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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

EDWARD ASNER, *et al.*,

Plaintiffs,

vs.

THE SAG-AFTRA HEALTH FUND, *et al.*,

Defendants.

Case No. 2:20-cv-10914-CAS (JEM)

CLASS ACTION SETTLEMENT AGREEMENT

Judge: Hon. Christina A. Snyder
Action Filed: December 1, 2020

This Class Action Settlement Agreement (the "Settlement Agreement") is entered into between and among, on the one hand, the Class Representatives, on behalf of themselves and all Class Members, and, on the other hand, the Defendants, as defined herein.

1. RECITALS

1.1. The SAG-AFTRA Health Plan (the "Plan") is a multiemployer welfare plan that provides health benefits primarily to employees of employers in the entertainment industry that are signatory to collective bargaining agreements with the union, Screen Actors Guild-American Federation of Television and Radio Artists ("SAG-AFTRA"), who qualify for health coverage based on their covered earnings. The Plan is the result of a January 1, 2017 merger between the Screen Actors Guild-Producers Health Plan (the "SAG Health Plan") and the AFTRA Health Plan (the "Merger").

1.2. In July 2020, the Board of Trustees of the Plan amended the Plan's benefit structure in various ways effective January 1, 2021, including to change the eligibility requirements for Senior Performers (the "Amendments").

1.3. On December 1, 2020, the Class Representatives, on behalf of themselves, a putative class of similarly situated participants and beneficiaries of the SAG Health Plan, and a putative class of similarly situated participants and beneficiaries of the Plan, filed a Class Action Complaint (the "Complaint") (ECF No. 1) in the United States District Court for the Central District of California titled *Asner, et al. v. The SAG-AFTRA Health Fund, et al.*, No. 20-cv-10914-CAS (JEM) (the "Action").

1.4. On March 26, 2021, in response to Defendants' motion to dismiss the Complaint (ECF No. 40), the Class Representatives amended the Complaint (ECF No. 43). As a result, the operative complaint became the First Amended Class Action Complaint (the "Amended Complaint").

1.5. The Amended Complaint is brought against the Board of Trustees of the SAG Health Plan, the Board of Trustees of the Plan, individually named Trustees of the two Boards (the "Trustee Defendants"), and against the Plan nominally "to facilitate comprehensive relief" (ECF No. 43 ¶ 45). Specifically, Counts I and III are brought against the Board of Trustees of the SAG Health Plan and the Trustee Defendants who served as Trustees of the SAG Health Plan, while Counts II and IV are brought against the Board of Trustees of the Plan and the Trustee Defendants who serve or served as Trustees of the Plan. Collectively, they assert (i) direct claims for breach of fiduciary duty under ERISA § 404(a)(1) (Counts I and II), and (ii) claims for co-fiduciary breach under ERISA § 405(a) (Counts III and IV).

1.6. The aforementioned claims are based on, *inter alia*, factual allegations that: (i) statements made in 2012 suggested that any decision to merge the SAG Health Plan and the AFTRA Health Plan would be based on a prudent investigation and governed by ERISA's fiduciary requirements (ECF No. 43 ¶¶ 4, 57-67, 71); (ii) the SAG Health Plan Trustees either failed to perform a prudent pre-merger investigation or approved the Merger despite projected Plan deficits (ECF No. 43 ¶¶ 19, 81, 165); (iii) the SAG Health Plan Trustees depleted the "Retiree Reserve" portfolio prior to the Merger by transferring it into the "Active Reserve" portfolio (ECF No. 88 at 5-7); (iv) statements made in June 2016 suggested that the recently-approved Merger would strengthen the financial health of the Plan (ECF No. 43 ¶¶ 6, 15, 68, 94); (v) the SAG-AFTRA Health Plan Trustees knew by mid-2018 that employer contributions and investment income would be insufficient to sustain the Plan's level of benefits (ECF No. 43 ¶¶ 12, 15, 79, 81, 94); (vi) the SAG-AFTRA Health Plan Trustees failed to disclose projected Plan deficits and prevented the negotiators of the 2019 Commercials CBA, 2019 Netflix CBA, and 2020

TV/Theatrical CBA from securing additional contributions (ECF No. 43 ¶¶ 17, 20, 98-106, 173); and (vii) the Amendments targeted participants age 65 and over in a manner that violated the Age Discrimination in Employment Act of 1967 ("ADEA"), California's Unruh Civil Rights Act, and Section 1557 of the Affordable Care Act (ECF No. 43 ¶¶ 21, 117-122, 129-132, 174, 176).

1.7. On April 30, 2021, Defendants filed a motion to dismiss the Amended Complaint, asserting, *inter alia*, that the challenged actions were not undertaken in a fiduciary capacity (ECF Nos. 45-48). The Court denied Defendants' motion to dismiss by Opinion and Order dated August 30, 2021 (ECF No. 61). The Court also denied Defendants' motion to certify the Court's August 30, 2021 Order for interlocutory appeal to the Ninth Circuit by Opinion and Order dated November 9, 2021 (ECF No. 70).

1.8. On September 24, 2021, Defendants filed their Answer to the Amended Complaint, denying all allegations of wrongdoing and liability and advancing certain affirmative and other defenses (ECF No. 64).

1.9. On December 29, 2021, the Court approved the parties' Joint Case Management Plan (ECF No. 72), which provided for a limited initial document production by Defendants in advance of mediation (ECF No. 71). On July 22, 2022, the Court entered a stipulated schedule for the parties to complete discovery and briefing on class certification (ECF No. 117).

1.10. On July 27, 2022, the Court dismissed with prejudice an action arising out of the same factual predicate that Class Counsel had filed on behalf of a putative class of SAG-AFTRA members in the United States District Court for the Central District of California titled *Fisher v. Screen Actors Guild-American Federation of Television and Radio Artists, et al.*, No. 21-cv-05215-CAS (JEM) (the "Fisher Action"). In the Fisher Action, it was alleged, *inter alia*, that certain of the Trustee Defendants who served as SAG-AFTRA

employees, officers, or bargaining committee members, as well as SAG-AFTRA and other individuals who served as SAG-AFTRA officers, breached their fiduciary duties under 29 U.S.C. § 501(a) by failing to disclose information about the Plan's funding in connection with the 2019 Commercials CBA, 2019 Netflix CBA, and 2020 TV/Theatrical CBA. The dismissal is currently on appeal to the Ninth Circuit (the "Fisher Appeal").

1.11. Throughout 2022, the parties engaged in settlement discussions, including through private mediation with Mediator Robert Meyer, Esq. of JAMS. The parties ultimately reached an agreement to settle. The terms of the parties' settlement are memorialized in this Settlement Agreement.

1.12. Class Representatives and Class Counsel consider it desirable and in the Class Members' best interests that the claims in the Action be settled upon the terms set forth below. Class Representatives and Class Counsel have concluded that such terms are fair, reasonable, and adequate, and that this settlement will result in valuable benefits to the Settlement Class.

1.13. In evaluating the terms of this Settlement Agreement, Class Counsel have taken into account: (i) the risk that the decisions that are the subject of the Action will ultimately be judged, by the district court or on appeal, to be settlor decisions that are not susceptible to challenge under ERISA's fiduciary rules; (ii) the risk that Defendants may be successful in whole or part in defending the merits of the claims asserted in the Action; (iii) the potential unavailability of relief even if the Class Representatives should prevail on the merits of their claims, including the potential inability to make prospective modifications to the Plan's benefit structure; (iv) the limited resources available from Defendants' fiduciary liability coverage, much of which would be consumed in defense costs if the litigation continues; and (v) the fact that

Defendants' fiduciary liability insurers had contested coverage with respect to some of the claims asserted in the Amended Complaint.

1.14. Defendants continue to deny all allegations of wrongdoing and deny all liability for the allegations and claims made in the Action. Defendants maintain that they are without fault or liability and are settling the Action solely to avoid the burden and costs of litigation and to prevent interference with the orderly operation of the Plan.

1.15. Therefore, the Settling Parties, in consideration of the promises, covenants, and agreements herein described, acknowledged by each of them to be satisfactory and adequate, and intending to be legally bound, do hereby mutually agree as follows:

2. DEFINITIONS

As used in this Settlement Agreement and the Exhibits thereto, unless otherwise defined, the following terms have the meaning specified below:

2.1. "**Action**" means the litigation titled *Asner, et al. v. The SAG-AFTRA Health Fund, et al.*, No. 20-cv-10914-CAS (JEM) in the United States District Court for the Central District of California.

2.2. "**ADEA**" means the Age Discrimination in Employment Act of 1967, as amended, 29 U.S.C. § 621, *et seq.*

2.3. "**Administrative Expenses**" means expenses incurred in the administration of this Settlement Agreement, including (a) all costs associated with providing CAFA Notices; (b) all costs associated with providing the Settlement Notice and HRA Notice and implementing the Plan of Allocation; (c) all fees and costs of the Escrow Agent; (d) all fees and costs of the Settlement Administrator; (e) all fees and costs of the Independent Settlement Evaluation Fiduciary; and (f) any taxes and tax expenses of the Qualified Settlement Fund. Administrative Expenses do not include the Settling Parties' respective

legal fees and costs. Administrative Expenses shall be paid from the Gross Settlement Amount.

2.4. "**Amended Complaint**" means the First Amended Class Action Complaint (ECF No. 43) filed in this Action.

2.5. "**Amendments**" means the amendments to the Plan's benefit structure and eligibility requirements that were adopted in 2020 and became effective on January 1, 2021.

2.6. "**Attorneys' Fees and Costs**" means the amount awarded by the Court as compensation for the services provided by Class Counsel and the costs incurred by Class Counsel in connection with the Action, which shall be paid from the Gross Settlement Amount.

2.7. "**Base Earnings Period**" means the period for establishing eligibility for future coverage under the Plan, which, for Senior Performers means the period October 1 to September 30 that precedes the Plan year.

2.8. "**Benefit Consultant**" shall have the same meaning as set forth in Article I, Section 5 of the Trust Agreement (attached hereto as Exhibit 7).

2.9. "**Benefits Committee**" means the SAG-AFTRA Health Plan Benefits Committee.

2.10. "**CAFA**" means the Class Action Fairness Act of 2005, 28 U.S.C. §§ 1711-1715.

2.11. "**Class Counsel**" means Chimicles Schwartz Kriner & Donaldson-Smith LLP, Johnson & Johnson LLP, and Law Offices of Edward Siedle. Chimicles Schwartz Kriner & Donaldson-Smith LLP are "Lead Class Counsel."

2.12. "**Class Members**" means all individuals in the Settlement Class, including the Class Representatives.

2.13. "**Class Period**" means the period from January 1, 2017 through the date the Court issues its Preliminary Approval Order.

2.14. "**Class Representatives**" means Michael Bell, Raymond Harry Johnson, David Jolliffe, Robert Clotworthy, Thomas Cook, Audrey Loggia, Deborah White, and Donna Lynn Leavy.[1]

2.15. "**Commercials CBA**" means the collective bargaining agreements that are periodically negotiated between SAG-AFTRA and The Joint Policy Committee, LLC entitled the SAG-AFTRA Commercials Contract.

2.16. **"Complaint**" means the Class Action Complaint (ECF No. 1) filed in this Action.

2.17. "**Continuation Value**" shall have the same meaning as set forth in Article I, Section 14 of the Trust Agreement (attached hereto as Exhibit 7).

2.18. "**Cost Consultant**" means the organization retained by the Plan to provide consulting or other services in accordance with the RFP described in Exhibit 5.

2.19. "**Court**" means the United States District Court for the Central District of California.

2.20. "**Defendants**" means the Plan, the Board of Trustees of the SAG Health Plan, the Board of Trustees of the Plan, and the Trustee Defendants.

2.21. "**Defense Counsel**" means Proskauer Rose LLP and Cohen, Weiss and Simon LLP.

2.22. "**Dollar Sessional Rule**" means the Plan's rule in effect between January 1, 2017 and December 31, 2020, that allowed a participant to satisfy the qualifying earnings threshold with residual earnings reported to the Plan as long as the participant had at least one dollar of sessional earnings reported to the Plan, which, for Retirees (including Senior Performers), was eliminated by the Amendments.

2.23. "**EEOC**" means the U.S. Equal Employment Opportunity Commission.

[1] Edward Asner and Sondra James Weil are omitted from the Class Representatives due to their deaths on August 29, 2021and September 12, 2021, respectively.

2.24. "**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 *et seq*.

2.25. "**Escrow Agent**" means Huntington Bank, or another entity agreed to by the Settling Parties.

2.26. "**Fairness Hearing**" means the hearing scheduled by the Court to consider (a) any objections from Class Members to the Settlement Agreement; (b) whether to finally approve the Settlement as fair, reasonable, and adequate under Federal Rule of Civil Procedure 23; (c) whether to certify the Settlement Class, for settlement purposes only, under Federal Rule of Civil Procedure 23; (d) the amount of any Attorneys' Fees and Costs to be awarded to Class Counsel; and (e) the amount of any Service Awards to be awarded to the Class Representatives.

2.27. "**Final**" when referring to the Final Approval Order or any other judgment or court order means that the period for any motions for reconsideration, motions for rehearing, appeals, petitions for certiorari, or the like ("Review Proceeding") has expired without the initiation of a Review Proceeding, or, if a Review Proceeding has been timely initiated, that it has been fully and finally resolved, either by court action or by voluntary action of any party, without any possibility of a reversal, vacatur, or modification of any judicial ruling, order, or judgment, including the exhaustion of all proceedings in any remand or subsequent appeal and remand. The Settling Parties agree that absent an appeal or other attempted Review Proceeding, the period after which the Final Approval Order becomes Final is thirty (30) days after its entry by the Court.

2.28. "**Final Approval Order**" means the order and final judgment approving the Settlement Agreement, implementing the terms of this Settlement Agreement, and dismissing the Action with prejudice as contemplated in Section 6 of this

Agreement, which order shall be in substantially the form set forth in Exhibit 3. The parties may agree to additions or modifications to the form of the Final Approval Order that they deem to be appropriate at the time that it is submitted to the Court for final approval of the Settlement.

2.29. "**Fisher Action**" means the litigation titled *Fisher v. Screen Actors Guild-American Federation of Television and Radio Artists, et al.*, No. 21-cv-05215-CAS (JEM) in the United States District Court for the Central District of California.

2.30. "**Fisher Appeal**" means the litigation titled *Fisher v. Screen Actors Guild-American Federation of Television and Radio Artists, et al.*, No. 22-55786 in the Ninth Circuit Court of Appeals.

2.31. "**Gross Settlement Amount**" means the payments and allocations totaling fifteen million dollars ($15,000,000) as described in Section 7.1. The Gross Settlement Amount does not include the additional allocations to the HRA Accounts of Qualifying Senior Performers described in Section 10.

2.32. "**HRA Account**" shall have the same meaning as set forth in Article I, Section 21 of the Trust Agreement (attached hereto as Exhibit 7) and Article I, Section 1.1(n) of the HRA Plan (attached hereto as Exhibit 8).

2.33. "**HRA Deadline**" means sixty (60) days after the date on which the HRA Notice is sent by the Settlement Administrator.

2.34. "**HRA Notice**" means the notice that will be sent by the Settlement Administrator to Senior Performers who do not have HRA Accounts, in substantially the form set forth in Exhibit 11.

2.35. "**HRA Plan**" means the SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan (attached hereto as Exhibit 8), and any future amendments thereto or restatements thereof.

2.36. "**Independent Settlement Evaluation Fiduciary**" means an independent fiduciary who will serve as a fiduciary to the Plan in accordance with Section 4 and who has no relationship with or interest in any of the Settling Parties.

2.37. "**Insurer Payment**" means seven million five hundred thousand dollars ($7,500,000) minus any Attorneys' Fees and Costs already paid directly by the Plan's insurance carriers to Class Counsel pursuant to Section 9, which shall be deposited into the Qualified Settlement Fund.

