PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

Summary of Material Modifications

SUMMARY OF MATERIAL MODIFICATIONS

TO: All Plan Participants

FROM: The Writers' Guild-Industry Health Fund

This document is a Summary of Material Modifications (SMM), intended to notify you of changes to your benefits under the Writers' Guild-Industry Health Fund.

Effective January 1, 2027:

- Premiums, coinsurance, coinsurance OOP maximums and deductibles will increase.
- In addition to the current Anthem PPO, a new benefit option called "Centivo" will be available. The Industry Health Network (TIHN) benefits will be eliminated.
- Extended Coverage Program (ECP) earnings minimums and the number of ECP points needed for Anthem PPO coverage will both increase. ECP points to maintain Centivo coverage will remain at 2.5 points per quarter.
- The Allowed Charge for out-of-network (OON) behavioral health services will be based on the same benchmark that the Fund uses for other OON covered services.
- Medicare-eligible retirees will receive prescription drug coverage under a new program coordinated with Medicare Part D.

Also, effective July 1, 2027:

- The minimum earnings threshold to qualify for Health Plan coverage will automatically increase each July 1st to 110% of the then-current network prime time story and teleplay minimum.

PLAN BENEFIT CHANGES

As you know, the 2026 WGA Theatrical and Television Basic Agreement included employer contribution increases and benefit changes, both intended to improve the health of The Writers' Guild-Industry Health Fund (the "Fund"). This summary describes the benefit changes that will be implemented to the Fund's plan of benefits (the "Health Plan") effective January 1, 2027.

Mandatory Premiums and Cost-Sharing: Participants on Earned Coverage will be required to make monthly premium contributions for individual coverage (and dependent coverage, if elected). Premiums, deductibles, and coinsurance out-of-pocket ("OOP") maximums will all increase for 2027. Starting in 2028, these amounts will then increase annually by 3%. **You must arrange to pay your monthly premium for coverage starting January 1, 2027, or your coverage will be canceled.**

New Health Plan Benefit Options: Participants will be able to choose between two different Health Plan benefit options for their in-network medical and hospital benefits: **Anthem PPO**, the current benefit option, and **Centivo**. The Centivo option provides a narrower network than the Anthem PPO, but it has lower premium costs and generally lower cost sharing. The Fund Office will make a plan comparison tool available to help you decide which option is right for you at the time of Open Enrollment, November 11, 2026. The tool will be available on our website: www.wgaplans.org.

Note: If you are a Medicare-eligible retiree enrolled in Certified Retiree coverage, your only Health Plan option is the Anthem PPO.

Relatedly, participants will no longer have access to The Industry Health Network (TIHN) benefit,

including discounted rates. However, you may be able to continue seeing providers in the TIHN network, subject to applicable cost-sharing under the Anthem PPO or Centivo benefit options (and, for those enrolled in Centivo, provided you have a referral in place from your primary care provider (PCP)).

Extended Coverage Program: The minimum covered earnings needed to accrue Extended Coverage Program (ECP) points will increase. Participants using points to extend coverage under the Anthem PPO plan will need to spend 4 points per quarter to maintain that benefit option. Centivo is available for the current point level of 2.5 points per quarter.

Allowed Charge for Out-of-Network Behavioral Health Services: The Allowed Charge for out-of-network (OON) behavioral health services will change to 150% of the Medicare rate for the service, which is the same benchmark the Fund uses for other OON covered services.

Retiree Drug Coverage: Medicare-eligible retirees enrolled in Certified Retiree coverage will receive prescription drug coverage under a new program coordinated with Medicare Part D called an Employer Group Waiver Plan (EGWP). Benefits under the EGWP must follow certain requirements outlined by the Center for Medicare and Medicaid Services (CMS). Retirees with higher incomes may be assessed a premium surcharge by the Social Security Administration.

Minimum Earnings: Starting July 1, 2027, the minimum earnings threshold to qualify for Health Plan coverage will increase each July 1 to 110% of the then-current network prime time story and teleplay minimum.

