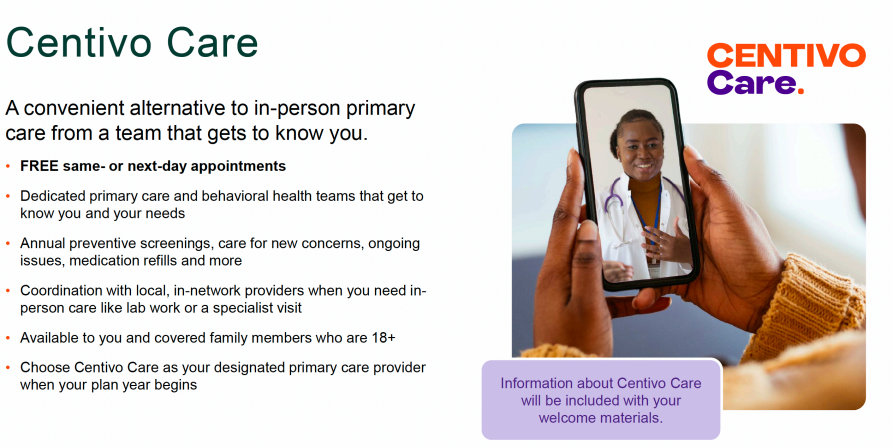
If you remain on active coverage, you can switch back to the Anthem PPO plan during the next open enrollment for the next calendar year. You will also be able to switch between Anthem PPO and Centivo if you have a qualifying “life event” such as getting married or divorced, the birth or adoption of a child, switching from active status onto Extended Coverage points, moving to a location that does not offer Centivo, or switching from Extended Coverage back into active status. When you choose Centivo, you pick your primary care physician at the start of the year and most of your medical services start with an appointment with them. Note that Anthem PPO users will also use open enrollment to add or confirm dependents to be covered and to pay participant and dependent premiums.

IS TELEHEALTH AVAILABLE?

Yes. Centivo offers Centivo Care and MD LIVE as virtual options for participants for medical care.

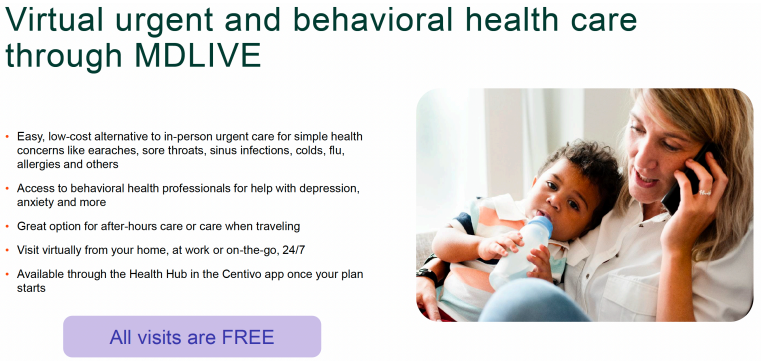
WHAT IS CENTIVO CARE AND HOW DOES IT WORK?

Centivo offers its own virtual network called Centivo Care. Centivo Care allows participants to select a virtual primary care provider. Centivo Care physicians are available in all 50 states. A participant with a Centivo virtual primary care provider will utilize the services of their specifically selected virtual care physician for their primary care needs. But many doctors in the Centivo network offer telehealth appointments also. You will find options in the Centivo app.



WHAT IS MD LIVE AND HOW DOES IT WORK?

In addition to telehealth sessions for accessing a virtual primary care provider for medical services provided by Centivo, you can also reach out to them when you are traveling or need help after hours. They call this service MD LIVE. MD LIVE operates in a very similar fashion to Anthem's Live Health Online, in that a participant can reach out to receive virtual care for one-off virtual care urgent and behavioral health needs.



WHAT IF I AM TRAVELING AND NEED MEDICAL SERVICES?

MD LIVE is available in all 50 states, and works like Live Health Online. It's one-time only care, for each individual transaction.

Centivo doctors can support both medical conditions and behavioral health concerns; these services are primarily for one-time semi-urgent matters.

MD LIVE physicians can also prescribe medications if needed.

WHAT IF I AM TRAVELING AND NEED EMERGENCY SERVICES OR URGENT CARE?

Urgent Care/Emergency services are available in all 50 states.

Urgent Care will require a $75 co-pay when a participant/dependent is away from home.

Emergency Room Care is treated as in-network no matter where you are and will result in a $300 co-pay.

WHAT IF I MOVE OUT OF CENTIVO NETWORK AREA?

If you enrolled in Centivo but move out of the network area, you are allowed to enroll back into Anthem PPO, as this is considered a life event. However, this only works if your original election was Centivo. If you enrolled in Anthem PPO and move out of state, you are not allowed to elect a new medical plan, as Anthem PPO is available in all 50 states.

WHAT IF A DEPENDENT MOVES OUT OF CENTIVO NETWORK AREA?

If your dependent moves out of the Centivo network area, they can utilize virtual PCP and have access to emergency care anywhere. If a procedure is required by a specialist, they are encouraged to travel to a Centivo network area. The only instance where a household can return to Anthem is if the primary participant moves to a non-Centivo covered geographic area.

MY DEPENDENT IS ATTENDING A UNIVERSITY IN A NON-CENTIVO-COVERED LOCATION. WILL THEY BE COVERED?

Centivo medical care is available in all 50 states in the following ways:

- When the student establishes their Centivo coverage, they will select a personal care physician (PCP), selecting either a traditional in-person PCP or a virtual care PCP (Centivo Care). They can access that PCP remotely at no charge. They can also get a referral to a physician nearest them if they are in need of in-person care.