2.38. "**Joint Press Release**" means the press release concerning the Settlement that will be issued jointly by Defendants, Class Representatives, Class Counsel, and Defense Counsel, in substantially the form set forth in Exhibit 9.

2.39. "**Maximum Gross Monetary Settlement Amount**" means the Gross Settlement Amount (*i.e.*, fifteen million ($15,000,000)), plus the maximum amount of additional allocations to the HRA Accounts of Qualifying Senior Performers that are potentially required pursuant to Section 10 of this Agreement (*i.e.*, five million six hundred thousand ($5,600,000)).

2.40. "**Merger**" means the January 1, 2017 merger between the SAG Health Plan and the AFTRA Health Plan.

2.41. "**Netflix CBA**" means the collective bargaining agreements that are periodically negotiated between SAG-AFTRA and Netflix Studios, LLC entitled the SAG-AFTRA Netflix Agreement.

2.42. "**Net Settlement Amount**" means the Gross Settlement Amount minus (a) the total amount of Attorneys' Fees and Costs (inclusive of Service Awards) awarded by the Court and paid to Class Counsel; and (b) the total amount of Administrative Expenses paid (plus any reserve for expected future Administrative Expenses as determined by the Settlement Administrator).

2.43. "**Non-Conflicted Trustees**" means the current trustees of the Plan who were not named as Trustee Defendants.

2.44. "**Notice of Additional Credited Earnings Opportunity**" means the disclosure to Class Members described in Section 11.5, which shall be in substantially the form attached hereto as Exhibit 10.

2.45. "**Participant**" shall have the same meaning as set forth in Article I, Section 32 of the Trust Agreement (attached hereto as Exhibit 7).

2.46. "**Plan**" means the SAG-AFTRA Health Plan.

2.47. "**Plan Monetary Payment**" means seven million five hundred thousand dollars ($7,500,000) minus the total amount to be allocated by the Plan to the HRA Accounts of Class Members who are entitled to a Settlement Allocation and who have (or who have communicated an intention to have) HRA Accounts as of the HRA Deadline, which shall be deposited into the Qualified Settlement Fund.

2.48. "**Plan of Allocation**" means the plan for calculating, allocating, and distributing the Net Settlement Amount to Class Members, as set forth in Exhibit 6 attached hereto.

2.49. "**Plan Website**" means the website at www.sagaftraplans.org/health.

2.50. "**Preliminary Approval Order**" means the order proposed by the Settling Parties and entered by the Court, in substantially the form attached hereto as Exhibit 1, that is to be filed by the Class Representatives, through Class Counsel, in connection with the motion for preliminary approval of this Settlement Agreement, as described in Section 3.1.

2.51. "**Qualified Settlement Fund**" means the interest-bearing settlement fund account to be established and maintained by the Escrow Agent in accordance with Section 8.1 herein and referred to as the Qualified Settlement Fund (within the meaning of Treas. Reg. § 1.468B-1).

2.52. "**Qualifying Senior Performer**" means an individual who, for any particular year: (i) meets the definition of "Senior Performer" under Article I, Section

1.1(v) of the HRA Plan (attached hereto as Exhibit 8), and (ii) is ineligible for active coverage under the Plan that year solely as a result of the Amendments' elimination of the Dollar Sessional Rule.

2.53. "**Released Claims**" means any and all actual or potential claims, actions, allegations, demands, rights, obligations, liabilities, damages, attorneys' fees, expenses, costs, and causes of action, whether arising under federal, state or local law, whether by statute, contract or equity, whether brought in an individual, derivative, or representative capacity, whether known or unknown, suspected or unsuspected, foreseen or unforeseen, that:

(a) were or could have been asserted in the Complaint or Amended Complaint (or in any submission made by the Class Representatives or Class Counsel in connection with the Action), or that arise out of, depend upon, or are based on any of the factual allegations asserted in the Complaint or Amended Complaint (or in any submission made by the Class Representatives or Class Counsel in connection with the Action), including, but not limited to, those that arise out of, depend upon, or are based on: (i) the Merger and/or the pre-Merger evaluation process, (ii) the SAG Health Plan's maintenance of assets in, or transfer of assets out of, a "Retiree Reserve" portfolio, (iii) disclosures or failures to disclose information regarding the Merger and/or the pre-Merger evaluation process, (iv) the Amendments, (v) disclosures or failures to disclose information regarding the Plan's financial condition, funding, and/or actual or potential amendments to the Plan that occurred on or before the Settlement Effective Date, or (vi) any alleged breach of fiduciary duty in connection with (i) through (v) above.

(b) arise out of, relate in any way to, are based on, or have any connection with the approval by the Independent Settlement Evaluation Fiduciary of the Settlement Agreement, unless brought against the Independent Fiduciary alone;

(c) arise out of, relate in any way to, are based on, or have any connection with the calculation, allocation, and/or distribution of the Net Settlement Amount to Class Members (*i.e.*, the Settlement Allocations) in accordance with the Plan of Allocation;

(d) arise out of, relate in any way to, are based on, or have any connection with the calculation, allocation, and/or distribution of additional amounts to the HRA Accounts of Qualifying Senior Performers or any amendments to the HRA Plan that provide for such additional allocations; or

(e) would be barred by *res judicata* based on entry by the Court of the Final Approval Order.

Released Claims do not include claims based on factual allegations that were not asserted in the Complaint or Amended Complaint (or in any other submission made by the Class Representatives or Class Counsel in connection with the Action), and do not include individual claims for relief under the terms of the Plan or the HRA Plan.

2.54. "**Released Parties**" means (a) each Defendant in this Action; (b) each Defendant's predecessors, successors, assigns, past, present, and future employers, affiliates, descendants, spouses, dependents, beneficiaries, marital community, heirs, executors, and administrators; (c) the Plan; (d) each of the Plan's past, present, and future trustees, fiduciaries, parties in interest, committees and committee members, Executive Directors, employers, employees, service providers, investment vehicles or funds, managers,

independent contractors, administrators, actuaries, consultants, accountants, attorneys, and auditors; and (e) each of the past, present, and future agents, representatives, attorneys, experts, advisors, insurers, shareholders, owners, directors, officers, and employees of the individuals and entities in (a) through (d).

2.55. "**Retirees**" shall have the same meaning as set forth in the Summary Plan Description.

2.56. "**RFP**" means the Request for Proposal process described in Exhibit 5.

2.57. "**SAG-AFTRA**" means the Screen Actors Guild-American Federation of Television and Radio Artists.

2.58. "**SAG-AFTRA Executive Committee**" means the Executive Committee members of the SAG-AFTRA National Board.

2.59. "**SAG-AFTRA National Board**" means the National Board of SAG-AFTRA.

2.60. "**SAG-AFTRA National Executive Director**" means the individual then serving in the role of National Executive Director for SAG-AFTRA.

2.61. "**SAG Health Plan**" means the Screen Actors Guild-Producers Health Plan.

2.62. "**Senior Performer**" means an individual who meets the definition of "Senior Performer" under Article I, Section 1.1(v) of the HRA Plan (attached hereto as Exhibit 8).

2.63. "**Service Awards**" means the amount awarded by the Court as compensation for the services provided by the Class Representatives in connection with the Action, which shall be payable out of any awarded Attorneys' Fees and Costs and recovered from the Gross Settlement Amount.

2.64. "**Settlement**" means the settlement to be consummated under this Settlement Agreement pursuant to the Final Approval Order.

2.65. "**Settlement Administrator**" means A.B. Data, the entity selected and retained by Class Counsel to administer the Settlement and Plan of Allocation.

2.66. "**Settlement Agreement**" means this Class Action Settlement Agreement and its Exhibits.

2.67. "**Settlement Allocation"** means the portion of the Net Settlement Amount that a particular Class Member is entitled to receive as a result of this Settlement, as determined by the Settlement Administrator and pursuant to the Plan of Allocation.

2.68. "**Settlement Class**" means the following class to be certified by the Court: All individuals who (i) were enrolled in health coverage under the Plan at any time during the Class Period, (ii) were notified that they qualified for health coverage under the Plan for any time during the Class Period, and/or (iii) qualified or had qualified as a Senior Performer as of the beginning of or during the Class Period, but excluding the Trustee Defendants.

2.69. "**Settlement Effective Date**" means the date on which the Final Approval Order is Final, provided that by such date the Settlement has not been terminated in accordance with Section 15 and provided that any appeal or challenge affecting only the Court's approval regarding any Attorneys' Fees and Costs or Service Awards shall in no way disturb or affect the finality of the other provisions of the Final Approval Order or the Settlement Effective Date.

2.70. "**Settlement Notice**" means the Notice of Proposed Class Action Settlement to be sent to Class Members identified by the Plan following the Court's issuance of the Preliminary Approval Order, in substantially the form attached hereto as Exhibit 2.

2.71. "**Settlement Website**" means the website established by the Settlement Administrator for purposes of communicating with Class Members about the Settlement at www.sagaftrahealthplansettlement.com.

2.72. "**Settling Parties**" means the Defendants and the Class Representatives (on behalf of themselves, the Plan, and each of the Class Members). Although only named nominally as a Defendant, the Plan is a party to this Settlement Agreement for purposes of enforcing certain of its terms.

2.73. "**Summary Plan Description**" means the Summary Plan Description for the Plan, effective January 1, 2023, and any future amendments thereto or restatements thereof.

2.74. "**Trust Agreement**" means the 2021 Amended Restated Agreement and Declaration of Trust Establishing the SAG-AFTRA Health Fund (attached hereto as Exhibit 7), and any future amendments thereto or restatements thereof.

2.75. "**Trustee Defendants**" means Daryl Anderson, Helayne Antler, Amy Aquino, Timothy Blake, Jim Bracchitta, John Carter Brown, Duncan Crabtree-Ireland, Barry Gordon, J. Keith Gorham, James Harrington, David Hartley-Margolin, Harry Isaacs, Robert W. Johnson, Sheldon Kasdan, Matthew Kimbrough, Lynne Lambert, Allan Linderman, Carol A. Lombardini, Stacy K. Marcus, Richard Masur, John T. McGuire, Diane P. Mirowski, Paul Muratore, Tracy Owen, Michael Pniewski, Ray Rodriguez, Marc Sandman, Sally Stevens, Gabriela Teissier, Lara Unger, Ned Vaughn, David Weissman, Russell Wetanson, David P. White, and Samuel P. Wolfson.[2]

2.76. "**TV/Theatrical CBA**" means the collective bargaining agreements that are periodically negotiated between SAG-AFTRA and the Alliance of Motion Picture and Television Producers entitled SAG-AFTRA Codified Basic Agreement and the SAG-AFTRA Television Agreement.

2.77. "**Union Trustees**" shall have the same meaning as set forth in Article I, Section 44 of the Trust Agreement (attached hereto as Exhibit 7).

[2] Shelby Scott is omitted from the Trustee Defendants due to her death on June 1, 2022.

3. PRELIMINARY SETTLEMENT APPROVAL AND NOTICE TO THE CLASS

3.1. **Preliminary Settlement Approval**. As soon as reasonably possible, Class Representatives, through Class Counsel, shall file with the Court a motion for preliminary approval of the Settlement and for entry of a Preliminary Approval Order in substantially the form attached hereto as Exhibit 1. The Preliminary Approval Order to be presented to the Court shall, among other things:

(a) Preliminarily certify the Settlement Class, as defined in Section 2.68, under Federal Rule of Civil Procedure 23(b)(1), for settlement purposes only and conditioned upon the Settlement receiving final approval following the Fairness Hearing;

(b) Preliminarily approve the Settlement as sufficiently fair, reasonable, and adequate to authorize dissemination of notice thereof to the Settlement Class and to conduct a final Fairness Hearing thereon;

(c) Approve the form of Settlement Notice attached as Exhibit 2 and the plan for dissemination thereof to Class Members as appropriate;

(d) Approve the form of CAFA Notice attached as Exhibit 4 and order that upon mailing, Defendants shall have fulfilled their obligations under CAFA;

(e) Provide that any objections to the Settlement must be filed at least twenty-eight (28) days prior to the scheduled Fairness Hearing and any responses to objections must be filed at least fourteen (14) days before the Fairness Hearing;

(f) Set the Fairness Hearing for no less than one hundred and ten (110) days after the date of the Preliminary Approval Order; and

(g) Preliminarily enjoin each Class Member, whether in his or her individual capacity or on behalf of the Plan, from commencing, prosecuting, or pursuing any claim or complaint against the Released Parties that relates in any way to the Released Claims.

3.2. **Settlement Notice and HRA Notice**. Within thirty (30) days of the entry of the Preliminary Approval Order or by such other deadline specified by the Court, the Settlement Administrator shall cause to be provided to each Class Member a Settlement Notice in the form and manner to be approved by the Court, which shall be in substantially the form attached hereto as Exhibit 2 (or a form subsequently agreed to by the Settling Parties and the Court). For Senior Performers who are entitled to a monetary payment or HRA allocation from the Net Settlement Amount pursuant to the Plan of Allocation, their Settlement Notice shall include the target amount of that payment or HRA allocation. For Senior Performers who do not have an HRA Account, the Settlement Notice shall include the HRA Notice, which shall be in substantially the form attached hereto as Exhibit 11 (or a form subsequently agreed to by the Settling Parties), and which shall advise recipients of their right to become a Participant in the HRA Plan and thereby receive allocations to an HRA Account.

3.2.1. The Plan shall provide the Settlement Administrator with any names and addresses (both email and postal) of Class Members and other data in the Plan's possession in order to facilitate the distribution of the Settlement Notice and HRA Notice. The costs associated with gathering the names and addresses in the Plan's possession shall not be treated as Administrative Expenses.

3.2.2. The Settlement Notice shall be sent to the last known postal address, or email address if sent electronically, of each Class Member on

record with the Plan. For Class Members who reside at the same address, a single mailing or email shall suffice.

3.2.3. The Settling Parties agree that, because the Plan does not possess either an email or postal address for all Class Members, the Plan Website will include a link to the Settlement Website and the following documents (or links to the following documents) will be posted to the Settlement Website as soon as practicable following the date of the Preliminary Approval Order (if not already posted), and will remain on the Settlement Website until the Plan completes its obligations pursuant to Section 11: the Amended Complaint, the Settlement Agreement and its Exhibits, Plaintiffs' motion for preliminary approval and any response thereto by Defendants, the Settlement Notice, the HRA Notice, Class Counsel's motion for Attorneys' Fees and Costs and Service Awards and any response thereto by Defendants, any Court orders related to the Settlement, any amendments or revisions to these documents, any responses by the Settling Parties to any objections that may be filed, and any other documents or information mutually agreed upon by the Settling Parties. No other information or documents will be posted on the Settlement Website unless agreed to in advance by the Settling Parties in writing or as ordered by the Court.

3.2.4. No later than thirty (30) days after the HRA Deadline, the Settlement Administrator will provide the Plan with a list of Senior Performers who have communicated an intention to establish HRA Accounts in response to the HRA Notice.

3.3. **CAFA Notice**. No later than ten (10) days after the motion for preliminary approval of this Settlement Agreement has been filed with the Court,

Defendants will prepare and serve the CAFA notices in substantially the form attached as Exhibit 4 hereto on the Attorney General of the United States and the attorneys general of all states in which Class Members reside, as specified by 28 U.S.C. § 1715.

4. REVIEW AND APPROVAL BY INDEPENDENT SETTLEMENT EVALUATION FIDUCIARY

4.1. **Retention**. The Plan will select an Independent Settlement Evaluation Fiduciary, subject to the agreement of the Class Representatives, which agreement shall not unreasonably be withheld.