You should read this Summary of Material Modifications ("SMM") carefully to understand how your benefits under the Health Plan will change. Important details about the coverage changes are included below. If you have any questions, please contact the Fund Office for further information.

Your Health Plan Options and Costs Are Changing

For coverage starting January 1, 2027, participants on Earned Coverage will choose between two different Health Plan benefit options for themselves and their covered dependents. Participants and their dependents must be enrolled in the same benefit option (either Anthem PPO or Centivo), which each have different participant and dependent premiums. The two options are as follows:

- **Anthem PPO**, which is the current Health Plan default for participants on Earned Coverage and retirees. This is a traditional participating provider network with a deductible, coinsurance, and coinsurance out-of-pocket maximums. Some benefit changes will be made to this option, as described below.

- **Centivo**, which has a narrower provider network with no in-network deductible, fixed in-network copayments, and an out-of-pocket maximum on copayments. You will need a referral from your Centivo primary care provider (PCP) for most services. You may be interested in this benefit option if you prefer paying a fixed amount each time you see a provider and you are comfortable choosing providers in your area in the smaller Centivo network. If you see a provider outside the Centivo network, you will need to satisfy a deductible, coinsurance, and coinsurance out-of-pocket maximum (which match the out-of-network amounts under the Anthem PPO). This benefit option is not available to Medicare-eligible retirees enrolled in Certified Retiree coverage or to Medicare-eligible totally disabled participants and dependents.
    - In the greater Los Angeles area, the Centivo option will include many providers from UCLA Health (including those in The Industry Health Network (TIHN) clinics). However, as explained above, TIHN benefits will no longer be available—instead, Centivo copayments will apply.
    - In the New York metro area, the Centivo option will include many providers at Mount Sinai, Montefiore, and other medical groups.

  Centivo has provider networks in many metropolitan areas, but you should confirm availability in your area before you select the Centivo option. More information on Centivo providers will be made available before open enrollment begins on November 11, 2026, at www.wgaplans.org.

Key Terms Used in this Document

Here is a reminder of the meaning of some of the key terms used throughout this document:

- **Deductible**. The annual deductible is the amount you must pay for covered services before the Fund begins paying its share of your covered expenses under the Plan.
- **Premiums.** Monthly premiums are the amount you pay each month to maintain your coverage under the benefit option.
- **Coinsurance.** This is the percentage of covered expenses that you must pay after meeting your deductible (and any applicable copayment).
- **Coinsurance Out-of-Pocket (OOP) Maximum.** After you meet your annual deductible, you and the Fund will share costs for covered services (coinsurance), up to the applicable coinsurance out-of-pocket (OOP) maximum. There are separate co-insurance OOP maximums for in-network and out-of-network covered services. The coinsurance OOP maximum also applies separately to each participant and covered dependent.

Active and Pre-Medicare Retiree Premiums

The following chart shows how the monthly participant premiums compare for the Anthem PPO and the Centivo options for active and pre-65 retirees. Monthly premiums will increase, effective January 1, 2027, to the amount in the 2027 column below. Each year thereafter, the premium will increase by 3% (rounded up to the nearest $1 increment).

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.

Details about setting up premium payments can be found on page [31] of your Summary Plan Description (SPD) and online at www.wgaplans.org.

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.							

For more details about each benefit option, read below.

Anthem PPO

Effective January 1, 2027, the Anthem PPO deductible will increase to $500 for the participant and $1,500 for family from the current amounts of $400 for participant and $1,200 for family per calendar year. Also, effective January 1, 2027, the Anthem PPO coinsurance out-of-pocket (OOP) maximum will increase to $2,500 in-network, while the out-of-network coinsurance maximum will remain $20,000. Starting January 1, 2028, and each year thereafter, the deductible and coinsurance OOP maximum for in-network services will increase by 3%, rounded up to the nearest $5 increment.

In addition to the changes to the deductible, effective January 1, 2027, in-network coinsurance will change from 85% paid by the Plan to 80% paid by the Plan.