- MD LIVE is available in all 50 states, and works like Live Health Online. It's one-time only care, for each individual transaction.
    - Centivo doctors can support both medical conditions and behavioral health concerns; these services are primarily for one-time semi-urgent matters.
    - MD LIVE physicians can also prescribe medications if needed.
- Urgent Care/Emergency services are available in all 50 states.
    - Urgent Care will require a $75 co-pay when a participant/dependent is away from home.
    - Emergency Room Care is treated as in-network no matter where you are and will result in a $300 co-pay.

As a practical measure, for normally scheduled PCP services, it is best to schedule appointments when the student is home for the holidays, summer. Or other such period.

WHAT IF I WANT TO CHANGE MY PRIMARY CARE PHYSICIAN DURING THE YEAR?

You may change your Centivo primary care physician at any time 365 days a year through the app, or the customer service line (during standard service line business hours).

HOW DO I FIND MY PRIMARY CARE DOCTOR OR SPECIALISTS?

Centivo offers an app or a phone number for finding your medical providers. To choose your primary care physician, you will find information about doctors convenient to you that are taking new patients. You can book your appointment right in the app. For specialists, once your doctor's office makes a referral, you can choose your specialist of choice based on descriptive information in the app.

DOES SEEING SPECIALISTS WITH CENTIVO REQUIRE A REFERRAL?

In most cases, yes. Under Centivo, women's health, mental health services, and physical therapy do not require a referral. Once the referral for a specialist is made, you can pick a provider with the app and book your appointment. Centivo is available to help, but you can manage your care yourself through the Centivo app.

PCP referrals are required for all services with Centivo, not just for specialists, except for the following:

- OB/GYN care
- mental health substance use disorder care
- emergency medical care
- urgent care

- diagnostics, including labs and imaging (however these must be ordered by the member's selected PCP or a physician for which the member has a referral or is referral exempt)
- chiropractic care
- acupuncture
- rehabilitative services

I AM MOVING FROM THE PPO PLAN TO CENTIVO, BUT I AM CURRENTLY IN THE MIDDLE OF TREATMENT FOR A HEALTH CONDITION WITH A DOCTOR WHO ISN'T IN THE CENTIVO NETWORK. WHAT ARE MY OPTIONS?

If you are actively receiving treatment for a serious, complex, or acute health condition (e.g., pregnancy in the second or third trimester when the new plan starts, ongoing cancer care, terminal illness, transplants under active treatment or recent major surgery), you may qualify for Continuity of Care/Transition of Care benefits.

1. **How to Apply:** Submit Centivo's Continuity of Care form no later than 30 days after your coverage effective date. Requests must be member-initiated.

2. **Approval Process:** Centivo will review your application and send a formal determination letter. If approved, the letter will specify the approved timeframe (typically up to 90 days) to continue seeing your current provider while transitioning to an in-network provider.

3. **Coverage Details:** Approved care is typically covered under a single-case agreement based on negotiated rates. Services received from an out-of-network provider without prior approval will not be covered. If you choose to remain with a non-network provider without approval, standard out-of-network rates apply.

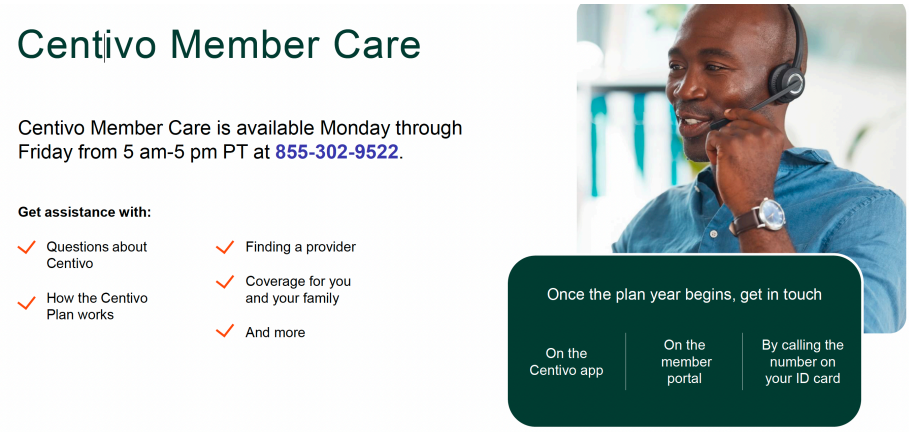
4. **Finding New Care:** Centivo and your new PCP can assist in finding in-network specialists and providers.

I WAS USING TIHN PREVIOUSLY. SINCE TIHN USES UCLA PHYSICIANS, WILL I STILL BE ABLE TO SEE MY TIHN PROVIDER IF I ELECT CENTIVO FOR COVERAGE?

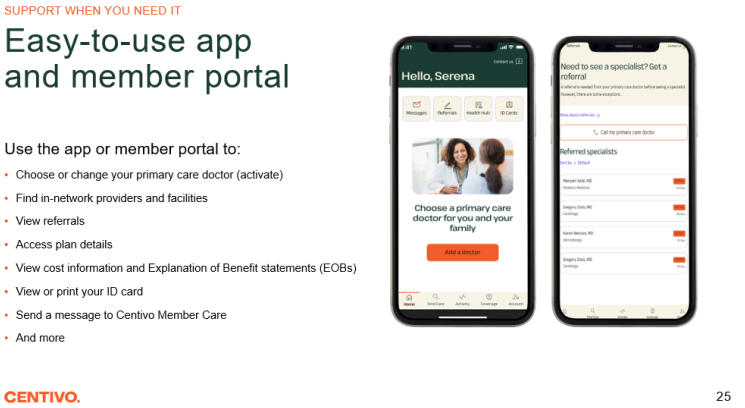
This is a situation where you need to exercise caution. Not all TIHN physicians will be covered by Centivo. You should check first. If your physician is not in the Centivo network you will be subject to higher costs. Please verify each provider before selecting Centivo, so that you are aware of these implications. You may or may not wish to select Centivo in these cases, unless you are ok with either changing your providers, or wish to accept out of network reimbursement rates for those outside of the Centivo network.