4.2. **Duties**. The Independent Settlement Evaluation Fiduciary shall have the following responsibilities, including whether to approve and authorize the settlement of Released Claims on behalf of the Plan:

(a) The Independent Settlement Evaluation Fiduciary shall review the Settlement and comply with all relevant conditions set forth in Prohibited Transaction Class Exemption 2003-39, "Release of Claims and Extensions of Credit in Connection with Litigation," issued December 31, 2003, by the United States Department of Labor, 68 Fed. Reg. 75,632, as amended ("PTE 2003-39") in making its determination, for the purpose of Defendants' reliance on PTE 2003-39; and

(b) The Independent Settlement Evaluation Fiduciary shall notify the Defendants (with copies to Class Counsel and Defense Counsel) directly of its determination in writing, which notification shall be delivered no later than forty-five (45) days before the Fairness Hearing.

4.3. **Provision of Information**. Defendants, Defense Counsel, and Class Counsel shall respond to reasonable requests for information by the Independent

Settlement Evaluation Fiduciary so that the Independent Settlement Evaluation Fiduciary can review and evaluate the Settlement Agreement.

4.4. **Conclusion by Defendants**. Within fifteen (15) days of receipt of the written determination by the Independent Settlement Evaluation Fiduciary, Defendants shall (i) review the determination by the Independent Fiduciary, (ii) conclude whether the Independent Settlement Evaluation Fiduciary has made the determinations required by PTE 2003-39, and (c) notify Class Counsel in writing of its conclusion in that regard.

5. SETTLEMENT ADMINISTRATOR

5.1. **Duties**. Among other things, the Settlement Administrator retained by Class Counsel shall be responsible for: (i) establishing and maintaining the Settlement Website; (ii) sending the Settlement Notice to each Class Member; (iii) sending the HRA Notices to certain Senior Performers; (iv) receiving responses to the HRA Notices regarding Senior Performers' intentions to establish HRA Accounts; (v) determining the share of the Net Settlement Amount to be allocated to each Class Member in accordance with the Plan of Allocation (*i.e.*, the Settlement Allocations); (vi) determining the amount of the Plan Monetary Payment; (vii) distributing Settlement Allocations to Class Members who are entitled to Settlement Allocations and who do not receive such amounts in the form of additional allocations to their HRA Accounts; and (viii) complying with all tax laws, rules, and regulations and withholding obligations.

5.2. **Provision of Information**. Defense Counsel and the Plan shall use reasonable efforts to respond timely to written requests, including by email, from the Settlement Administrator for reasonably accessible data that is reasonably necessary to effect notice and implement the Plan of Allocation.

5.3. **Confidentiality and Information Security**. The Settlement Administrator shall enter into a business associate agreement and any other types of confidentiality and information security agreements agreed to by the Settling Parties, in order to ensure the confidentiality and privacy of protected health information and personal identifying information provided to the Settlement Administrator in connection with the Settlement.

5.3.1. The Settlement Administrator shall use the data provided by the Plan solely for the purpose of meeting its obligations as Settlement Administrator, and for no other purpose.

5.3.2. At the request of the Settling Parties, the Settlement Administrator shall provide a written protocol addressing how the Settlement Administrator will maintain and store information provided to it in order to ensure that reasonable and necessary precautions are taken to safeguard the privacy and security of such information.

5.4. **List of Recipients**. No later than twenty-one (21) days after the Settlement Administrator has distributed Settlement Allocations to Class Members who are entitled to Settlement Allocations and who do not have (and have not communicated an intention to have) HRA Accounts as of the HRA Deadline, the Settlement Administrator shall prepare and provide to Class Counsel and Defense Counsel a list of all individuals who received such payment and the amount of such payment.

5.5. **No Liability**. Neither Defendants nor Defense Counsel are responsible for the Settlement Administrator's work, nor may they be held liable for any act or omission by the Settlement Administrator (including any act or omission resulting in a cybersecurity incident). Defendants and Defense Counsel have no responsibility and no liability for any taxes or tax expenses owed by, or tax reporting or withholding obligations, if any, of the Qualified Settlement Fund.

6. FINAL SETTLEMENT APPROVAL

6.1. **Final Settlement Approval**. No later than sixty (60) days before the Fairness Hearing (or no later than a date set by the Court in its Preliminary Approval Order), Class Counsel shall submit to the Court a motion for final approval of the Settlement and for entry of a Final Approval Order in substantially the form attached hereto as Exhibit 3 (or a form subsequently agreed to by the Settling Parties). The Final Approval Order to be presented to the Court shall, among other things:

(a) Certify the Settlement Class, as defined in Section 2.68, under Federal Rule of Civil Procedure 23(b)(1), for the sole purpose of settling and resolving the Action;

(b) Approve the Settlement as fair, reasonable, and adequate, and direct the Settling Parties to consummate the Settlement Agreement;

(c) Determine that Class Members were provided with appropriate notice of the Settlement in accordance with Federal Rule of Civil Procedure 23(c)(2)(A) and all due process rights under the U.S. Constitution;

(d) Determine that all CAFA requirements have been satisfied;

(e) Dismiss with prejudice the Action;

(f) Order that each Class Member (including the Class Representatives) shall be (i) deemed to have, and by operation of the Final Approval Order shall have fully, finally, and forever settled, released, relinquished, waived, and discharged all Released Claims against the Released Parties, as set forth in the Settlement Agreement, and (ii) is permanently barred and enjoined from asserting, commencing, prosecuting, or continuing any of the Released Claims, as set forth in the Settlement Agreement.

7. PAYMENTS OF THE GROSS SETTLEMENT AMOUNT

7.1. **Gross Settlement Amount**. In addition to the provisions described below in Sections 10 and 11, Defendants have agreed to settle the Action for an amount of fifteen million dollars ($15,000,000) to the Settlement Class, with one-half (*i.e.*, seven million five hundred thousand dollars ($7,500,000)) being the responsibility of the Plan's fiduciary liability insurance carriers and one-half (*i.e.*, seven million five hundred thousand dollars ($7,500,000)) being the responsibility of the Plan.

7.2. **Insurer Payment**. No later than twenty (20) days after the Settlement Effective Date, and provided Defendants and/or Defense Counsel have been provided with all necessary payment instructions, Defendants will cause the amount of the Insurer Payment to be deposited into the Qualified Settlement Fund or delivered as a check to the Settlement Administrator.

7.3. **Plan Monetary Payment**. At the time provided below in Section 8.3.2, and provided Defendants and/or Defense Counsel have been provided with all necessary payment instructions, Defendants will cause the amount of the Plan Monetary Payment to be deposited into the Qualified Settlement Fund or delivered as a check to the Settlement Administrator.

8. PAYMENTS FROM THE QUALIFIED SETTLEMENT FUND

8.1. **Establishment**. No later than five (5) days after the Final Approval Order is issued, the Escrow Agent shall establish an escrow account. The Settling Parties agree that the escrow account is intended to be, and will be, an interest-bearing Qualified Settlement Fund within the meaning of Treas. Reg. § 1.468B-1.

8.2. **Disbursements**. Following the deposit of the Insurer Payment and the Plan Monetary Payment into the Qualified Settlement Fund, Class Counsel shall

direct the Escrow Agent to disburse money from the Qualified Settlement Fund as follows:

8.2.1. For Attorneys' Fees and Costs (inclusive of Service Awards) that have been awarded by the Court and have not been previously paid to Class Counsel;

8.2.2. For Administrative Expenses;

8.2.3. For distribution of the Net Settlement Amount to Class Members who are entitled to a Settlement Allocation and who do not receive such amount in the form of additional allocations to their HRA Accounts; and

8.2.4. For distribution to the Plan of any amounts remaining in the Qualified Settlement Fund due to the inability to locate or pay Class Members (in accordance with Section 8.5 below).

8.3. **Plan of Allocation**. Class Counsel shall propose to the Court a Plan of Allocation, in substantial conformity to the one attached hereto as Exhibit 6, which shall provide for the calculation, allocation, and distribution of the Net Settlement Amount to Class Members (*i.e.*, the Settlement Allocations). The Settlement Administrator shall be exclusively responsible and liable for calculating, based on information to be provided by the Plan, the amounts payable to, or allocable to the HRA Accounts of, each Class Member pursuant to the Plan of Allocation. The Plan shall provide the Settlement Administrator with the information reasonably needed to make those calculations.

8.3.1. After the Settlement Administrator has determined whether to make any adjustments to Settlement Allocation amounts given the amount of Administrative Expenses that remain unpaid or are expected to be incurred in the future (as described in the Plan of Allocation), the Settlement Administrator will advise the Plan of the Settlement

Allocation amounts to be apportioned to each Class Member entitled to a Settlement Allocation pursuant to the Plan of Allocation, as well as advise the Plan of the amount of the Plan Monetary Payment.

8.3.2. No later than twenty (20) days after the Settlement Effective Date or ten (10) days after the Settlement Administrator has advised the Plan of the amounts in Section 8.3.1, whichever is later, the Plan Monetary Payment will be paid and the Plan will begin making additional allocations to the HRA Accounts of Class Members who are entitled to a Settlement Allocation, in amounts corresponding to the Settlement Allocations determined by the Settlement Administrator. To the extent needed, the HRA Plan shall be amended to provide for these additional allocations. The allocations will be made pursuant to the following process:

(a) The Plan will first allocate Settlement Allocations to Class Members with established HRA Accounts.

(b) The Plan will next allocate, on a rolling basis, Settlement Allocations to Class Members who communicated an intention to have an HRA Account by the HRA Deadline and who establish an HRA Account by May 1, 2024.

(c) By May 30, 2024, the Plan will advise the Settlement Administrator of the names of those Class Members who communicated an intention to have an HRA Account by the HRA Deadline and who, nonetheless, did not establish an HRA Account by May 1, 2024. For these Class Members, the Plan will make a supplemental monetary payment totaling the amount of their Settlement Allocations, as directed by the Settlement Administrator. This supplemental payment will be

deposited into the Qualified Settlement Fund or delivered as a check to the Settlement Administrator.

8.3.3. For all Class Members entitled to a Settlement Allocation who do not receive such amount in the form of additional allocations to their HRA Accounts, the Settlement Administrator will distribute their Settlement Allocations in the form of a monetary payment from the Qualified Settlement Fund.

8.4. **No Liability**. Nothing herein shall constitute approval or disapproval of the Plan of Allocation by Defendants, and Defendants shall have no responsibility or liability for the Plan of Allocation and shall take no position for or against the Plan of Allocation.

8.5. **Remainder**. After the distribution of the Net Settlement Amount to Class Members (*i.e.*, the Settlement Allocations) is completed, and after the Settlement Administrator has exhausted reasonable efforts to effect payment, amounts allocable to Class Members who cannot be located, who do not cash their Settlement payment, or who otherwise cannot receive their Settlement payment shall be paid to the Plan first for paying any Administrative Expenses owed to the Plan and second for the purpose of defraying general administrative expenses of the Plan.

9. ATTORNEYS' FEES AND COSTS AND SERVICE AWARDS

9.1. **Motion**. Class Counsel will file a motion for an award of Attorneys' Fees and Costs (not to exceed one-third of the Maximum Gross Monetary Settlement Amount or $6,866,667) and Service Awards (not to exceed $5,000) for each of the Class Representatives who choose to request Service Awards no later than sixty (60) days before the Fairness Hearing. The motion will specify that any Service Awards are payable out of any awarded Attorneys' Fees and

Costs, and any Attorneys' Fees and Costs (inclusive of Service Awards) will be deducted from, and are not in addition to, the Gross Settlement Amount.

9.2. **Opposition**. Defendants reserve all rights to oppose Class Counsel's motion for Attorneys' Fees and Costs and Service Awards. Any such opposition papers will be filed no later than twenty-one (21) days before the Fairness Hearing. Class Counsel may file a reply no later than fourteen (14) days before the Fairness Hearing.

9.3. **Payment**. No later than twenty-five (25) days after the Court's Final Approval Order and the award of Attorneys' Fees and Costs provided for therein becomes Final (*i.e.*, the Settlement Effective Date), the Settlement Administrator shall distribute the full amount of any award of Attorneys' Fees and Costs (inclusive of Service Awards) from the Qualified Settlement Fund to Lead Class Counsel, on behalf of Class Counsel.

9.4. **Distribution/Allocation amongst Class Counsel**. Lead Class Counsel Chimicles Schwartz Kriner & Donaldson-Smith LLP shall have sole responsibility and discretion to allocate and distribute the Attorneys' Fees and Costs amongst Class Counsel.

9.5. **Quick Pay Option for Payment During Appeal**. Notwithstanding the foregoing, in the event of an appeal or challenge to the Court's Final Approval Order or the award of Attorneys' Fees and Costs provided for therein, Class Counsel may require the Plan's fiduciary liability insurance carriers to pay the full amount of any award of Attorneys' Fees and Costs directly to Lead Class Counsel, on behalf of Class Counsel, within fifty-five (55) days after Class Counsel directs such payment, provided that (i) Class Counsel directs such payment no earlier than forty-five (45) days after the Court's Final Approval Order; (ii) Class Counsel includes in its direction all necessary payment and routing information to facilitate the transfer; and (iii) Class Counsel provides

a letter of credit, if requested by the Plan's fiduciary liability insurance carriers, no less than five (5) business days before payment is due. Any disputes regarding the reasonableness of such a request or the security provided by any letter of credit shall be decided by Mediator Robert Meyer Esq. of JAMS.

9.5.1. **Repayment Obligation**. In the event (i) the Settlement Agreement is terminated under Section 15, (ii) the Court's Final Approval Order or the award of Attorneys' Fees and Costs provided for therein is vacated, overturned, reversed, or rendered void, or (iii) the amount of awarded Attorneys' Fees and Costs is reduced by the Court or an appellate court, Class Counsel and their law firms (including all shareholders, members, and/or partners of their law firms) shall be jointly and severally liable to repay the amount of Attorneys' Fees and Costs received, by depositing such amount, plus interest at the average of 30-day Treasuries over the relevant period, into the Qualified Settlement Fund.

10. AMENDMENT TO HRA PLAN

10.1. Defendants agree that, as further consideration to settle the Action, the Board of Trustees will amend the HRA Plan within thirty (30) days after the Settlement Effective Date to provide for additional allocations to the HRA Accounts of Qualifying Senior Performers (provided they have established HRA Accounts as of the date the allocations are made), in accordance with the provisions below.

10.2. **Additional Allocations**. The HRA Plan amendment will provide that, for each of the eight years, 2023 through 2030, additional amounts will be allocated to the HRA Accounts of that year's Qualifying Senior Performers, with the amounts calculated in the following manner:

10.2.1. The aggregate amount of additional allocations to the HRA Accounts of Qualifying Senior Performers in each year will be equal to one-half of the aggregate contributions made to the Plan with respect to the Qualifying Senior Performers' residual earnings reported to the Plan that were processed by the Plan during the previous October 1 through September 30 Base Earnings Period (which earnings will be capped at $125,000 per Qualifying Senior Performer for such calculation). The aggregate amount in any particular year will not, however, exceed a maximum of $700,000.

10.2.2. The aggregate amount of additional allocations for each year will be apportioned among Qualifying Senior Performers based on the relative amount of their residual earnings reported to the Plan (up to $125,000) and processed in the applicable October 1 through September 30 Base Earnings Period, with each Qualifying Senior Performer being grouped into an earnings band corresponding to an additional fixed dollar amount to be allocated to their HRA Account. The earnings bands will be specified in the HRA Plan amendment.

10.2.3. Where the aggregate amount of additional allocations to the HRA Accounts of all Qualifying Senior Performers in each year has been reduced to avoid exceeding the maximum of $700,000, each Qualifying Senior Performer's allocation shall be reduced proportionately.

10.2.4. The allocations for 2023 will be made as soon as practicable after the Settlement Effective Date, and will allow for allocations to any Class Members who has enrolled in an HRA account by May 1, 2024. Allocations for subsequent years will be made at the beginning of the year.