The chart below shows the deductible, coinsurance OOP limit, and coinsurance percentage

in effect for 2026, with the amounts that will apply in 2027 and 2028.

	2026		2027		2028	
Deductible	**Participant**	**Family**	**Participant**	**Family**	**Participant**	**Family**
	$400	$1,200	$500	$1,500	$515	$1,545
Coinsurance OOP Limit (per member)	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	$1,000	$20,000	$2,500	$20,000	$2,575	$20,000
Coinsurance (Fund % / Your %)	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	85% / 15%	60% / 40%	80% / 20%	60% / 40%	80% / 20%	60% / 40%
*Keep in mind that for future years, the deductible and in-network coinsurance OOP limit each increase by 3% per year.						

Centivo

During open enrollment for the plan year starting January 1, 2027, participants will be able to enroll in a new Health Plan benefit option called "Centivo". This benefit option requires designation of a Centivo-affiliated primary care provider (PCP) and has a more limited provider network, no deductible, and a fixed copayment structure. As noted above, this benefit option is not available to Medicare-eligible retirees enrolled in Certified Retiree coverage. Centivo participants are eligible for the Health Fund's prescription drug benefit (through Express Scripts), infertility benefit (administered by Carrot), Hinge Health (virtual physical therapy), Lantern (surgical specialists), and Rula (virtual mental health services).

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 page 69 of 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.

Your in-network OOP Limit for the Centivo option is $2,000 for an individual and $4,000 for family.

You will get the most value from your coverage by seeing Centivo providers. If you receive care from providers outside of the Centivo network, the fixed copayment schedule generally will not apply, and you will be subject to the same out-of-network cost-sharing that applies to the Anthem PPO benefit. This means that you will need to satisfy the Anthem PPO out-of-network deductible, pay out-of-network coinsurance, and satisfy the out-of-network OOP coinsurance limit. You will pay significantly more if you see an out-of-network provider instead of a provider in the Centivo Network.

Moving out of Centivo coverage area

If a participant or dependent covered by Centivo permanently relocates outside of the Centivo coverage area, the relocation will constitute a Life Event, and the participant would be able to switch coverage from the Centivo plan to the Anthem plan, provided they notify the Plan within 30 days.

Temporary relocations by participants or dependents outside the Centivo coverage area (*e.g.*, to attend college or work on set) will not constitute a Life Event. Timing and notice requirements for Life Events are explained on page [33] of the SPD. If you do not make an election with respect to a permanent relocation outside the Centivo coverage area, the default rules regarding your coverage in the SPD and/or open enrollment materials will apply and you will be required to pay your premium for the quarter to avoid cancellation of your coverage.

Out-of-Network Allowed Charge

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.

Changes to the Extended Coverage Program ("ECP")

The Extended Coverage Program provides participants with extended coverage program (ECP) points to maintain Health Plan coverage during periods when they would otherwise lose Earned Coverage. You must have earned at least 10 ECP points to qualify for Extended Coverage Program benefits. ECP points are automatically deducted from the balance of eligible participants to extend coverage on a quarterly basis.

Starting January 1, 2027:

- The amount of ECP points that you need for coverage under the Extended Coverage Program is increasing for the Anthem PPO. To maintain coverage under the Anthem PPO benefit option, you will need to use 4 ECP points per quarter. To maintain coverage under the Centivo benefit option, you will need to use 2.5 ECP points per quarter.
- If a participant is on Extended Coverage and their ECP points balance is nearly depleted, participants will receive a one-point subsidy as follows:
    - If a participant with Anthem PPO coverage has 3 ECP points, the Fund will subsidize one point to provide one additional quarter of coverage
    - If a participant with Centivo coverage has 1.5 ECP points, the Fund will subsidize one point to provide an additional quarter of coverage