HOW DO I REACH OUT TO CENTIVO IF I NEED SERVICES?

If you have questions about Centivo or medical services you may require, Centivo Member Care is available to answer your concerns.



In addition to contacting Centivo through their website (pwga.centivo.com) or by phone, 855-302-9522, they also have an app:



ARE ALL THE CUSTOMER SERVICE INQUIRIES HANDLED THROUGH THE APP OR CENTIVO MEMBER CARE?

Centivo offers both the app and phone consultations to find providers. Mostly, though, you work through your primary care physician and their office for referrals and then use the app to find a specialist you like, book your appointment, and track your appointments and medical records.

ARE THERE PREMIUMS FOR PARTICIPANTS AND DEPENDENTS UNDER THE CENTIVO PLAN?

Yes. The premium is $25 per month for the participant only, $50 per month for the participant and one dependent, and $75 per month for the participant and more than one dependent. Dependent coverage follows the participant, whether it is Anthem or Centivo. Centivo premiums are lower than the Anthem PPO premiums of $75 per month for the participant only, $150 per month for the participant and one dependent, and $200 per month for the participant and more than one dependent. For both Centivo and Anthem, these premiums will increase 3% in January of 2028, 2029, and 2030.

You can enroll in AutoPay and set up automatic payments of your premiums to ensure your coverage does not lapse for lack of timely payment. To set up AutoPay, sign in through our website (www.wgaplans.org) or the PWGA App and select "AutoPay". This is a one-time process that will help ensure your premiums are automatically paid each month.

	2026	2027			2028		
		Participant	Participant +1	Family	Participant	Participant +1	Family
Anthem PPO	$0 participant, $50 for dependent coverage	$75	$150	$200	$78	$155	$206
Centivo	N/A	$25	$50	$75	$26	$52	$78
*Keep in mind that for future years, premiums for both options automatically increase 3% per year.							

IMPORTANT: Starting January 1, 2027, Health Plan benefit options for active and pre-65 retiree coverage will require payment of monthly premiums for you and your covered dependents. If you do not arrange to pay your monthly premium, your Health Plan coverage will be canceled.

WHAT ARE THE CO-PAYS FOR CENTIVO?

For in-network primary care visits, there is no co-pay. The visit is free. Basic diagnostic care (e.g., basic labs, x-rays, etc.) is $10, while more complex/advanced diagnostics is $150 (e.g., MRI, CT scan, etc.). The co-pay for an in-network specialist visit is $25, urgent care is $75, lab work and imaging are $10, ER visits are $300, outpatient surgery is $250, inpatient surgery is $400, and an in-network hospital stay is $600. These payments are made up to the out-of-pocket max of $2,000 for an individual or $4,000 for a family.

Your cost-sharing for covered services provided by Centivo network providers will be limited to a fixed copayment—no deductible or coinsurance. The copayment schedule for in-network services for the 2027 plan year is shown below:

In-Network Service	Copayment
Primary Care Visit	$0
Specialist Visit	$25
Urgent Care	$75
Lab Work and X-Rays	$10
Emergency Room Visits	$300
Outpatient Surgery	$250
Inpatient Surgery	$400
Inpatient Hospital Stay	$600
Prescription Drug Copayments	Same as the standard Anthem PPO benefit.

Please note that most services except for primary, emergency, and urgent care visits require a referral from your PCP. Please see the SPD for special disclosures about your right to select any available participating PCP, your right to designate a pediatrician for a child's PCP, and your generally not needing authorization to access obstetrical or gynecological care.

There is no percentage co-insurance with Centivo for in-network care. All the co-pays are standard, predictable, and shown in the app before you book your appointment.

IS THE DEDUCTIBLE FOR CENTIVO DIFFERENT THAN FOR THE ANTHEM PLAN?

There is no deductible for the Centivo plan for in-network care. The OON deductible is the same ($500/$1,500).

IS THERE A DIFFERENT OUT-OF-POCKET MAXIMUM FOR CENTIVO COMPARED TO THE ANTHEM PPO PLAN?

With Centivo, the out-of-pocket maximum for in-network care is $2,000 for an individual and $4,000 for a family. This will be lower than the limits for the Anthem PPO plan of $2,500 per person. With the low co-pay structure, and no percentage co-insurance, most Centivo patients never reach the out-of-pocket maximums.

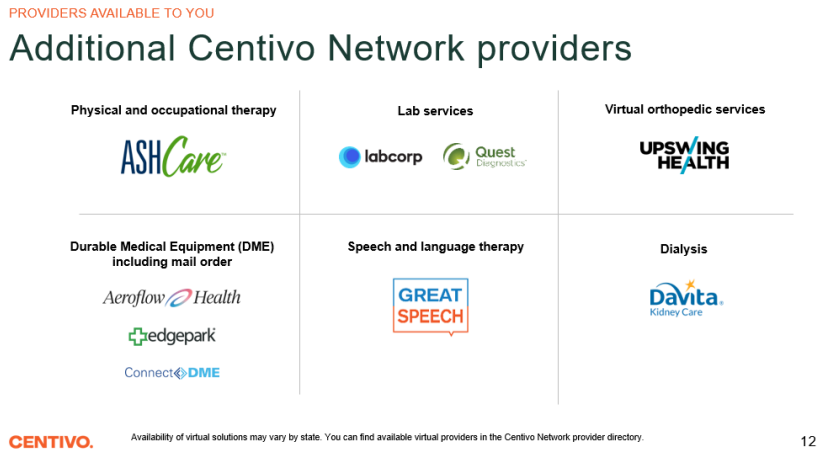
For out-of-network care under both Centivo and the Anthem PPO, the out-of-pocket maximum is $20,000.