10.2.5. Nothing in this Section 10 shall be deemed to prohibit or limit the discretion of the Plan or its trustees to make other types of additional allocations to the HRA Accounts of any Plan participants or to re-institute the Dollar Sessional Rule.

10.3. **Cessation of Additional Allocations**. Notwithstanding the foregoing, the HRA Plan amendment will provide that, if projections of the Plan's Continuation Value are such that modifications to the Plan are required under Article XIII, Section 3 of the Trust Agreement, the additional allocations to the HRA Accounts of Qualifying Senior Performers will cease as of the date it is determined that such modifications are required.

11. PROVISIONS REGARDING PLAN DISCLOSURES AND ADMINISTRATION

11.1. Defendants agree that, as further consideration to settle the Action, the following provisions shall become operative no later than thirty (30) days after the Settlement Effective Date, and shall be in effect for four (4) years from the Settlement Effective Date (except where otherwise provided).

11.2. **Disclosures**.

11.2.1. The following disclosures will be made to the SAG-AFTRA National Board or SAG-AFTRA Executive Committee, via the SAG-AFTRA National Executive Director:

(a) No later than thirty (30) days after each Benefits Committee meeting, the Plan will provide the SAG-AFTRA National Executive Director with the projections required in Article XIII, Section 2 of the Trust Agreement, and any accompanying reports of the Benefit Consultant (including proposed changes to participant premiums, eligibility

thresholds, or benefits, or any combination thereof, suggested by the Benefit Consultant).

(b) No later than five (5) days after the minutes of the Plan's Board of Trustees' first meeting of each year are approved, the Plan will provide the SAG-AFTRA National Executive Director with a copy of the minutes to the extent they relate to Continuation Value and the projections referred to in Section 11.2.1(a).

11.2.2. No later than five (5) days after the Union Trustees decide on a proposed modification they intend to make pursuant to Article XIII of the Trust Agreement, the Union Trustees will provide the SAG-AFTRA National Executive Director with the substance of the proposed modification.

11.2.3. The information described in Sections 11.2.1 and 11.2.2 will be provided on the condition that: (i) SAG-AFTRA agrees to hold it strictly confidential consistent with and subject to SAG-AFTRA's confidentiality rules, (ii) at any SAG-AFTRA meeting in which the information is discussed, the presiding officer and/or chair invoke a rule of confidentiality with regard to the information, and (iii) SAG-AFTRA will not disclose the information (whether by email, at a membership meeting, or otherwise) to anyone other than the members of the SAG-AFTRA National Board, the members of the SAG-AFTRA Executive Committee, or the SAG-AFTRA National Executive Director and the SAG-AFTRA National Executive Director's designees. If SAG-AFTRA (or any member of the SAG-AFTRA National Board or SAG-AFTRA Executive Committee)

breaches this confidentiality obligation, the Plan shall have the right to discontinue any future disclosures under Sections 11.2.1 and 11.2.2.

11.2.4. Defendants dispute the Amended Complaint's allegations that Defendants made inadequate disclosures to the Union negotiators about the Plan's financial condition in connection with the negotiation of the 2019 Commercials CBA, 2019 Netflix CBA, and 2020 TV/Theatrical CBA. They also dispute Plaintiffs' assertions that the filing of this Action contributed to the making of detailed disclosures to the Union negotiators during the negotiations leading to the 2022 Commercials CBA, as well as Plaintiffs' assertion that such disclosures to the Union negotiators resulted in increased contributions to the Plan. Defendants do agree that such detailed disclosures were in fact made to the Union negotiators and that they were more detailed than the disclosures made to the Union negotiators in connection with the negotiation of the 2019 Commercials CBA, 2019 Netflix CBA, and 2020 TV/Theatrical CBA. Defendants also agree that the 2022 Commercials CBA increased the contribution rate to the Plan relative to the 2019 Commercials CBA contribution rate to the Plan. In contrast, Plaintiffs believe that the filing of this Action and the detailed allegations in the Amended Complaint were a substantial factor that caused the detailed disclosures to be made to the Union negotiators in connection with the negotiations leading to the 2022 Commercials CBA. Despite these disagreements, the Settling Parties agree that, for purposes of resolving this Action, including the dispute over this issue, it is appropriate to formalize their understanding that

disclosures in connection with future collective bargaining should resemble those made in the negotiations leading to the 2022 Commercials CBA. Toward that end, it is agreed that, prior to the commencement of collective bargaining negotiations relating to the Commercials CBA, Netflix CBA, or TV/Theatrical CBA, the Plan will provide detailed reports to the SAG-AFTRA National Board and the SAG-AFTRA negotiating committees regarding the projected funding needed to sustain the then-current participant premiums, eligibility thresholds, and benefits for the duration of the agreements being negotiated.

11.3. **Cost Consultant**. No later than thirty (30) days after the Settlement Effective Date, the Plan will commence the Request for Proposal ("RFP") process described in Exhibit 5 to select a Cost Consultant. Once retained, the Cost Consultant will provide an oral report and issue a written report advising on potential cost-saving measures (in areas other than those in which the Plan has already achieved cost-savings in recent years, as indicated in the memorandum attached to Exhibit 5).

11.4. **Plan Amendment**. No later than thirty (30) days after the Settlement Effective Date, the Plan's Board of Trustees will amend the Plan's Summary Plan Description as follows with respect to the manner in which Retirees' (including Senior Performers') sessional earnings are applied for purposes of qualifying for active coverage under the Plan:

(a) Senior Performers will be able to use additional sessional earnings reported to the Plan within forty-five (45) days of the September 30 end of their Base Earnings Period (meaning fifteen (15) days beyond the 30-day period in which employers are expected to submit such earnings) toward active coverage qualification for the benefit period

beginning the following January 1, provided that the covered employment generating the sessional earnings occurred on or before the referenced September 30. Any Senior Performer wishing to do so must affirmatively make this request with the Plan office within the 45-day window period.

(b) Any such late reported earnings that are counted for purposes of qualifying for Plan coverage in a particular year will be excluded in the following year's active qualification evaluation.

(c) Senior Performers will have two opportunities from 2023 through 2028 to retrospectively apply late reported earnings in this manner.

11.5. **Notice of Additional Credited Earnings Opportunity**. In conjunction with the amendment described above in Section 11.4, the Plan will post a Notice of Additional Credited Earnings Opportunity on the Plan Website (in substantially the form attached hereto as Exhibit 10) so that Senior Performers potentially impacted by this provision are aware of the opportunity. The Plan Website will also advise Senior Performers of their ability to determine the amount of sessional earnings reported to the Plan for the applicable quarter and the October 1 through September 30 Base Earnings Period. In addition, the Plan will send at least two emails each year to Senior Performers for whom it has an email address with a link to the Benefits Manager log-in on the Plan Website where the Senior Performer can review their reported sessional earnings.

12. RELEASES AND COVENANTS NOT TO SUE

12.1. As of the Settlement Effective Date, the Class Members (including the Class Representatives) (on behalf of themselves and their respective heirs, beneficiaries, executors, administrators, estates, past and present partners, officers, directors, agents, attorneys, predecessors, successors, and assigns),

on their own behalves and on behalf of the Plan, shall be deemed to have fully, finally, and forever settled, released, relinquished, waived, and discharged all Released Parties from the Released Claims, regardless of whether or not such Class Members receive a monetary benefit from the Settlement, filed an objection to the Settlement or to any application by Class Counsel for an award of Attorneys' Fees and Costs or Service Awards, and whether or not the objections have been allowed.

12.2. As of the Settlement Effective Date, Defendants and each Class Member shall be deemed to have fully, finally, and forever settled, released, relinquished, waived, and discharged any claims against the Class Representatives that arise out of the institution, prosecution, settlement or dismissal of the Action.

12.3. As of the Settlement Effective Date, each Class Member shall be deemed to have fully, finally, and forever settled, released, relinquished, waived, and discharged any claims against the Released Parties, Defense Counsel, and Class Counsel that arise from the allocation of the Gross Settlement Amount or Net Settlement Amount (including with respect to any tax liability or penalties).

12.4. As of the Settlement Effective Date, the Plan (subject to Independent Settlement Evaluation Fiduciary approval as required by Section 4) shall be deemed to have fully, finally, and forever settled, released, relinquished, waived, and discharged all other Released Parties from the Released Claims.

12.5. As of the Settlement Effective Date, the Class Members (including the Class Representatives) (on behalf of themselves and their respective heirs, beneficiaries, executors, administrators, estates, past and present partners, officers, directors, agents, attorneys, predecessors, successors, and assigns), on their own behalves and on behalf of the Plan and the Plan (subject to Independent Settlement Evaluation Fiduciary approval as required by Section

4), expressly agree that they, acting individually or together, or in combination with others, shall not sue or seek to institute, maintain, prosecute, argue, or assert in any action or proceeding, any cause of action, demand, or claim on the basis of, connected with, or arising out of any of the Released Claims. Nothing herein shall preclude any action to enforce the terms of this Settlement Agreement.

12.6. Class Counsel and Class Members (including the Class Representatives) may hereafter discover facts in addition to or different from those that they know or believe to be true with respect to the Released Claims. Such facts, if known by them, might have affected the decision to settle with the Released Parties, or the decision to release, relinquish, waive, and discharge the Released Claims, or the decision of a Class Member not to object to the Settlement. Notwithstanding the foregoing, Class Members (including the Class Representatives) shall expressly, upon the entry of the Final Approval Order, be deemed to have, and, by operation of the Final Approval Order, shall have fully, finally, and forever settled, released, relinquished, waived, and discharged any and all Released Claims. Class Members (including the Class Representatives) acknowledge and shall be deemed by operation of the Final Approval Order to have acknowledged that the foregoing waiver was bargained for separately and is a key element of the Settlement embodied in this Settlement Agreement of which this release is a part.

12.7. With respect to the Released Claims, it is the intention of the Settling Parties and all other Class Members expressly to waive to the fullest extent of the law: (i) the provisions, rights and benefits of Section 1542 of the California Civil Code, which provides that "A general release does not extend to claims that the creditor or releasing party does not know or suspect to exist in his or her favor at the time of executing the release and that, if known by him or her,

would have materially affected his or her settlement with the debtor or released party"; and (ii) the provisions, rights and benefits of any similar statute or common law of any other jurisdiction that may be, or may be asserted to be, applicable.

12.8. All claims asserted in the Action shall be dismissed with prejudice.

12.9. Within seven (7) days after the Settlement Effective Date, if it has not been done already, Class Counsel will cause the Fisher Action and Fisher Appeal to be dismissed with prejudice.

13. CONFIDENTIALITY

13.1. Except as set forth explicitly below, the Settling Parties, Class Counsel, and Defense Counsel agree to keep confidential all positions, assertions, and offers made during settlement negotiations relating to the Action and the Settlement Agreement, except that they may discuss the negotiations with the Class Members, the Independent Settlement Evaluation Fiduciary, and the Settling Parties' auditors, tax, legal, and regulatory advisors, provided in each case that they (a) secure written agreements with such persons or entities that such information shall not be further disclosed to the extent such persons are not already bound by confidentiality obligations at least as restrictive as those in this Section and which would otherwise cover the Settlement Agreement; and (b) comply with this Section in all other respects.

13.2. The Settling Parties, Class Counsel, and Defense Counsel agree that, in conjunction with the filing of the motion for preliminary approval of the Settlement, they will issue a Joint Press Release, in substantially the form attached hereto as Exhibit 9, regarding the Settlement, and will not otherwise affirmatively contact any media sources regarding the Settlement. The Joint Press Release will be distributed to *Variety*, *Deadline*, *The Wrap*, and *Hollywood Reporter*. In response to any inquiries from media sources with

respect to the Settlement approval proceedings, the Settling Parties, Class Counsel, and Defense Counsel will refer to the Joint Press Release and the Settlement Website and will provide no additional comments. Notwithstanding the foregoing, Defendants and Defense Counsel reserve the right to respond to any public statements or to any statements reported in the media made by or on behalf of the Class Representatives or Class Members that go further than the substance of Exhibit 9, and the Class Representatives and Class Counsel reserve the right to respond to any public statements or to any statements reported in the media made by or on behalf of Defendants that go further than the substance of Exhibit 9.

13.3. The Settling Parties, Class Counsel, and Defense Counsel agree that they will not publicly disclose the terms of the Settlement until after the motion for preliminary approval of the Settlement has been filed with the Court, other than as necessary to administer or effectuate the Settlement, or unless such disclosure is pursuant to a valid legal process, a request by a regulatory agency, or as otherwise required by law, government regulations including corporate reporting obligations, or order of the Court.

13.4. To the extent necessary with respect to the motions for preliminary and final approval of the Settlement, and responses to any objections to the Settlement, the parties may disclose certain aspects of the Settlement negotiations relevant to the Court's evaluation, provided that before disclosing such aspects of the settlement negotiations, the parties shall meet and confer with each other and obtain the other parties' consent, which shall not be unreasonably withheld.

14. REPRESENTATIONS AND WARRANTIES

14.1. The Settling Parties represent:

(a) That they are voluntarily entering into this Settlement Agreement as a result of arm's length negotiations among their counsel, and that in

executing this Settlement Agreement they are relying solely upon their own judgment, belief, and knowledge, and upon the advice and recommendations of their own independently selected counsel, concerning the nature, extent, and duration of their rights and claims hereunder and regarding all matters that relate in any way to the subject matter hereof;

(b) That they assume the risk of mistake as to facts or law;

(c) That they recognize that additional evidence may come to light, but that they nevertheless desire to avoid the expense and uncertainty of litigation by entering into the Settlement;

(d) That they have read carefully the contents of this Settlement Agreement, and this Settlement Agreement is signed freely by each individual executing this Settlement Agreement on behalf of each of the Settling Parties; and

(e) That they have made such investigation of the facts pertaining to the Settlement and all matters pertaining thereto, as they deem necessary.

14.2. Each individual executing this Settlement Agreement on behalf of a Settling Party does hereby personally represent and warrant to the other Settling Parties that he/she has the authority to execute this Settlement Agreement on behalf of, and fully bind, each principal that each such individual represents or purports to represent.

15. TERMINATION, CONDITIONS OF SETTLEMENT, AND EFFECT OF DISAPPROVAL, CANCELLATION, OR TERMINATION

15.1. The Settlement Agreement shall automatically terminate, and thereby become null and void with no further force or effect if:

(a) The Non-Conflicted Trustees do not approve the Settlement on behalf of the Plan following deliberations thereon;

(b) Under Section 4, (i) either the Independent Settlement Evaluation Fiduciary does not approve the Settlement, or disapproves the Settlement for any reason whatsoever or the Defendants reasonably conclude that the Independent Settlement Evaluation Fiduciary's approval does not include the determinations required by PTE 2003-39 in either case; and (ii) the Settling Parties do not mutually agree to modify the terms of the Settlement to facilitate an approval by the Independent Settlement Evaluation Fiduciary in the manner required by PTE 2003-39;

(c) The Preliminary Approval Order or the Final Approval Order are not entered by the Court substantially in the form submitted by the Settling Parties or in a form which is otherwise agreed to by the Settling Parties;

(d) The Settlement Class is not certified as defined herein or in a form which is otherwise agreed to by the Settling Parties;

(e) This Settlement Agreement is disapproved by the Court or fails to become effective for any reason whatsoever; or

(f) The Preliminary Approval Order or Final Approval Order is finally reversed on appeal, or is modified on appeal, and the Settling Parties do not mutually agree to any such modifications.

15.2. If the Settlement Agreement is terminated, deemed null and void, or has no further force or effect, the Action and the Released Claims asserted by Class Representatives shall for all purposes with respect to the Settling Parties revert to their status as though the Settling Parties never executed the Settlement Agreement.

15.3. It shall not be deemed a failure to approve the Settlement Agreement if the Court denies, in whole or in part, Class Counsel's request for Attorneys' Fees and Costs or Service Awards and/or modifies any of the awards relating to Attorneys' Fees and Costs or Service Awards.