- The earnings minimums to accrue ECP points are increasing effective January 1, 2027. The earnings minimum to accrue a second ECP point is also increasing effective January 1, 2028 and 2029. In addition, a participant can only earn a maximum of two ECP points in any four-quarter earnings cycle.
- Specifically, beginning January 1, 2027, a point will no longer be earned by meeting the earnings requirement for a year of coverage. Instead, the first point will be earned by reaching a minimum earnings threshold of $200,000 of covered earnings over a four-quarter earnings cycle. The earnings minimum to receive a second ECP point will increase as shown below:

Points Accrued	2027 Earnings Minimum for ECP	2028 Earnings Minimum for ECP	2029 Earnings Minimum for ECP
No points accrued	<$200,000	<$200,000	<$200,000
1 ECP point	$200,000-$324,999	$200,000-$374,999	$200,000-$399,999
2 ECP points	≥$325,000	≥$375,000	≥$400,000

Earnings Minimums for Health Care Coverage

The Health Plan uses minimum earnings thresholds to determine eligibility for health care coverage. Effective July 1, 2027, the minimum earnings threshold to qualify for Health Plan coverage will increase to 110% of the then-current network prime time story and teleplay minimum, which will be $53,773 as of July 1, 2027. The minimum earnings threshold will increase each July 1 to 110% of the then-current network prime time story and teleplay minimum.

Prescription Drug Coverage for Medicare-Eligible Certified Retirees

Effective January 1, 2027, Medicare-eligible individuals enrolled in Certified Retiree coverage will receive prescription drug coverage through an employer group waiver plan (EGWP). 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. However, the prescription drugs included on the formulary and their tier classification may change, as explained below.

All Medicare-eligible individuals enrolled in Certified Retiree coverage will be automatically enrolled into the EGWP. Medicare-eligible individuals enrolled in Certified Retiree coverage can opt out of the EGWP, but will need to find other prescription drug coverage if they do so. Retirees will be sent an advance notice that provides more information about the EGWP and how the Plan will coordinate your prescription drug and medical benefits with Medicare.

As a technical matter, the EGWP works by structuring your drug coverage through Medicare Part D. This means that prescription drug coverage will follow a Medicare Part D drug

formulary. As a result, there may be some changes to your current Health Plan prescription drug coverage; if your prescription coverage will change, ESI will contact you regarding impacted medications and preferred alternatives.

Depending on your income, you may be required to pay an additional Medicare Part D monthly surcharge in addition to your monthly Medicare Part D 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 prescription drug coverage under the Plan would end.

Important: You must be enrolled in Medicare Part A and/or 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 [page 85] of the SPD.

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 the Plan's prescription drug coverage.

Extension of One-In-Three Rule to Participant Premiums

As described above, it is very important to make timely payment of participant and dependent premiums to avoid cancelation of your coverage. The Health Plan currently has a limited exception for late payments of dependent premiums, called the One-in-Three rule (see page [31] of the SPD).

Specifically, a Participant may submit a written request to the Fund Office, asking that an exception be made to allow a late payment and reinstate dependent coverage. The written request must be received no later than 45 days from the first day of the calendar quarter for which payment was due. The Fund Office will grant the request and no subsequent late payment exceptions will be allowed for three years (36 months) from the date the initial exception was made.

This One-in-Three rule will also apply to participant premiums.

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This summary is intended to satisfy the requirement for issuance of an SMM. You should take the time to read this SMM carefully and keep it with the Summary Plan Description ("SPD") that was previously provided to you. If any conflict should arise between this summary and the terms of the SPD (other than with respect to the specific terms and provisions this summary is modifying), or if any point is not discussed in this summary or is only partially discussed, the terms of the applicable SPD will govern

in all cases. If you need another copy of the SPD or if you have any questions regarding these changes 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). Please keep in mind that the benefits in the Plan are not vested, and the Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan or any benefits provided under the Plan (or qualification for such benefits), in whole or in part, at any time and for any reason (including, but not limited to, with respect to retirees).

2900 W. Alameda Avenue Suite 1100 • Burbank, CA 91505-4267 • 818.846.1015 • 800.227.7863 • FAX 818.526.6571
www.wgaplans.org