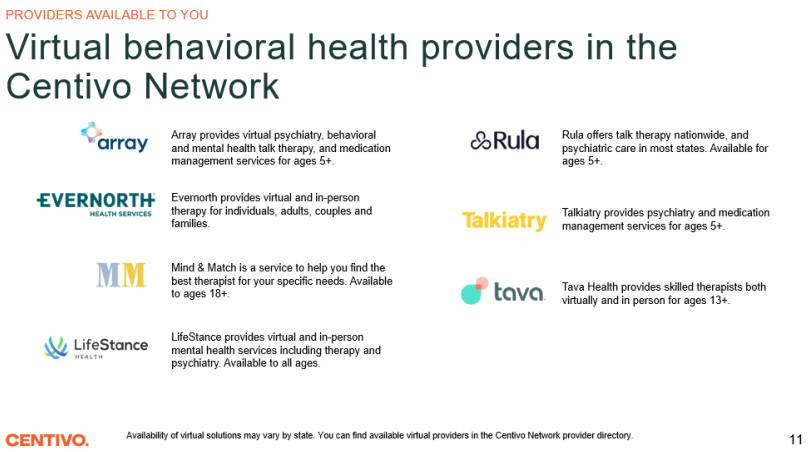
CAN I USE THE NEW LANTERN DISCOUNTED SURGERY SERVICE AND THE HINGE HEALTH PHYSICAL THERAPY SERVICE THE PLAN JUST STARTED?

Yes. Both of these options are available through Centivo, as are some of the other 3rd party services to which you have become accustomed. That said, when searching for a provider the participant should identify themselves as Centivo-covered when searching through Rula or one of the other providers listed below.

Note: When searching for providers, make sure you provide your Centivo ID # so that you will ensure you are being connected to someone in the Centivo network with its concomitant pricing.

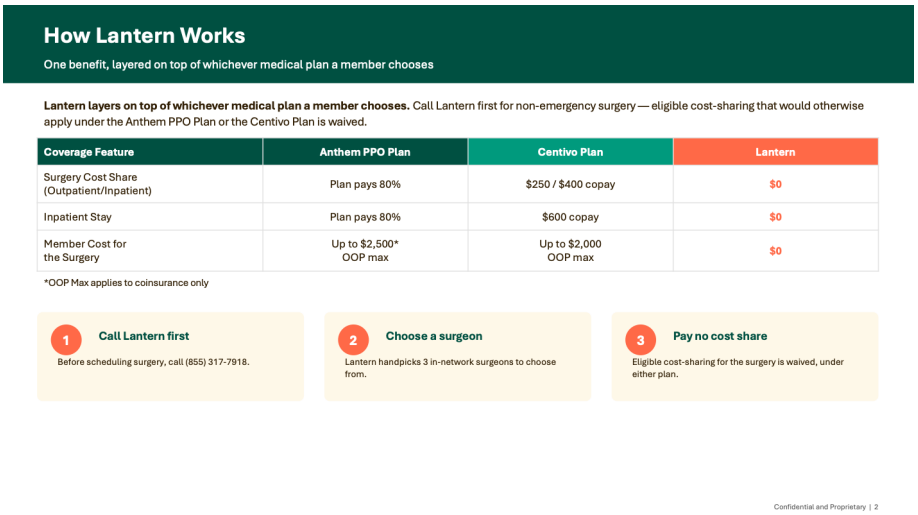
Additionally, there are new providers available to you as well:





Note: With all of these providers, you should search through either the Centivo website or the Centivo app to make sure that they are included in your Centivo network so that you do not inadvertently select someone to whom you would have to pay the OON rate.

WHAT ARE THE LANTERN COSTS?



CAN CERTIFIED RETIREES USE CENTIVO?

Pre-age 65 Certified Retirees can use Centivo, but age 65+ retirees who have Medicare as primary can only use the Anthem Blue Cross PPO plan. If you are an over 65 certified retiree, who achieves the earnings minimum in covered earnings, you will receive active coverage for 1 year. While on active coverage, you will be eligible for the Centivo plan. Once you cease to achieve the earnings minimum in a subsequent year, you will return to inactive status, and only be eligible for the Anthem PPO plan.

CAN PARTICIPANTS USING THE EXTENDED COVERAGE PROGRAM USE CENTIVO?

Yes, and it uses fewer points: 2.5 points per quarter, rather than 4.0 points per quarter for the PPO. If you elect Centivo as your provider, you will be able to have a longer period coverage with the same number of points than you would under Anthem.

CAN I SWITCH TO THE CENTIVO PLAN IF I MOVE FROM ACTIVE COVERAGE TO POINTS?

Yes. Prior to the quarter where coverage will switch from Active to points, a member can select to switch to Centivo.

IF I AM ON POINTS AND WILL RETURN TO ACTIVE COVERAGE, CAN I SWITCH FROM CENTIVO TO ANTHEM?

Yes. If a member has earned active coverage, they may select Anthem prior to the quarter active coverage begins again.

CAN I STILL GO OUT OF NETWORK TO NON-CENTIVO DOCTORS?

Yes. You will pay the existing out-of-network 40% co-insurance after your deductible is satisfied, with the Plan paying 60%. This is same OON rate as used by Anthem Blue Cross.

> Important: payment is based on the allowed amount, not billed charges. Some providers use what is referred to as "balance billing" where they ask the patient to pay the difference between what is covered by insurance and what they propose as their cost.

WHAT WILL IT COST ME IF I USE OUT-OF-NETWORK PROVIDERS

When a Participant seeks health services from an Out-of-Network (OON) provider, the OON coverage is calculated at 60% of the allowed amount (also known as reasonable and customary, which Centivo defines as 150% of the Medicare rate). Because OON providers can bill you for the remaining balance above this rate, your total cost is often much higher. OON care counts toward the annual out-of-pocket maximum of $20,500 (which includes your $500 annual deductible). By contrast, when you use in-network providers (INN), your Centivo plan covers 100% of eligible costs after your applicable copay. Your INN out-of-pocket costs are capped at just $2,000 per individual (or $4,000 per family) per year. While saving money is a primary reason to stay in-network, using in-network doctors also offer several other important protections and benefits.
Click HERE to learn more.