16. NO ADMISSION OF WRONGDOING

16.1. This Settlement Agreement, whether or not consummated, and any negotiations or proceedings hereunder are not, and shall not be construed as, deemed to be, or offered or received as evidence of an admission by or on the part of any Released Party of any wrongdoing, fault, or liability whatsoever by any Released Party, or give rise to any inference of any wrongdoing, fault, or liability or admission of any wrongdoing, fault, or liability in the Action or any other proceeding, and the Defendants and Released Parties admit no wrongdoing, fault or liability with respect to any of the allegations or claims in the Action.

16.2. This Settlement Agreement, whether or not consummated, and any negotiations or proceedings hereunder, shall not constitute admissions of any liability of any kind, whether legal or factual. Subject to Federal Rule of Evidence 408, the Settlement and the negotiations related to it are not admissible as substantive evidence, for purposes of impeachment, or for any other purpose. Defendants deny all allegations of wrongdoing and deny all allegations and claims in the Action. Defendants contend that the Plan has been managed, operated, and administered at all relevant times in accordance with ERISA, including its fiduciary duty provisions, and other applicable laws.

17. GENERAL PROVISIONS

17.1. The Settling Parties agree to cooperate fully with each other in seeking Court approval of the Preliminary Approval Order and the Final Approval Order,

and to do all things as may reasonably be required to effectuate preliminary and final approval and the implementation of this Settlement Agreement according to its terms.

17.2. This Settlement Agreement shall be interpreted, construed, and enforced in accordance with applicable federal law and, to the extent that federal law does not govern, by California law.

17.3. Each Settling Party to this Settlement Agreement hereby acknowledges that he, she, or it has consulted with and obtained the advice of counsel prior to executing this Settlement Agreement and that this Settlement Agreement has been explained to that Settling Party by his, her, or its counsel.

17.4. Any headings included in this Settlement Agreement are for convenience only and do not in any way limit, alter, or affect the matters contained in this Settlement Agreement or the Sections they caption.

17.5. References to a person are also to the person's permitted successors and assigns, except as otherwise provided herein.

17.6. Whenever the words "include," "includes" or "including" are used in this Settlement Agreement, they shall not be limiting but shall be deemed to be followed by the words "without limitation."

17.7. Before entry of the Preliminary Approval Order and approval of the Independent Settlement Evaluation Fiduciary, this Settlement Agreement may be modified or amended only by written agreement signed by or on behalf of all Settling Parties. Following approval by the Independent Settlement Evaluation Fiduciary, the Settlement Agreement may be modified or amended only if such modification or amendment is set forth in a written agreement signed by or on behalf of all Settling Parties and only if the Independent Settlement Evaluation Fiduciary approves such modification or amendment in writing. Following entry of the Preliminary Approval Order, this Settlement

Agreement may be modified or amended only by written agreement signed on behalf of all Settling Parties, and only if the modification or amendment is approved by the Independent Settlement Evaluation Fiduciary in writing and approved by the Court.

17.8. This Settlement Agreement and the Exhibits attached hereto constitute the entire agreement among the Settling Parties and no representations, warranties, or inducements have been made to any Settling Party concerning the Settlement other than those contained in this Settlement Agreement and the Exhibits thereto.

17.9. The provisions of this Settlement Agreement may be waived only by an instrument in writing executed by the waiving party and specifically waiving such provisions. The waiver of any breach of this Settlement Agreement by any Settling Party shall not be deemed to be or construed as a waiver of any other breach or waiver by any other Settling Party, whether prior to, subsequent to, or contemporaneous with this Settlement Agreement.

17.10. Each of the Settling Parties agrees, without further consideration, and as part of finalizing the Settlement hereunder, that it will in good faith execute and deliver such other documents and take such other actions as may be necessary to consummate and effectuate the subject matter of this Settlement Agreement.

17.11. All of the covenants, representations, and warranties, express or implied, oral or written, concerning the subject matter of this Settlement Agreement are contained in this Settlement Agreement. No Settling Party is relying on any oral representations or oral agreements. All such covenants, representations, and warranties set forth in this Settlement Agreement shall be deemed continuing and shall survive the Settlement Effective Date.

17.12. All of the Exhibits attached hereto are incorporated by reference as though fully set forth herein. The Exhibits are:

(a) Exhibit 1 – Preliminary Approval Order;

(b) Exhibit 2 – Settlement Notice;

(c) Exhibit 3 – Final Approval Order;

(d) Exhibit 4 – Form of CAFA Notice;

(e) Exhibit 5 – Cost Consultant RFP Process;

(f) Exhibit 6 – Plan of Allocation;

(g) Exhibit 7 – Trust Agreement;

(h) Exhibit 8 – HRA Plan;

(i) Exhibit 9 – Joint Press Release;

(j) Exhibit 10 – Notice of Additional Credited Earnings Opportunity; and

(k) Exhibit 11 – HRA Notice.

17.13. No provision of the Settlement Agreement or of the Exhibits attached hereto shall be construed against or interpreted to the disadvantage of any Settling Party to the Settlement Agreement because that Settling Party is deemed to have prepared, structured, drafted, or requested the provision.

17.14. Any notice, demand, or other communication to the Settling Parties under this Settlement Agreement shall be in writing and shall be deemed duly given upon receipt if it is addressed to each of the intended recipients as set forth below and personally delivered, sent by registered or certified mail postage prepaid, or delivered by reputable express overnight courier:

IF TO THE CLASS REPRESENTATIVES:

Steven A. Schwartz
CHIMICLES SCHWARTZ KRINER
& DONALDSON-SMITH LLP
361 West Lancaster Avenue

Haverford, PA 19041
steveschwartz@chimicles.com

-and-

Robert J. Kriner, Jr.
CHIMICLES SCHWARTZ KRINER
& DONALDSON-SMITH LLP
2711 Centerville Road, Suite 201
Wilmington, DE 19808
rjk@chimicles.com

IF TO DEFENDANTS:

Myron D. Rumeld
PROSKAUER ROSE LLP
Eleven Times Square
New York, NY 10036
mrumeld@proskauer.com

-and-

Jani K. Rachelson
Evan Hudson-Plush
COHEN, WEISS and SIMON LLP
900 Third Avenue, Suite 2100
New York, NY 10022-4869
jrachelson@cwsny.com

17.15. This Settlement Agreement may be executed in one or more counterparts. All executed copies of this Settlement Agreement and photocopies thereof (including emailed copies of the signature pages), shall have the same force and effect and shall be as legally binding and enforceable as the original.

17.16. The Settling Parties agree that Defense Counsel, Myron D. Rumeld, has been authorized to execute the Settlement Agreement on behalf of the Trustee Defendants. Signatures for the Trustee Defendants themselves will be collected as soon as reasonably practicable, but will not impact the enforceability of the Settlement Agreement or delay its approval.

17.17. The Settling Parties agree that an authorized representative of the Non-Conflicted Trustees will execute the Settlement Agreement on behalf of the

Plan as soon as reasonably practicable, but that this may not occur until after the Settlement has been submitted to the Court for preliminary approval.

17.18. The Settling Parties agree that the Court shall maintain continuing jurisdiction over the Settlement proceedings to assure the effectuation thereof for the benefit of the Settlement Class, and the Court shall have jurisdiction as to all matters relating to the enforcement and interpretation of the Settlement Agreement.

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IN WITNESS WHEREOF, the Settling Parties have executed this Settlement Agreement on the dates set forth below.

FOR PLAINTIFFS, Individually and as Class Representatives of the Settlement Class:

Dated: 4/7/2023

DocuSigned by:
Michael Bell
8D84L2LA28D74C8...

MICHAEL BELL

Dated: 4/8/2023

DocuSigned by:
Raymond Harry Johnson
D05A2B52D5BL4D7...

RAYMOND HARRY JOHNSON

Dated: 4/7/2023

DocuSigned by:
DAVE
LLI DBDALL19D487...

DAVID JOLLIFFE

Dated: 4/8/2023

DocuSigned by:
Robert Clotworthy
624C4BDB2191434...

ROBERT CLOTWORTHY

Dated: 4/9/2023

Thomas Cook

THOMAS COOK

Dated: _____

AUDREY LOGGIA

Dated: _____

DEBORAH WHITE

IN WITNESS WHEREOF, the Settling Parties have executed this Settlement Agreement on the dates set forth below.

FOR PLAINTIFFS, Individually and as Class Representatives of the Settlement Class:

Dated: _____

MICHAEL BELL

Dated: _____

RAYMOND HARRY JOHNSON

Dated: _____

DAVID JOLLIFFE

Dated: _____

ROBERT CLOTWORTHY

Dated: _____

THOMAS COOK

Dated: _____

AUDREY LOGGIA

Dated: April 6, 2023

Deborah White

DEBORAH WHITE

IN WITNESS WHEREOF, the Settling Parties have executed this Settlement Agreement on the dates set forth below.

FOR PLAINTIFFS, Individually and as Class Representatives of the Settlement Class:

Dated: _____

MICHAEL BELL

Dated: _____

RAYMOND HARRY JOHNSON

Dated: _____

DAVID JOLLIFFE

Dated: _____

ROBERT CLOTWORTHY

Dated: _____

THOMAS COOK

Dated: _____

AUDREY LOGGIA

Dated: _____

DEBORAH WHITE

Dated: 4/9/2023

DocuSigned by:
DONNA LYNN LEAVY
01C056193EE74E0...

DONNA LYNN LEAVY

IN WITNESS WHEREOF, the Settling Parties have executed this Settlement Agreement on the dates set forth below.

FOR PLAINTIFFS, Individually and as Class Representatives of the Settlement Class:

Dated: _____

MICHAEL BELL

Dated: _____

RAYMOND HARRY JOHNSON

Dated: _____

DAVID JOLLIFFE

Dated: _____

ROBERT CLOTWORTHY

Dated: _____

THOMAS COOK

Dated: 4/6/2023

AUDREY LOGGIA

Dated: _____

DEBORAH WHITE

FOR THE TRUSTEE DEFENDANTS:

Dated: 4-10-23

/s/ Myron D. Rumeld

Myron D. Rumeld
PROSKAUER ROSE LLP
Eleven Times Square
New York, NY 10036

Dated: _____

_____
DARYL ANDERSON

Dated: _____

_____
HELAYNE ANTLER

Dated: _____

_____
AMY AQUINO

Dated: _____

_____
TIMOTHY BLAKE

Dated: _____

_____
JIM BRACCHITTA

Dated: _____

_____
JOHN CARTER BROWN

Dated: _____

_____
DUNCAN CRABTREE-IRELAND

Dated: _____

_____
BARRY GORDON

Dated: _____

_____
J. KEITH GORHAM

Dated: _____

_____
JAMES HARRINGTON

Dated: _____

_____
DAVID HARTLEY-MARGOLIN

Dated: _____ _____
HARRY ISAACS

Dated: _____ _____
ROBERT W. JOHNSON

Dated: _____ _____
SHELDON KASDAN

Dated: _____ _____
MATTHEW KIMBROUGH

Dated: _____ _____
LYNNE LAMBERT

Dated: _____ _____
ALLAN LINDERMAN

Dated: _____ _____
CAROL A. LOMBARDINI

Dated: _____ _____
STACY K. MARCUS

Dated: _____ _____
RICHARD MASUR

Dated: _____ _____
JOHN T. MCGUIRE

Dated: _____ _____
DIANE P. MIROWSKI

Dated: _____ _____
PAUL MURATORE

Dated: _____ _____
TRACY OWEN

Dated: _____ _____

MICHAEL PNIEWSKI
Dated: _____

Dated: _____
RAY RODRIGUEZ

Dated: _____
MARC SANDMAN

Dated: _____
SALLY STEVENS

Dated: _____
GABRIELA TEISSIER

Dated: _____
LARA UNGER

Dated: _____
NED VAUGHN

Dated: _____
DAVID WEISSMAN

Dated: _____
RUSSELL WETANSON

Dated: _____
DAVID P. WHITE

Dated: _____
SAMUEL P. WOLFSON

FOR THE PLAN:

Dated: _____

Representative of the Non-Conflicted Trustees

APPROVED AS TO FORM AND CONTENT:

Dated: 4-10-23

/s/ Steven A. Schwartz
Steven A. Schwartz
CHIMICLES SCHWARTZ KRINER & DONALDSON-SMITH LLP
361 West Lancaster Avenue
Haverford, PA 19041

Counsel for Plaintiffs, the Class Representatives, and the rest of the Settlement Class

Dated: 4-10-23

/s/ Myron D. Rumeld
Myron D. Rumeld
PROSKAUER ROSE LLP
Eleven Times Square
New York, NY 10036

Dated: 4-10-23

/s/ Jani K. Rachelson
Jani K. Rachelson
COHEN, WEISS and SIMON LLP
900 Third Avenue, Suite 2100
New York, NY 10022-4869

Counsel for Defendants

EXHIBIT 1

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

EDWARD ASNER, *et al.*,

Plaintiffs,

vs.

THE SAG-AFTRA HEALTH FUND, *et al.*,

Defendants.

Case No. 2:20-cv-10914-CAS-JEM

[PROPOSED] ORDER GRANTING PRELIMINARY APPROVAL OF CLASS ACTION SETTLEMENT

Date: [INSERT]
Time: 10:00 a.m.
Courtroom: 8D
Judge: Hon. Christina A. Snyder

Action Filed: December 1, 2020

This Action[1] arises under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* ("ERISA"), and involves claims for alleged breaches of fiduciary duty by trustees of the Screen Actors Guild-Producers Health Plan and the SAG-AFTRA Health Plan. Now before the Court is Plaintiffs' unopposed Motion for Preliminary Approval of Class Action Settlement (the "Motion") (ECF No. ___). The terms and conditions of the Settlement are set forth in the Class Action Settlement Agreement, executed on April 10, 2023, and the exhibits thereto (ECF No. ___).

Having considered the Settlement Agreement, the briefing submitted in support of the unopposed Motion, and the arguments of counsel, and good cause appearing therefore, the Court hereby GRANTS the Motion and ORDERS AS FOLLOWS:

PRELIMINARY CERTIFICATION OF SETTLEMENT CLASS

1. For settlement purposes only, and conditioned upon the Settlement receiving final approval following the Fairness Hearing, the Court hereby preliminarily certifies the following Settlement Class pursuant to Rules 23(a) and 23(b)(1) of the Federal Rules of Civil Procedure:

> All individuals who (i) were enrolled in coverage under the Plan at any time during the Class Period, (ii) were notified that they qualified for coverage under the Plan for any time during the Class Period, and/or (iii) qualified or had qualified as a Senior Performer as of the beginning of or during the Class Period, but excluding the Trustee Defendants.

The Class Period runs from January 1, 2017 through the date of this Preliminary Approval Order.

2. For settlement purposes only, and conditioned upon the Settlement receiving final approval following the Fairness Hearing, the Court preliminarily finds

[1] All capitalized terms not otherwise defined in this Preliminary Approval Order shall have the same meaning as ascribed to them in the Settlement Agreement.

that the prerequisites for a class action under Rule 23(a) are satisfied. Specifically, the Court finds:

a. **Numerosity**. The Settlement Class is ascertainable from records kept by the Plan and is so numerous that joinder of all Class Members in the Action is impracticable.

b. **Commonality**. There are questions of law and/or fact common to all Class Members.

c. **Typicality**. The Class Representatives' claims are typical of the claims of the Class Members they seek to represent.

d. **Adequacy**. The Class Representatives and Class Counsel have fairly and adequately represented the interests of the Settlement Class and will continue to do so.

3. For settlement purposes only, and conditioned upon the Settlement receiving final approval following the Fairness Hearing, the Court preliminarily finds that the prerequisites for a class action under Rule 23(b)(1) are satisfied. Specifically, the Court finds that prosecuting separate actions by individual Class Members would create a risk of inconsistent or varying adjudications that could establish incompatible standards of conduct for the Trustees Defendants with respect to the fiduciary duties that apply to them.