Understanding Your Out-of-Pocket Costs: In-Network vs. Out-of-Network

When you receive care, what you pay depends entirely on whether your provider is in the Centivo network.

- In-Network (Maximum Cost Protection): Centivo has already negotiated fixed, fair market rates. The plan covers 100% of these contracted services after your copay, and your total out-of-pocket cost are capped at a maximum of $2,000 per individual, and $4,000 per family, per year.
- Out-of-Network (Limited Cost Protection): Non-contracted providers are not bound by Centivo rates and can charge any amount they choose. Even if a service has a standard "allowed amount (also known as "reasonable and customary" rate), you are financially responsible for whatever balance the provider charges once you sign their financial agreement.

Centivo			
	In-Network		Out-of-Network
Copay / Coinsurance	Copay	Coinsurance	Coinsurance
Primary care visit	$0	0%	40%
Specialist visit	$25	0%	40%
Urgent care visit	$75	0%	40%
Emergency room visit	$300	0%	40%
Lab work / x-rays	$10	0%	40%
Outpatient surgery	$250	0%	40%
Inpatient surgery	$400	0%	40%
Inpatient hospital stay	$600	0%	40%

Below is an example of how this works in practice:

INN – Contract Rate Example:

Example #1:
Primary Care Visit
Billed Amount: $2,000.00
Allowed Amount: $600.00 (patient responsibility) = $0.00
Paid Amount: $600.00
Provider write-off: $1,400.00
Patient Total Responsibility: $0.00

Example #2:
Specialist Visit
Billed Amount: $2,000.00
Allowed Amount: $600.00 - $25.00 copay (patient responsibility)
Paid Amount: $575.00
Provider write-off: $1,400.00
Patient Total Responsibility: $25.00

OON Non-Contracted Example:

Billed Amount: $2,000.00
Allowed Amount: $700.00 – (the max rate the plan recognized) deductible Amount: $500.00 (paid by you first from the allowed amount)
Remaining Allowed Amount: $200.00
Centivo Paid Amount (60%): $120.00
Patient Coinsurance Amount (40%): $80.00
Balance Billing (Provider's Extra Change): $1,300.00 (the amount over the $700.00)
Patient Total Responsibility: $1,880.00 (deductible $500.00 + coinsurance $80.00+ balance bill $1,300.00)

Takeaway: Stay in-network whenever possible to avoid paying the difference out of pocket

Call Centivo BEFORE You Sign or Pay

Before scheduling out-of-network care, contact us to confirm the procedure is covered and understand your out-of-pocket costs. If you sign an agreement or pay upfront, you could be stuck paying 100% of an overcharged bill. **Reach out to Centivo first -** they may be able to negotiate a lower rate with the provider on your behalf, but only if you contact Centivo before care is delivered.

QUALITY OF SERVICES

Here is why staying in-network makes a difference:

- **Guaranteed Quality:** In-network providers pass rigorous annual background and safety checks. Out-of-Network doctors receive no such vetting and could face practice restrictions.
- **No Financial Surprises:** In-network rates are locked by contract, leaving you with only your standard copay. Out-of-network doctors can charge whatever they choose.
- **Zero Billing Hassle:** In-network offices handle all claims paperwork and bill Centivo directly. Going out-of-network often means filing the paperwork yourself.

Note: if you choose an out-of-network provider, you'll need to download and submit claim forms yourself- and you'll be on the hook for any uncontrolled out-of-pocket costs.

RECOURSE IF SOMETHING GOES WRONG WHEN UTILIZING OON PROVIDERS

When a participant uses an OON provider, the health plan has no contractual relationship with that provider. As a result, the plan has **no legal or administrative leverage to intervene, dispute charges, or enforce contractual protections** if issues arise (such as balance billing, quality of care concerns, or billing disputes). Unlike in-network providers who are bound by plan contracts to adhere to fee schedules, appeal processes, and billing standards OON providers operate entirely outside those agreements.

THE BOTTOM LINE

Choosing In-Network Protects Your Care and Your Wallet:

- Better Protection & Lower Costs: INN providers must honor contracted rates, and the plan can hold them accountable if something goes wrong.
- Zero Plan Recourse Out-of-Network: Out of network providers set their own prices. Because no contract exists, the plan cannot step in, advocate for you, or resolve billing issues if problems occur.
- Your Responsibility: Always confirm coverage beforehand and expect potentially sever out-of- pocket expenses.

OUT OF NETWORK BEHAVORIAL HEALTH REIMBURSEMENT

Centivo reimburses out-of-network behavioral health services at 150% of the Medicare rate (M150). This rate is consistent with all out-of-network medical services across the board and aligns with standard insurance industry benchmarks.

What it Means for You:

- **Your Share of the Cost:** When you see an out-of-network provider, your out-of-pocket costs (coinsurance or copays) are calculated based on this 150% Medicare allowed charge.
- **Potential Balance Billing:** Out-of-network providers do not accept our set allowed charges as payment in full. If your provider charges more than 150% of the Medicare rate, you may be billed for the remaining difference.
- **In-Network Care Saves You Money:** You can avoid extra out-of-pocket costs entirely by choosing an in-network provider.

What is 150% of Medicare?
Medicare sets standard rates for healthcare services across the country. Our plan uses 1.5 times that base amount as the maximum limit for calculating what the Fund pays for out-of-network services.

Maximize Your In-Network Savings: Therapy & Psychiatry: Connect with In-Network Providers via Rula

Access to In-network Behavioral Health Providers through Rula
Participants enrolled in Centivo can access in-network virtual mental health providers through Rula. For more information, visit www.wgaplans.org/rula

DOES CENTIVO OFFER MENTAL HEALTH SERVICES? WHAT IF I GO TO A THERAPIST WHO IS NOT IN THE CENTIVO NETWORK?

Yes. Centivo offers mental health care. You can find providers and costs in their app. If you go out of the Centivo network, you pay the out-of-network costs, as you would for any other out-of-network provider.

And, remember, you can self-refer for mental health care with Centivo (i.e., you do not have to get a referral from your primary care physician).

WHAT ABOUT ER CARE?

ER Care is covered as in-network regardless of where you go.

DOES ENROLLING IN CENTIVO CHANGE MY PHARMACY COVERAGE?
No, you still use Express Scripts and the co-pays are the same.

DOES CENTIVO OFFER COBRA COVERAGE?
Yes. A member can continue coverage on Centivo with COBRA after moving off of active coverage or points.

WHAT IF THERE ARE MULTIPLE INSURANCE PROVIDERS? HOW IS BILLING HANDLED?

It is most common for the claim to be made by the primary provider. For example, if another plan paid primary and we are paying secondary, we would receive the claim from the provider and/or the participant with the other carrier's EOB for what was covered as primary.

> If a claim is submitted by a provider, they would submit the EOB to the secondary payor after primary claim has been processed.

WHEN CENTIVO COORDINATES AS SECONDARY, IS PROVIDER'S NETWORK STATUS TAKEN INTO ACCOUNT? FOR EXAMPLE, IF I AM A DGA MEMBER AND USE A CEDARS SINAI PROVIDER WITH ANTHEM AS PRIMARY, WOULD CENTIVO APPLY IN-NETWORK BENEFIT IF I ALSO HAVE SECONDARY PWGA COVERAGE? OR WOULD THE OON BENEFIT APPLY?

Centivo would follow their own network status, so the OON would apply for that example.

MY SPOUSE AND I ARE BOTH WRITERS, WITH FULL HEALTH COVERAGE. CAN ONE OF US ELECT CENTIVO AND THE OTHER ANTHEM BLUE CROSS?

Dual writer households, where both writers have their own earned coverage, can each select their own health plan (Centivo or Anthem Blue Cross). They can also select which plan will cover their dependents.

DOES CENTIVO OPERATE AS A MEDICARE PART A & B SUPPLEMENT POLICY FOR POST-65/MEDICARE PRIMARY RETIREES?

Centivo does not operate as a Medicare Part A or B policy, but there could be instances when a participant is covered by Medicare and Centivo would coordinate as secondary (i.e. ESRD, SSDI). If a participant is 65 or older, working, and in Active status, Centivo will act as primary coverage. The participant will return to Medicare and Anthem once their Active status terminates.

IF I HAVE CENTIVO, CAN I STILL CALL THE HEALTH FUND WITH QUESTIONS?

Yes. The Health Fund will always be available to assist you. However, you should contact Centivo first for any issues because they are the primary providers.

WILL MY EOBS STILL BE IN MYPLANS? WILL THEY LOOK THE SAME OR DIFFERENT?

You will be able to find your EOBs in the MyPlans App as well as the Centivo app.

Note: MyPlans is only available to participants, not dependents.

CAN MY BUSINESS MANGER HANDLE MY BILLING AND OTHER PAPERWORK IF I ELECT TO USE CENTIVO?

Yes. You will need to fill out an *Authorization to Disclose Protected Health Information (PHI)*. The form is available here.

OPEN ENROLLMENT

WHEN IS IT?

For this year, Open Enrollment (including Centivo as an option) will run from November 11 to December 15, 2026 to allow participants more time to make their decision about what health care provider to select.

HOW WILL OPEN ENROLLMENT BE FACILITATED?

You will be able to select a plan and pay premiums during open enrollment online through MyPlans, on the www.wgaplans.org website and mobile app. Over 90% of our health plan eligible participants are already registered users of MyPlans, and you will need to register for MyPlans in order to complete the process.

> Note: MyPlans is only available to participants, not dependents.

You will be able to select your medical plan (Centivo or Anthem PPO), confirm the dependents who will be covered, and complete your AutoPay processing, which will enable automatic payment of your premium payments effective January 1, 2027.

> Note: This FAQ document will also be updated regarding the MyPlans on-line open enrollment access instructions and process, when available.

IF YOU HAVE OPEN ENROLLMENT QUESTIONS?

Be on the lookout for additional information regarding the open enrollment process, along with how to get assistance in the coming weeks.

> Note: In addition to the special communications that will be issued, this FAQ document will continually be updated with new information.

If you have any questions, you can reach the Health Fund through the MyPlans app, by the website at: https://www.wgaplans.org/contact-us/, or via phone: (818) 846-1015.

WHO CAN MAKE CHANGES TO PLAN ELECTIONS?

The decision to elect Centivo or Anthem Blue Cross rests solely with the primary participant. Dependent coverage will always follow primary participant's election.

ARE THERE ANY RESTRICTIONS REGARDING WHO CAN SELECT CENTIVO AS A PLAN OPTION?

There are some restrictions. If a participant, or their spouse, is a Certified Retiree on Medicare, then Centivo is not available as a plan option. Participants outside of Los Angeles and New York should also confirm that Centivo has covered providers in their area.

WHAT IF I AM SELECTING COBRA AS MY COVERAGE OPTION?

The COBRA election process will remain the same as it is now. You can choose either single or family, however, you must also elect the medical plan (either Centivo, Anthem, or Low Option) – only available through Anthem – as each will have different COBRA rates.

WHAT IF I ADD NEW DEPENDENT(S) OUTSIDE OF THE OPEN ENROLLMENT PERIOD DUE TO A LIFE EVENT?

Newly added dependent(s) will automatically be covered under your current medical plan election.