4. For settlement purposes only, and conditioned upon the Settlement receiving final approval following the Fairness Hearing, the Court preliminarily appoints Chimicles Schwartz Kriner and Donaldson-Smith LLP as Lead Class Counsel for the Settlement Class, and Johnson & Johnson LLP and Law Offices of Edward Siedle as additional Class Counsel. In accordance with Rule 23(g), the Court finds that Class Counsel are capable of fairly and adequately representing the interests of the Settlement Class, and that Class Counsel: (i) have done appropriate work identifying and investigating potential claims in the Action; (ii) are experienced in handling class

actions, other complex litigation, and the types of ERISA claims asserted in the Action; (iii) are knowledgeable of the applicable law; and (iv) have committed the necessary resources to represent the Settlement Class.

5. For settlement purposes only, and conditioned upon the Settlement receiving final approval following the Fairness Hearing, the Court preliminarily appoints Plaintiffs Michael Bell, Raymond Harry Johnson, David Jolliffe, Robert Clotworthy, Thomas Cook, Audrey Loggia, Deborah White, and Donna Lynn Leavy as the Class Representatives of the Settlement Class.

PRELIMINARY APPROVAL OF THE TERMS OF THE SETTLEMENT

6. The Court hereby preliminarily approves the Settlement, finding it sufficiently fair, reasonable, and adequate to authorize dissemination of notice thereof to the Settlement Class and to conduct a final Fairness Hearing thereon. The Court preliminarily finds that the requirements for settlement approval under Federal Rule of Civil Procedure 23(e)(2) are satisfied. Specifically, the Court finds:

a. **Adequate Representation**. Class Counsel and the Class Representatives have adequately represented the Settlement Class. Class Representatives have no conflicts of interest with Class Members insofar as they all qualified for coverage under the Plan and/or qualified as Senior Performers under the Plan and were thus impacted by the Amendments. Further, Class Counsel and the Class Representatives have vigorously prosecuted the Action on behalf of the Settlement Class, including with respect to defending against Defendants' motion to dismiss the First Amended Complaint, obtaining an initial set of documents from Defendants, and issuing subpoenas to third parties.

b. **Arm's Length Negotiations**. The Settlement resulted from arm's length negotiations, with no signs of collusion or bad faith. Class Counsel and Defense Counsel are experienced in similar class action litigation and engaged in extensive

negotiations that were facilitated by an experienced professional mediator (Robert Meyer, Esq., of JAMS).

c. **Adequate Relief**. The Settlement provides adequate relief for the Settlement Class while avoiding the costs, risks, and delay of continued litigation. In addition to a Gross Settlement Amount with a value of $15,000,000, to be allocated to certain Class Members who are Senior Performers (after Administrative Expenses and Attorneys' Fees and Costs are subtracted therefrom), the Settlement also provides other valuable benefits to the Settlement Class. Class Members who are Qualifying Senior Performers will receive additional allocations to their HRA Accounts (which could total up to $5,600,000) and the Plan will institute various changes for a period of four years (including to disclose financial information about the Plan to the negotiators of collective bargaining agreements).

i. *Costs, Risks, and Delay.* If Plaintiffs were to proceed with this Action, they would face various risks at each stage of the litigation that could preclude any relief, such as losing on a motion for class certification, on a motion for summary judgment, at trial, or on appeal. Plaintiffs also face the risk that, even if they prevail on the merits of their claims, their desired relief (*e.g.*, amendments to the Plan) may be unavailable as a matter of law.

ii. *Distribution Method.* The Settlement provides for an effective method of distributing the relief to Class Members. Class Members entitled to monetary relief will not be required to file claims; rather, those with HRA Accounts will receive their Settlement Allocations in those accounts, and those without HRA Accounts will receive a check from a Settlement Administrator.

iii. *Proposed Award of Attorneys' Fees.* The Settlement Agreement caps any potential request for Attorneys' Fees and Costs at $6,866,667, which is one-third of the Maximum Gross Monetary Settlement Amount.

iv. *Side Agreements.* Apart from the Settlement Agreement, there are no agreements made in connection with the Settlement to consider under Rule 23(e)(2)(C)(iv).

d. **Equitable Relief**. The Settlement treats Class Members equitably relative to each other insofar as it provides for a Settlement Administrator who has the final authority to determine the amount of each Class Member's Settlement Allocation, in accordance with a Plan of Allocation agreed upon by the Settling Parties.

APPROVAL OF THE NOTICE PLAN

7. The Court hereby approves the form of the proposed Settlement Notice attached as Exhibit 2 to the Settlement Agreement (ECF No. ___). The Court finds that the Settlement Notice fairly, accurately, and reasonably informs Class Members of appropriate information about: (1) the nature of this Action and the essential terms of the Settlement Agreement; (2) how to obtain additional information regarding this Action and the Settlement, in particular, by visiting the Settlement Website and/or contacting Lead Class Counsel; and (3) how to object to the Settlement if they wish to do so. The Settlement Notice also fairly and adequately informs Class Members that if they do not comply with the specified procedures and the deadline for objections, they will lose any opportunity to have any objection considered at the Fairness Hearing or to otherwise contest approval of the Settlement or appeal from any order or judgment entered by the Court in connection with the Settlement.

8. The Court hereby approves of the plan for dissemination of the Settlement Notice as set forth in Section 3.2 of the Settlement Agreement. Pursuant to Section 3.2, the Settlement Administrator will send the Settlement Notice to each Class Member for whom the Plan has either an email or postal address on record within 30 days of the date of this Preliminary Approval Order. In addition, in recognition that the Plan does not possess either an email or postal address for all Class Members, the Plan Website will include a link to the Settlement Website and certain documents (including the

Settlement Notice) will be posted to the Settlement Website as soon as practicable following the date of this Preliminary Approval Order. The Court finds that such dissemination of the Settlement Notice is appropriate and reasonably calculated to apprise Class Members of the proposed Settlement and their right to object thereto.

9. The Court hereby directs the Settlement Administrator and the Settling Parties to disseminate the Settlement Notice as set forth in Section 3.2 of the Settlement Agreement. Proof that the Settlement Notice has been disseminated shall be filed before the Settlement is finally approved.

10. The Court hereby approves the form of the proposed Class Action Fairness Act of 2005 ("CAFA") notice attached as Exhibit 4 to the Settlement Agreement (ECF No. ___). Upon mailing of the CAFA notice to the appropriate state and federal officials specified in 28 U.S.C. § 1715, Defendants shall have fulfilled their obligations under CAFA. Proof that the CAFA notices have been mailed shall be filed before the Settlement is finally approved.

OBJECTIONS

11. All Class Members have the right to object to any aspect of the Settlement pursuant to the procedures and schedule set forth in the Settlement Agreement and the Settlement Notice. Any objections shall be heard, and any papers submitted in support of said objections shall be considered, by the Court at the Fairness Hearing if the papers have been filed validly with the Clerk of the Court at least 28 days prior to the Fairness Hearing.

12. All written objections and supporting papers must include (a) the case name and number; (b) the objector's name, address, telephone number, and email address; (c) the specific grounds for the objection along with any supporting papers, materials, briefs or evidence that the objector wishes the Court to consider when reviewing the objection; (d) the objector's signature; and (e) a statement whether the objector or the objector's attorney intends to appear at the Fairness Hearing. If the objector or the

objector's attorney has objected to a class action settlement during the past five years, the objection must also disclose all cases in which the objector or the objector's attorney has filed an objection by caption, court and case number, and for each case, the disposition of the objection, including whether any payments were made to the objector or his or her counsel, and if so, the incremental benefits, if any, that were achieved for the class in exchange for such payments.

13. Class Members who appear at the Fairness Hearing will be permitted to argue only those matters that were set forth in a written objection. No Class Member will be permitted to raise matters at the Fairness Hearing that the Class Member could have raised in such a written objection, but failed to do so, and all objections to the Settlement that are not set forth in such a written objection are deemed waived. Any Class Member who fails to comply with the preceding provisions, and as otherwise ordered by the Court, will be barred from appearing at the Fairness Hearing.

14. Any Settling Party may file a response to an objection by a Class Member at least 14 days before the Fairness Hearing.

FAIRNESS HEARING

15. The Court hereby schedules the Fairness Hearing at 10:00 A.M. on [INSERT], which date is more than 110 days after the date of this Preliminary Approval Order, to consider (i) any objections from Class Members to the Settlement that are timely and properly served in accordance with this Preliminary Approval Order, (ii) whether to finally approve the Settlement as fair, reasonable, and adequate, (iii) whether to finally certify the Settlement Class, (iv) the amount of any Attorneys' Fees and Costs to be awarded to Class Counsel, and (v) the amount of any Service Awards to be awarded to the Class Representatives.

16. The Fairness Hearing may, without further direct notice to the Class Members, other than by notice to Class Counsel, be adjourned or continued by order of the Court. Notice of such continuance shall be posted on the Settlement Website.

17. Class Counsel's Motion for Attorneys' Fees and Costs and Service Awards shall be filed no later than 60 days before the Fairness Hearing, Defendants' opposition thereto (if any) shall be filed no later than 21 days before the Fairness Hearing, and Class Counsel's reply thereto (if any) shall be filed no later than 14 days before the Fairness Hearing.

18. Plaintiffs' Motion for Final Approval of the Settlement shall be filed no later than 28 days before the Fairness Hearing. The Motion for Final Approval shall include the determination of the Independent Settlement Evaluation Fiduciary.

PRELIMINARY INJUNCTION

19. Pending a final determination of whether the Settlement should be approved, each Class Member (including Plaintiffs), whether in his or her individual capacity or on behalf of the Plan, is hereby prohibited and enjoined from commencing, prosecuting, or pursuing any claim or complaint against the Released Parties (including Defendants) that relates in any way to the Released Claims.

STAY OF PROCEEDINGS

20. Pending a final determination of whether the Settlement should be approved, the Court hereby stays all proceedings in this Action, other than those proceedings necessary to carry out or enforce the terms and conditions of the Settlement Agreement.

IF SETTLEMENT DOES NOT BECOME EFFECTIVE

21. In the event that the Settlement Agreement is not finally approved by the Court or does not reach the Settlement Effective Date, or the Settlement Agreement is terminated pursuant to its terms for any reason, the Settling Parties reserve all of their rights, including the right to continue with the Action and all claims and defenses pending at the time of the Settlement and Defendants reserve the right to oppose class certification. Furthermore, this Preliminary Approval Order and all findings contained within it shall become null and void and have no force and effect whatsoever and shall

not be admissible or discoverable in this or any other proceeding.

MINOR CHANGES TO SETTLEMENT AGREEMENT

22. Class Counsel and Defense Counsel are hereby authorized to use all reasonable procedures in connection with approval and administration of the Settlement that are not materially inconsistent with this Preliminary Approval Order or the Settlement Agreement, including making, without further approval of the Court, minor changes to the Settlement Agreement, to the form or content of the Settlement Notice, or to the form or content of any other exhibits attached to the Settlement Agreement, that the Settling Parties jointly agree are reasonable or necessary, and which do not limit the rights of the Class Members under the Settlement Agreement.

SCHEDULE OF SETTLEMENT PROCEEDINGS

23. The Court shall maintain continuing jurisdiction over these Settlement proceedings to assure the effectuation thereof for the benefit of the Settlement Class.

24. The Court hereby approves the following schedule for Settlement-related events:

DATE	EVENT
[INSERT]	Entry of Preliminary Approval Order
[INSERT]	Last day for Settlement Administrator to send Settlement Notice to Class Members
[INSERT]	Last day for Class Counsel's Motion for Attorneys' Fees and Costs and Service Awards
[INSERT]	Last day for Class Members to object to Settlement
[INSERT]	Last day for Plaintiffs' Motion for Final Approval of the Settlement
[INSERT]	Last day for Defendants' opposition to Motion for Attorneys' Fees and Costs and Service Awards (if any)
[INSERT]	Last day for Settling Parties to respond to objections to Settlement

[INSERT]	Last day for Class Counsel's reply to Motion for Attorneys' Fees and Costs and Service Awards (if any)
[INSERT]	Fairness Hearing

IT IS SO ORDERED.

DATED: _____

_____
The Honorable Christina A. Snyder
United States District Judge

EXHIBIT 2

NOTICE OF PROPOSED CLASS ACTION SETTLEMENT

TO: All individuals who (i) were enrolled in health coverage under the SAG-AFTRA Health Plan at any time from January 1, 2017 through [XXX PA date], (ii) were notified that they qualified for health coverage under the Plan for any time from January 1, 2017 through [XXX PA date], and/or (iii) qualified or had qualified as a Senior Performer as of January 1, 2017 or at any time from January 1, 2017 through [XXX PA date].

A Federal Court authorized this Notice. This is not a solicitation from a lawyer.

- Please read this Notice and the Settlement Agreement available at www.sagaftrahealthplansettlement.com carefully. Your legal rights may be affected whether you act or don't act. This Notice is a summary, and it is not intended to, and does not, include all of the specific details of the Settlement Agreement. To obtain more specific details concerning the Settlement, please read the Settlement Agreement and other Court documents available on the website above, such as the First Amended Class Action Complaint and Plaintiffs' Memorandum of Law in Support of Preliminary Approval of Class Action Settlement ("Preliminary Approval Memorandum"). Any amendments to the Settlement Agreement or any other settlement documents will be posted on that website. You should visit that website if you would like more information about the Settlement and any possible amendments to the Settlement Agreement or other changes, including changes to the date, time, or location of the Fairness Hearing, or other Court orders concerning the Settlement.

- Plaintiffs Michael Bell, Raymond Harry Johnson, David Jolliffe, Robert Clotworthy, Thomas Cook, Audrey Loggia, Deborah White, and Donna Lynn Leavy ("Plaintiffs" or "Class Representatives"), along with Edward Asner and Sondra James Weil (who are now deceased), brought this class action lawsuit on behalf of Class Members, seeking recovery for alleged breaches of fiduciary duty under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1000 *et seq.* ("ERISA"), by Trustees of the Screen Actors Guild-Producers Health Plan ("SAG Health Plan") and the SAG-AFTRA Health Plan (the "Plan"). Plaintiffs believe their claims have merit for the reasons set forth in their Amended Class Action Complaint and their Preliminary Approval Memorandum. Defendants deny that Plaintiffs' claims have any merit and deny all allegations of wrongdoing, and nothing in the Settlement is an admission or concession on Defendants' part of any fault or liability whatsoever.

- To settle Plaintiffs' claims:

    - The Plan and the Plan's fiduciary liability insurers have each agreed to contribute $7.5 million, for a total of $15 million, which will be used to compensate certain Class Members who are Senior Performers and their age 65+ spouses who no longer qualified for health coverage from the Plan in 2021 or 2022 due to the 2020 Amendments; to pay any Attorneys' Fees and Costs to Class Counsel (including any Service Awards to the Class Representatives) that are deemed appropriate and awarded by the Court; and to pay certain necessary Administrative Expenses of the Settlement;

- The Plan's Board of Trustees has agreed to amend the SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan ("HRA Plan") to provide for additional allocations into the HRA Accounts of Qualifying Senior Performers (defined below) that could total up to $700,000 per year for up to eight years (for a potential maximum of $5.6 million); and

- The Plan has agreed to implement certain Disclosures and Administrative Changes (defined below) negotiated by the parties that Plaintiffs believe address the concerns raised in the First Amended Class Action Complaint regarding the alleged breaches of fiduciary duty.

- Your legal rights will be affected whether you act or don't act. This Notice includes information on the Settlement and the lawsuit. Please read the entire Notice carefully.