MEDICAL PLAN ELECTION

WHAT HAPPENS IF I CAN'T DECIDE BETWEEN ANTHEM BLUE CROSS AND CENTIVO?

If you do not make an election during the Open Enrollment period, you – and your dependents – will automatically be enrolled in Anthem Blue Cross along with the concomitant automatic premium payments.

MY SPOUSE AND I ARE BOTH WRITERS AND HAVE SEPARATELY QUALIFIED FOR COVERAGE. CAN WE EACH ELECT OUR OWN MEDICAL PLAN?

Yes, you and your spouse may each elect a medical plan of your own.

HOW CAN I DECIDE WHICH MEDICAL PLAN IS BETTER FOR ME?

Health Fairs and Webinars: The Health Fund will be holding health fairs on August 29 and November 14, 2026 in Los Angeles so that you can have a chance to meet with staff and ask questions. A similar health fair will be held in New York on October 22. There will also be Zoom sessions available on September 17 and November 10, 2026. Additionally, the Health Fund will send materials provided by Centivo and the Health Fund to help participants make the best use of the resources available to them on an ongoing basis.

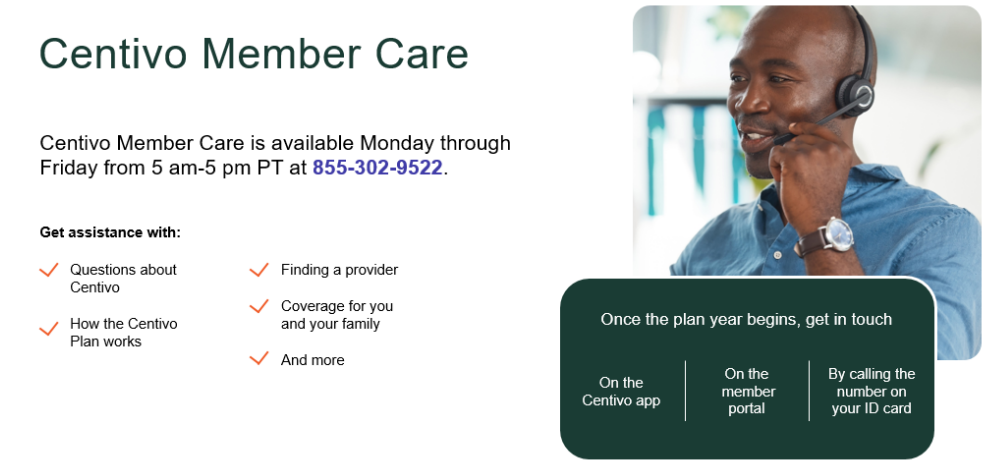
Decision-Support Tool: If you want to compare your costs under Centivo versus what you would pay using Anthem Blue Cross, you can do so on a forthcoming new app, Budgie Health. Budgie Health will load your previous year's medical claims and then provide you with information about what those same services would cost under Centivo. Instructions regarding how to access Budgie for health plan selection decision support will be provided in a future communication to all participants.

> Note: This FAQ document will also be updated regarding Budgie access instructions, when available.

Because Centivo is working with the UCLA Health system in Los Angeles, many of the medical professionals available under TIHN are also part of Centivo. You can find out whether your current TIHN provider is within the Centivo network by using their app which also allows you to select a Centivo primary care physician (PCP) who will be responsible for referring you to medical personnel inside the Centivo system. Instructions regarding how to access the Centivo app for primary care physician verification/selection decision support will be provided in a future communication to all participants.

Note: This FAQ document will also be updated regarding Centivo access instructions, when available.

You can also reach out to Centivo for answers to your open enrollment questions:



MONTHLY PREMIUMS

DO I HAVE TO PAY A PREMIUM?

Yes. Participants will now have to pay a premium for coverage. The amount of your premium payment depends on the program you choose, either Centivo or the existing Anthem Blue Cross PPO Plan, along with the number of dependents you elect to cover within your household.

Though the cost of the premiums is listed monthly, premiums will continue to be paid quarterly, with the option to pay for the full year.

> When the participant makes the election to use either Centivo or Anthem Blue Cross, **automatic payments** will be set up so that there is no possibility of inadvertently losing coverage due to lack of premium payment.

I AM ALREADY ENROLLED IN AUTOPAY. DO I HAVE TO ENROLL AGAIN?

Yes. All participants must re-enroll in autopay during this year's open enrollment in support of their plan election, and to confirm their associated premium payments effective January 1, 2027.

> Note: Once every three years, the Health Plan will allow a late payment of the participant and/or dependent premium. If you find yourself in a situation where you have missed the participant and/or dependent premium payment deadline, you still have a chance to continue your coverage.

CONTINUING COVERAGE

IF I AM CONTINUING COVERAGE (CONTINUING COVERAGE MEANS YOU ALREADY HAVE COVERAGE AND IT CONTINUES INTO THE NEXT QUARTER OR BEYOND) AND IT IS OUTSIDE OF THE OPEN ENROLLMENT PERIOD, CAN I MAKE A MEDICAL PLAN ELECTION?

No. Your coverage automatically defaults to the medical plan selected during the immediately preceding coverage period.

WHAT HAPPENS WHEN MY COVERAGE ENDS?

After your active health coverage ends, it is considered a "life event" and you will continue your health coverage if you have enough Extended Coverage Points (ECP). If you do not have enough ECPs, you may be entitled to COBRA coverage to temporarily continue your health insurance plan by paying the monthly COBRA fees.

WHAT HAPPENS IF I BECOME A RETIREE?

If you become a retiree and are under age 65, you will continue coverage under your existing medical plan election. If you are at or above age 65, your coverage will default to Medicare, with the Anthem PPO secondary and all dependents fall under the same medical plan.

WHAT HAPPENS IF I CONTINUE COVERAGE WITH ECP POINTS OR COBRA?

If your coverage is changed to Extended Coverage Program or COBRA, it is considered a "life event" and you are allowed to elect a new medical plan.

WHAT IF I AM REINSTATED AFTER A BREAK IN COVERAGE?

If you lose coverage for one full quarter or longer and then become reinstated, you are allowed to elect a new medical plan.

WHAT IF I AM REINSTATED AFTER A BREAK IN COVERAGE DUE TO ERROR (E.G. LATE CONTRIBUTIONS)?

If you lose coverage due to an error and then become reinstated, you are automatically placed back into the medical plan selected during the immediately preceding coverage period. The only exception occurs if the break in service coincides with Annual Open Enrollment, in which case you can elect the plan option of your choice.

EMPLOYER GROUP WAIVER PLAN (EGWP)

WHAT IS EGWP?

EGWP stands for the "Employer Group Waiver Plan" which is a prescription drug program administered by Express Scripts (ESI) for participants covered by Medicare. Effective January 1, 2027 Medicare-eligible participants and Certified Retirees over 65 years of age who do not have earned coverage from employment will be required to enroll in the EGWP Medicare drug formulary, which will result in a more generous federal rebate. This change will primarily impact behind-the-scenes Health Plan administrative processes, and your coverage will continue to be administered by ESI and have the same cost-sharing design as for Anthem PPO prescription drug coverage, meaning your copayments and tier structure will not change. Under EGWP, a small number of prescribed drugs will be reviewed for possible generic alternatives.

> Note: Moving Medicare eligible participants and certified retirees from the traditional Centers for Medicare & Medicaid Services (CMS) model to EGWP will be part of the Open Enrollment process for coverage effective January 1, 2027.

HOW DO I ENROLL IN EGWP?

All Medicare eligible individuals and certified retirees over 65 years of age, enrolled in the current CMS plan, will be automatically enrolled into the EGWP, as part of the open enrollment process. Your default medical plan will be Anthem PPO. (Centivo is not an available plan option for Medicare eligible participants and Certified Retirees over 65 years of age who are inactive writers.) Medicare eligible participants and Certified Retirees over 65 years of age will be sent an advance notice that provides more information about the EGWP.

You can only be enrolled in one Medicare Part D plan at a time. Since the EGWP is a Medicare Part D plan, you should not enroll in another Medicare Part D plan if you want to maintain your prescription drug coverage under the Plan. If you do enroll in other Part D coverage, this will result in loss of your Anthem PPO coverage along with the Plan's prescription drug coverage (EGWP).

AM I ELIGIBLE FOR THE CENTIVO PLAN IF I AM A CERTIFIED RETIREE OVER 65, AND I RETURN TO WORK AS A WRITER AND ACHIEVE THE EARNINGS MINIMUM?

Yes. If you are an over 65 Certified Retiree, who achieves the earnings minimum in covered earnings, you will receive active coverage for 1 year. While on active coverage, you will be eligible for the Centivo plan. Once you cease to achieve the earnings

minimum in a subsequent year, you will return to inactive status, and only be eligible for the Anthem PPO plan.

I AM MEDICARE-ELIGIBLE BUT HAVE NOT ENROLLED. WOULD I STILL HAVE PRESCRIPTION DRUG COVERAGE?

You must be enrolled in Medicare Part A and Part B in order to maintain prescription drug coverage through this program. If you are Medicare-eligible and you are not enrolled in Medicare, you will not have prescription drug coverage. For important details about Medicare coordination of benefits, see the SPD.

WHAT HAPPENS TO MY HEALTH PLAN BENEFITS IF I OPT OUT OF EGWP?

In order to be eligible for Anthem PPO, the default medical plan available to Medicare-eligible individuals and Certified Retirees over 65 years of age, EGWP is your PWGA-sponsored Part D prescription drug coverage.

> Note: If you elect to opt out of EGWP, you must enroll in another Part D prescription drug coverage to avoid potential complications enumerated below.

WHAT ARE THE OTHER IMPLICATIONS TO ME IF I OPT OUT OF EGWP?

There may be different outcomes depending on the scenario:

- If a retiree declines PWGA's Part D coverage and enrolls in a Medicare Part D plan immediately, there will be no late enrollment penalties with Medicare.

- If a retiree declines PWGA's EGWP prescription drug coverage and does not enroll in Medicare Part D, they may incur a lifetime Medicare Part D late enrollment penalty when they do enroll in Medicare Part D if they go 63 or more consecutive days without coverage.

Because PWGA offers creditable coverage, retirees should either enroll in the PWGA EGWP plan or an alternative Part D plan to avoid late enrollment penalties.

IS THERE A PREMIUM TO PAY?

Depending on your income, you may also be required to pay an additional Medicare Part D monthly surcharge in addition to your monthly Medicare prescription drug Part D coverage premium. The Social Security Administration (SSA) will notify you if you owe a monthly surcharge and what you will pay in addition to your regular Part D premium. If you do owe the additional premium, it is paid directly to SSA, not to ESI or the Plan.

However, if you do not pay the surcharge and are disenrolled from Medicare Part D, your Plan prescription drug coverage would end as well.

If your income is above $109,000 for an individual or $218,000 for married filing jointly, premiums may range based on income from $14.50 per month to $91 per month. Information about the premiums and earnings brackets can be found on the Centers for Medicare/Medicaid Services website, in the charts labeled “Part D”: 2026 Medicare Parts A & B Premiums and Deductibles | CMS.

IF I OPT OUT OF EGWP CAN I EVER REINSTATE MY HEALTH PLAN COVERAGE UNDER THE HEALTH FUND?

Yes. If you are Certified Retiree over 65 years of age, and elect to opt out of EGWP, you will be able to resume coverage, but have to wait until the next open enrollment period in November, 2027, at which time you must opt-in to EGWP as your Part D prescription drug coverage.

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