- The Court in charge of this case has given its preliminary approval to the Settlement and approved this Notice but has not yet decided whether to grant final approval of the Settlement. If the Court finally approves the Settlement, it will issue an Order requiring Defendants and the Plan to comply with the terms of the Settlement. Once the time for any appeals has run or any such appeals have been rejected: (i) the $15 million settlement amount (minus any Attorneys' Fees and Costs and Administrative Expenses) will be paid to, or allocated into the HRA Accounts of, certain Class Members who are Senior Performers, as directed by Plaintiffs and provided for in the Settlement Agreement, (ii) the additional allocations into the HRA Accounts of Qualifying Senior Performers will begin, and (iii) the Disclosures and Administrative Changes provided for in the Settlement Agreement will be implemented.

- The following rights and options—and deadlines to exercise them—are explained in this Notice.

YOUR LEGAL RIGHTS AND OPTIONS	
DO NOTHING	You do not need to do anything. Inclusion in the Settlement is automatic, and if the Court approves the Settlement all Class Members will be bound by its terms.
OBJECT TO THE SETTLEMENT	If you object to the Settlement, or otherwise wish to comment on the Settlement, you can write to the Court explaining why you agree or disagree with the Settlement, Attorneys' Fees and Costs, or Service Awards.
GO TO THE HEARING	Ask to speak in Court about your objection to the Settlement.

BASIC INFORMATION

1. What is this Notice About?

This Notice is to inform you about a Settlement reached in this litigation before the Court decides whether to grant final approval of this Settlement. This Notice explains the lawsuit, the Settlement, and your legal rights. The Court in charge is the United States District Court for the Central District of California. This litigation is known as *Asner, et al. v. The SAG-AFTRA Health Fund, et al.*, No. 20-cv-10914-CAS (JEM). The people who sued are called the "Plaintiffs" or "Class Representatives." The Trustees of the SAG Health Plan and the SAG-AFTRA Health Plan that they sued are called the "Defendants" or the "Defendant Trustees."

2. What is this Lawsuit About?

Plaintiffs claim that the Defendant Trustees of the SAG Health Plan breached their ERISA fiduciary duties in connection with the January 1, 2017 merger of the SAG Health Plan and the AFTRA Health Plan, which resulted in the SAG-AFTRA Health Plan (the "Merger"). Plaintiffs allege that these Trustees falsely assured participants that the Merger would strengthen the health plan and ensure comprehensive health benefits for all participants in the future.

Plaintiffs also claim that the Defendant Trustees of the SAG-AFTRA Health Plan breached their ERISA fiduciary duties in connection with Plan amendments that were adopted in July 2020 and became effective on January 1, 2021 ("2020 Amendments"). Among other things, the 2020 Amendments: (a) eliminated health coverage based on an age and service rule; (b) for Senior Performers taking a pension, eliminated the so-called Dollar Sessional Rule, which credited residuals earnings toward eligibility qualification so long as they had $1 of sessional earnings; (c) raised certain earnings thresholds to qualify for health coverage; and (d) eliminated secondary coverage for Senior Performers and their age 65+ spouses. Plaintiffs allege that the enactment of the 2020 Amendments violated ERISA and federal and state anti-discrimination laws, including the Age Discrimination in Employment Act of 1967, 29 U.S.C. § 621, *et seq.* ("ADEA"). Plaintiffs further allege that, in connection with the approval of three major collective bargaining agreements in 2019 and 2020, the Defendant Trustees violated ERISA by failing to disclose to union negotiators the amount of funding needed to sustain the Plan's benefit structure and their intention to balance the Plan's books in part by reducing the cost of providing Plan coverage to participants taking a pension who were age 65 and older.

Throughout the litigation and in the Settlement Agreement, the Defendant Trustees have denied that they breached any applicable fiduciary duties, violated any age discrimination laws, failed to make any disclosures required by law, or committed any wrongdoing whatsoever. They maintain that, with respect to both the Merger and the 2020 Amendments, they engaged in a prudent process with the advice of consultants to reach prudent decisions that were in the best interests of participants in light of projected funding deficits that had arisen due to ever-increasing health care costs. Defendants further assert that, in an effort to mitigate the adverse consequences of the Plan's financial shortfall, the Plan has adopted numerous changes that have substantially reduced administrative expenses and the cost of benefits, as a result of which the Plan's administrative expenses compare very favorably to those of similarly situated plans.

3. Why is this a Class Action?

In a class action, one or more people, called the "Class Representatives," sue on behalf of themselves and other people with similar claims in the specific class action. All of these people together are the "class" or "class members." In a class action, one court may resolve the issues for all class members.

4. Why is there a Settlement?

The Court has not decided in favor of the Plaintiffs or Defendants. Instead, both sides have agreed to the Settlement to avoid the costs and risks of a lengthy trial and appeals process. The parties reached the settlement with assistance from a nationally-renowned mediator. Nothing in the Settlement Agreement is an admission or concession on Defendants' part of any fault or liability whatsoever, nor is it an admission or concession on Plaintiffs' part that their claims lacked merit. The Class Representatives and Class Counsel believe the Settlement is fair, reasonable, and adequate, and in the best interests of the Class Members.

THE SETTLEMENT

5. How do I Know if I may be Included in the Settlement Class?

The Settlement Class includes: All individuals who (i) were enrolled in health coverage under the SAG-AFTRA Health Plan at any time from January 1, 2017 through [XXX PA date], (ii) were notified that they qualified for health coverage under the Plan for any time from January 1, 2017 through [XXX PA date], and/or (iii) qualified or had qualified as a Senior Performer as of January 1, 2017 or at any time from January 1, 2017 through [XXX PA date]. The Defendant Trustees are excluded from the Settlement Class.

The fact that you are included in the Settlement Class, and receiving this Notice, does not mean that you are necessarily entitled to receive a monetary payment (or allocation into your HRA Account) from the Settlement.

The Settlement Agreement, the Amended Class Action Complaint, the Preliminary Approval Memorandum, the Preliminary Approval Order by the Court, and other relevant pleadings and Court orders are accessible on the Settlement Website at www.sagaftrahealthplansettlement.com.

6. How Much Money does the Settlement Provide?

The monetary components of the Settlement include: (1) the payment of $15 million, comprised of $7.5 million to be paid by the Plan's fiduciary liability insurance carriers plus $7.5 million paid or allocated by the Plan, and (2) the requirement that the Plan allocate a total maximum of $5.6 million, comprised of making allocations of up to an additional $700,000 per year for eight years into the HRA Accounts of Qualifying Senior Performers, who are defined as Senior Performers who are ineligible for active coverage under the Plan that year solely as a result of the 2020 Amendments' elimination of the Dollar Sessional Rule.

7. How Will the Money Provided in the Settlement be Allocated?

- **$15 Million Fund**: After deduction for any Attorneys' Fees, Costs, Service Awards, and Administrative Expenses approved by the Court, the balance of the $15 million fund will be paid or allocated to Senior Performers and their age 65+ spouses who lost active or secondary health coverage from the Plan in 2021 or 2022 due to the 2020 Amendments. The following are the targeted amounts of these payments or allocations. (Each of the Senior Performer and their age 65+ spouse will receive the targeted amount.) If the Court approves the Settlement, the actual payments or allocations may be increased or decreased *pro rata* depending on the amount left in the $15 million fund after payment of Attorneys' Fees, Costs, Service Awards, and Administrative Expenses approved by the Court:

    - **$4,400** - For Senior Performers and their spouses who received active health coverage from the Plan in December 2020 but did not qualify for active coverage in 2021 due to the elimination of the Dollar Sessional Rule in the 2020 Amendments.

    - **$2,200** - For Senior Performers and their spouses who received active health coverage from the Plan in December 2020 but did not qualify for active coverage in 2021 due to the elimination of the age and service rules and/or raising of the earnings thresholds to qualify for health coverage as part of the 2020 Amendments.

    - **$1,100** - For Senior Performers and their spouses who received active health coverage from the Plan in December 2020 and who qualified for active health coverage in 2021 but did not qualify for active coverage in 2022 due to the 2020 Amendments.

    - **$400** – For Senior Performers and their spouses who received secondary health coverage from the Plan in December 2020 but did not receive secondary coverage in 2021 due to the 2020 Amendments.

        Per the Plan's records, you qualify for a target payment or allocation of [$4,400/$2,200/$1,100/$400] -OR- [Per the Plan's records, you do not qualify for a payment or allocation from the $15 million fund]

- **Additional HRA Allocations:** For up to eight years (2023 – 2030), the Plan will allocate up to $700,00 into the HRA Accounts of Qualifying Senior Performers. The aggregate amount of additional allocations to the HRA Accounts of Qualifying Senior Performers in each year will be equal to one-half of the aggregate contributions made to the Plan with respect to the Qualifying Senior Performers' residual earnings reported to and processed by the Plan during the prior year's Base Earnings Period (which earnings will be capped at $125,000 per Qualifying Senior Performer). The aggregate amount of additional allocations for each year will be apportioned among Qualifying Senior

Performers based on the relative amount of their residual earnings reported to the Plan (up to $125,000). The details of this allocation are set forth in Section 10 of the Settlement Agreement, which is available on the Settlement Website.

8. What Other Remedial Changes will the Plan Be Required to Implement if the Court Approves the Settlement?

In addition to the monetary payments and allocations into HRA Accounts described above, the Settlement requires the Plan to make certain Disclosures and Administrative Changes that were negotiated by the parties. With the exception of the provisions concerning the Cost Consultant, the Disclosures and Administrative Changes will be in effect for four years after the Settlement Effective Date. The following is a summary of the Disclosures and Administrative Changes agreed to as part of the Settlement. More details about these provisions are set forth in Section 11 of the Settlement Agreement, available at www.sagaftrahealthplansettlement.com.

- **Disclosures**. The following disclosures will be made to the SAG-AFTRA National Board or SAG-AFTRA Executive Committee, via the SAG-AFTRA National Executive Director:

  - No later than thirty (30) days after each Benefits Committee meeting, the Plan will provide the SAG-AFTRA National Executive Director with the projections required in Article XIII, Section 2 of the Trust Agreement, and any accompanying reports of the Benefit Consultant (including proposed changes to participant premiums, eligibility thresholds, or benefits, or any combination thereof, suggested by the Benefit Consultant).

  - No later than five (5) days after the minutes of the Plan's Board of Trustees' first meeting of each year are approved, the Plan will provide the SAG-AFTRA National Executive Director with a copy of the minutes to the extent they relate to Continuation Value and the projections referred to above.

  - No later than five (5) days after the Union Trustees decide on a proposed modification they intend to make pursuant to Article XIII of the Trust Agreement, the Union Trustees will provide the SAG-AFTRA National Executive Director with the substance of the proposed modification.

  - Prior to the commencement of collective bargaining negotiations relating to the Commercials CBA, Netflix CBA, or TV/Theatrical CBA, the Plan will provide reports to the SAG-AFTRA National Board and the SAG-AFTRA negotiating committees regarding the funding needed to sustain the then-current participant premiums, eligibility thresholds, and benefits for the duration of the agreements being negotiated. Disclosures of this nature were made by the Plan in connection with the negotiations leading to the 2022 Commercials CBA, which provides for increased contributions to the Plan.

- **Cost Consultant**. No later than thirty (30) days after the Settlement Effective Date, the Plan will follow the Request for Proposal ("RFP") process described in Exhibit 5 to the Settlement Agreement to select a Cost Consultant. Once retained, the Cost Consultant will provide an oral report and issue a written report advising on potential cost-saving measures in areas other than those in which the Plan has already achieved cost-savings in recent years (as indicated in the memorandum attached as Exhibit 5 to the Settlement Agreement).

- **Plan Amendment**. No later than thirty (30) days after the Settlement Effective Date, the Plan's Board of Trustees will amend the Plan's Summary Plan Description as follows with respect to the manner in which Retirees' (including Senior Performers') sessional earnings are applied for purposes of qualifying for active coverage under the Plan:

    - Senior Performers will be able to use additional sessional earnings reported to the Plan within forty-five (45) days of the September 30 end of their Base Earnings Period (meaning fifteen (15) days beyond the 30-day period in which employers are expected to submit such earnings) toward active coverage qualification for the Benefit Period beginning the following January 1, provided that the covered employment generating the sessional earnings occurred on or before the referenced September 30. Any Senior Performer wishing to do so must affirmatively make this request with the Plan office within the 45-day window period.

    - Any such late reported earnings that are counted for purposes of qualifying for Plan coverage in a particular year will be excluded from the following year's active qualification evaluation.

    - Retirees (including Senior Performers) will have two opportunities from 2023 through 2028 to retrospectively apply late reported earnings in this manner.

- **Notice of Additional Earnings Application Opportunity**. In conjunction with the Plan Amendment described above, the Plan will post a Notice of Additional Credited Earnings Opportunity on the Plan Website (in substantially the form attached as Exhibit 10 to the Settlement Agreement) so that Senior Performers potentially impacted by this provision are aware of the opportunity. The Plan Website will also advise Senior Performers of their ability to determine the amount of sessional earnings reported to the Plan for the applicable quarter and the October 1 through September 30 Base Earnings Period. In addition, the Plan will send at least two emails each year to Senior Performers for whom it has an email address with a link to the Benefits Manager log-in on the Plan Website where the Senior Performer can review their reported sessional earnings.

9. What Am I Giving Up If the Court Approves the Settlement?

In exchange for the relief provided by the Settlement, the parties agreed that all Class Members (including the Class Representatives) would forever release the Released Claims against the

Released Parties. As set out more fully in the Settlement Agreement, "Released Claims" means any and all claims that:

(a) were or could have been asserted in the Complaint or Amended Complaint (or in any submission made by the Class Representatives or Class Counsel in connection with the Action), or that arise out of, depend upon, or are based on any of the factual allegations asserted in the Complaint or Amended Complaint (or in any submission made by the Class Representatives or Class Counsel in connection with the Action), including, but not limited to, those that arise out of, depend upon, or are based on: (i) the Merger and/or the pre-Merger evaluation process, (ii) the SAG Health Plan's maintenance of assets in, or transfer of assets out of, a "Retiree Reserve" portfolio, (iii) disclosures or failures to disclose information regarding the Merger and/or the pre-Merger evaluation process, (iv) the Amendments, (v) disclosures or failures to disclose information regarding the Plan's financial condition, funding, and/or actual or potential amendments to the Plan that occurred on or before the Settlement Effective Date, or (vi) any alleged breach of fiduciary duty in connection with (i) through (v) above.

(b) arise out of, relate in any way to, are based on, or have any connection with the approval by the Independent Settlement Evaluation Fiduciary of the Settlement Agreement, unless brought against the Independent Fiduciary alone;

(c) arise out of, relate in any way to, are based on, or have any connection with the calculation, allocation, and/or distribution of the Net Settlement Amount to Class Members (i.e., the Settlement Allocations) in accordance with the Plan of Allocation;

(d) arise out of, relate in any way to, are based on, or have any connection with the calculation, allocation, and/or distribution of additional amounts to the HRA Accounts of Qualifying Senior Performers or any amendments to the HRA Plan that provide for such additional allocations; or

(e) would be barred by *res judicata* based on entry by the Court of the Final Approval Order.

The governing releases are found within the Settlement Agreement, which is available at www.sagaftrahealthplansettlement.com. The Settlement Agreement describes the Released Claims in further detail. This is only a summary of the Released Claims, and it is not a binding description. Read the Settlement Agreement carefully because those releases will be binding on you as a Settlement Class Member if the Court grants final approval of the Settlement.

THE LAWYERS REPRESENTING YOU

10. Do I Have a Lawyer Representing Me?

The Court has appointed the following lawyers as Lead Class Counsel to represent you and all other members of the Settlement Class:

Steven A. Schwartz
SAS@chimicles.com
CHIMICLES SCHWARTZ KRINER & DONALDSON-SMITH LLP
361 West Lancaster Avenue

Robert J. Kriner, Jr.
RJK@chimicles.com
CHIMICLES SCHWARTZ KRINER & DONALDSON-SMITH LLP
2711 Centerville Road, Suite 201

Haverford, PA 19041
(610) 642-8500

Wilmington, DE 19808
(302) 656-2500

Additional counsel assisting Plaintiffs' Lead Class Counsel include the following:

Neville L. Johnson
JOHNSON & JOHNSON LLP
439 N. Canon Drive, Suite 200
Beverly Hills, CA 90210

Edward Siedle
LAW OFFICES OF EDWARD SIEDLE
17789 Fieldbrook Circle West
Boca Raton, FL 33496

You will not be charged for contacting these lawyers. If you want to be represented by or consult with your own lawyer concerning the terms of the Settlement, you may hire one at your own expense.

11. How Will the Lawyers Be Paid?

Class Counsel will ask the Court to pay them for the time they spent and reimburse them for the expenses they incurred prosecuting the lawsuit. Any Attorneys' Fees and Costs awarded by the Court will be paid out of the $7.5 million paid by the Plan's fiduciary liability insurers.

Class Counsel will ask the Court for Attorneys' Fees and Costs not to exceed $6,866,667, which is one-third of the $15 million in payments or allocations from the Plan and its insurers plus the maximum $5.6 million in additional potential allocations for Qualifying Senior Performers. To date, Class Counsel represent that they have spent over 4,500 hours prosecuting the lawsuit, and they have not been paid anything for their work yet. They also represent that they have advanced approximately $70,000 in costs to cover the expenses necessary to pursue the lawsuit. Class Counsel will file with the Court a detailed Motion supporting their request for Attorneys' Fees and Costs. Class Counsel will file that Motion before the deadline for objections, and you will be able to review it at www.sagaftrahealthplansettlement.com. Any payment to the attorneys will be subject to Court approval, and the Court may award less than the requested amount. Defendants have reserved the right to oppose Class Counsel's request for Attorneys' Fees and Costs.

12. What Will Plaintiffs Michael Bell, Raymond Harry Johnson, David Jolliffe, Robert Clotworthy, Thomas Cook, Audrey Loggia, Deborah White, and Donna Lynn Leavy Receive Out of the Settlement?

Class Counsel will ask the Court to award each Class Representative $5,000 as a Service Award for their efforts in bringing this litigation. The Class Representatives spent significant time consulting with counsel, responding to interrogatories, and reviewing various court and mediation documents. In addition, Mr. Joliffe participated in mediation sessions and provided extensive assistance to Class Counsel with respect to settlement negotiations. Class Counsel have agreed that any Service Awards will be paid out of the amount awarded by the Court for Attorneys' Fees and Costs. Mr. Jolliffe has committed to donating his Service Award to the SAG Foundation. Defendants have reserved the right to oppose Class Counsel's request for Service Awards.

In addition, Class Counsel will request that the Court approve the provisions in Section 12 of the Settlement Agreement. Pursuant to that section, each Class Member shall fully, finally, and forever

settle, release, relinquish, waive, and discharge any claims he or she may have against the Class Representatives that arise out of the institution, prosecution, settlement or dismissal of the Action.

OBJECTING TO THE SETTLEMENT

13. How Do I Object to or Comment on the Settlement?

You can ask the Court not to approve the Settlement by filing an objection. You can also object to the request for Attorneys' Fees and Costs, the proposed Service Awards for each of the Class Representatives, or Plaintiffs' request that Class Members release any claims against the Class Representatives. You can't ask the Court to order a different Settlement or order different Disclosures and Administrative Changes; the Court can only approve or reject this Settlement. If the Court does not approve the Settlement, none of the Settlement benefits described above will be paid or allocated into HRA Accounts, the Plan's Board of Trustees will not be required to implement the Disclosures and Administrative Changes provided for by the Settlement, and the litigation between the parties will resume.

Any objection to the proposed Settlement must be in writing. Any objection must be submitted to the Court either by mailing it to the United States District Court for the Central District of California, 350 W. First Street, Los Angeles, CA 90012, ATTN Honorable Christina A. Snyder, or by filing them in person with the Court. Any objection must be filed or postmarked on or before XXX, 2023.

All written objections and supporting papers must include (a) the case name and number (*Asner, et al. v. The SAG-AFTRA Health Fund, et al.*, No. 20-cv-10914-CAS (JEM)); (b) your name, address, telephone number, and email address; (c) the specific grounds for your objection along with any supporting papers, materials, briefs or evidence that you wish the Court to consider when reviewing the objection; (d) your signature; and (e) a statement whether you or your attorney intends to appear at the Fairness Hearing. If you or your attorney has objected to a class action settlement during the past 5 years, the objection must also disclose all cases in which you or your attorney has filed an objection by caption, court and case number, and for each case, the disposition of the objection, including whether any payments were made to the objector or his or her counsel, and if so, the incremental benefits, if any, that were achieved for the class in exchange for such payments.

Any party to the litigation may file a response to an objection before the Fairness Hearing.

If you file a timely written objection, you may, but are not required to, appear at the Fairness Hearing, either in person or through your own attorney. If you appear through your own attorney, you are responsible for hiring and paying that attorney.

If you do not comply with these procedures and timely object, you will lose any opportunity to have your objection considered at the Fairness Hearing or to otherwise contest approval of the Settlement or to appeal from any order or judgment entered by the Court in connection with the Settlement.

14. Can I Opt Out of the Settlement?

No. The Court has preliminarily certified this case as a class action pursuant to Federal Rule of Civil Procedure 23(b)(1), and that subsection of Rule 23 does not include provisions for class members to opt out.

THE FINAL FAIRNESS HEARING

The Court will hold a hearing to decide whether to approve the Settlement and any requests by Class Counsel for fees, costs, and expenses and the proposed Service Awards for the Class Representatives. You may attend and you may ask to speak, but you do not have to do so.

15. When and Where Will the Court Decide Whether to Approve the Settlement?

The Court will hold a Final Fairness Hearing at 10:00 A.M. on XXX, 2023, at Courtroom 8D of the United States District Court for the Central District of California, 350 W. First Street, Los Angeles, CA 90012. The hearing may be moved to a different date or time without additional notice, so check www.sagaftrahealthplansettlement.com or call Class Counsel to confirm that the date has not been changed. At this hearing, the Court will consider whether the Settlement is fair, reasonable, and adequate. If there are objections or comments, the Court will consider them at that time and will listen to people who have asked to speak at the hearing. The Court may also decide how much to pay Class Counsel and whether to reimburse Class Counsel for certain costs, and whether to pay Service Awards to the Class Representatives. At or after the hearing, the Court will decide whether to approve the Settlement.

16. Do I Have to Attend the Hearing?

No. Class Counsel will answer any questions the Court may have. But you are welcome to attend, at your expense, if you wish. If you send an objection or comment, you do not have to come to Court to talk about it. As long as you filed or mailed your written objection on time, the Court will consider it. You may also hire or consult with your own lawyer at your own expense to attend on your behalf, but you are not required to do so.

17. May I Speak at the Hearing?

If you send an objection to or comment on the Settlement that notes your intention to appear, you or your counsel may have the right to speak at the Fairness Hearing as determined by the Court. You or your counsel may argue only those matters that were set forth in your written objection.

GET MORE INFORMATION

18. How Do I Get More Information?

This Notice summarizes the proposed Settlement. For the precise terms and conditions of the Settlement, please see the Settlement Agreement available at www.sagaftrahealthplansettlement.com. For more information on the Settlement, you may contact Lead Class Counsel identified above in Question 10. Updates about the Settlement will be posted at www.sagaftrahealthplansettlement.com. Finally, you may visit the office of the Clerk of the

Court at the address above, between 8:30 a.m. and 5:00 p.m., Monday through Friday, excluding Court holidays.

PLEASE DO NOT TELEPHONE THE COURT, THE COURT CLERK'S OFFICE, OR THE FUND OFFICE TO INQUIRE ABOUT THIS SETTLEMENT.

Dated: XXX, 2023

By Order of the Court, United States District Court for the Central District of California

EXHIBIT 3

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

EDWARD ASNER, *et al.*,

Plaintiffs,

vs.

THE SAG-AFTRA HEALTH FUND, *et al.*,

Defendants.

Case No. 2:20-cv-10914-CAS-JEM

[PROPOSED] ORDER GRANTING FINAL APPROVAL OF CLASS ACTION SETTLEMENT

Date: [INSERT]
Time: 10:00 a.m.
Courtroom: 8D
Judge: Hon. Christina A. Snyder

Action Filed: December 1, 2020

This Action[1] arises under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* ("ERISA"), and involves claims for alleged breaches of fiduciary duty by trustees of the Screen Actors Guild-Producers Health Plan and the SAG-AFTRA Health Plan. Now before the Court is Plaintiffs' unopposed Motion for Final Approval of Class Action Settlement (the "Motion") (ECF No. ___). The terms and conditions of the Settlement are set forth in the Class Action Settlement Agreement, executed on [INSERT], and the exhibits thereto (ECF No. ___).

On [INSERT], this Court entered a Preliminary Approval Order that, among other things: (i) preliminarily certified the Settlement Class defined in the Settlement Agreement; (ii) preliminarily approved the terms of the Settlement; (iii) approved and directed distribution of the Settlement Notice to Class Members; and (iv) preliminarily enjoined parallel proceedings (ECF No. ___).

A Fairness Hearing was held by the Court on [INSERT] to consider (i) any objections from Class Members to the Settlement that were timely and properly served in accordance with the Preliminary Approval Order; (ii) whether to finally approve the Settlement as fair, reasonable, and adequate; (iii) whether to finally certify the Settlement Class; (iv) the amount of any Attorneys' Fees and Costs to be awarded to Class Counsel; and (v) the amount of any Service Awards to be awarded to the Class Representatives.

In determining whether to grant final approval of the Settlement, the Court has considered, among other things: (i) the unopposed Motion and all supporting documents; (ii) the Settlement Agreement itself; (iii) the form and manner of the Settlement Notice; (iv) the absence of any objection by any Class Member [TBD]; (v) the absence of any objection by any state or federal officials after they were all provided with the notices required by the Class Action Fairness Act of 2005 ("CAFA"),

[1] All capitalized terms not otherwise defined in this Final Approval Order shall have the same meaning as ascribed to them in the Settlement Agreement.

28 U.S.C. §1715 [TBD]; (vi) the Independent Settlement Evaluation Fiduciary's approval of the Settlement on behalf of the Plan in accordance with Prohibited Transaction Exemption 2003-39 [TBD]; and (vii) the oral argument at the Fairness Hearing.

Based upon the foregoing considerations, and good cause appearing therefore, the Court hereby GRANTS the Motion and ORDERS AS FOLLOWS:

1. This Final Approval Order hereby incorporates and makes a part hereof: (i) the Settlement Agreement (including the exhibits thereto); and (ii) the findings and conclusions contained in the Court's Preliminary Approval Order.

2. This Court has jurisdiction over the subject matter of this Action and over the Settling Parties as well as all members of the Settlement Class.

FINAL CERTIFICATION OF SETTLEMENT CLASS

3. For the sole purpose of settling and resolving the Action, the Court hereby certifies the following Settlement Class pursuant to Rules 23(a) and 23(b)(1) of the Federal Rules of Civil Procedure:

> All individuals who (i) were enrolled in coverage under the Plan at any time during the Class Period, (ii) were notified that they qualified for coverage under the Plan for any time during the Class Period, and/or (iii) qualified or had qualified as a Senior Performer as of the beginning of or during the Class Period, but excluding the Trustee Defendants.

The Class Period runs from January 1, 2017 through the date of the [INSERT] Preliminary Approval Order.

4. For the sole purpose of settling and resolving the Action, the Court finds that the prerequisites for a class action under Rule 23(a) are satisfied. Specifically, the Court finds:

a. **Numerosity**. The Settlement Class is ascertainable from records kept by the Plan and is so numerous that joinder of all Class Members in the Action is impracticable.

b. **Commonality**. There are questions of law and/or fact common to all Class Members.

c. **Typicality**. The Class Representatives' claims are typical of the claims of the Class Members they seek to represent.

d. **Adequacy**. The Class Representatives and Class Counsel have fairly and adequately represented the interests of the Settlement Class and will continue to do so.

5. For the sole purpose of settling and resolving the Action, the Court finds that the prerequisites for a class action under Rule 23(b)(1) are satisfied. Specifically, the Court finds that prosecuting separate actions by individual Class Members would create a risk of inconsistent or varying adjudications that could establish incompatible standards of conduct for the Trustees Defendants with respect to the fiduciary duties that apply to them.

6. For the sole purpose of settling and resolving the Action, the Court appoints Chimicles Schwartz Kriner and Donaldson-Smith LLP as Lead Class Counsel for the Settlement Class, and Johnson & Johnson LLP and Law Offices of Edward Siedle as additional Class Counsel. In accordance with Rule 23(g), the Court finds that Class Counsel are capable of fairly and adequately representing the interests of the Settlement Class, and that Class Counsel: (i) have done appropriate work identifying and investigating potential claims in the Action; (ii) are experienced in handling class actions, other complex litigation, and the types of ERISA claims asserted in the Action; (iii) are knowledgeable of the applicable law; and (iv) have committed the necessary resources to represent the Settlement Class.

7. For the sole purpose of settling and resolving the Action, the Court appoints Plaintiffs Michael Bell, Raymond Harry Johnson, David Jolliffe, Robert Clotworthy, Thomas Cook, Audrey Loggia, Deborah White, and Donna Lynn Leavy as the Class Representatives of the Settlement Class.

FINAL APPROVAL OF SETTLEMENT NOTICE

8. On [INSERT], a declaration was filed with this Court stating that the approved Settlement Notice was disseminated as set forth in Section 3.2 of the Settlement Agreement (ECF No. ___). The Settlement Notice was sent directly to each Class Member for whom the Plan has either an email or postal address on record and it was also posted on the Settlement Website, a link to which was posted on the Plan Website.

9. The Court hereby finds and concludes that Class Members have been provided with appropriate notice of the Settlement and that such notice fully satisfied all notice requirements under the law, including Federal Rule of Civil Procedure 23(c)(2)(A) and all due process rights under the U.S. Constitution. The Court finally approves the Settlement Notice in all respects.

10. On [INSERT], a declaration was filed with this Court stating that the approved CAFA notices were timely mailed to the appropriate state and federal officials in accordance with 28 U.S.C. § 1715, and that no objections to the Settlement were received [TBD] (ECF No. ___). The Court finds that Defendants have fully satisfied all requirements under CAFA, and that the absence of any objection from state or federal officials further supports final approval of the Settlement.

FINAL APPROVAL OF THE TERMS OF THE SETTLEMENT

11. Despite having received appropriate notice, no Class Members filed objections to the Settlement nor appeared at the Fairness Hearing [TBD].

12. The Court hereby fully and finally approves the Settlement set forth in the Settlement Agreement, finding it fair, reasonable, and adequate in all respects, and

finding that the requirements for settlement approval under Federal Rule of Civil Procedure 23(e)(2) are satisfied. Specifically, the Court finds:

a. **Adequate Representation**. Class Counsel and the Class Representatives have adequately represented the Settlement Class. Class Representatives have no conflicts of interest with Class Members insofar as they all qualified for coverage under the Plan and/or qualified as Senior Performers under the Plan and were thus impacted by the Amendments. Further, Class Counsel and the Class Representatives have vigorously prosecuted the Action on behalf of the Settlement Class, including with respect to defending against Defendants' motion to dismiss the First Amended Complaint, obtaining an initial set of documents from Defendants, and issuing subpoenas to third parties.

b. **Arm's Length Negotiations**. The Settlement resulted from arm's length negotiations, with no signs of collusion or bad faith. Class Counsel and Defense Counsel are experienced in similar class action litigation and engaged in extensive negotiations that were facilitated by an experienced professional mediator (Robert Meyer, Esq., of JAMS).

c. **Adequate Relief**. The Settlement provides adequate relief for the Settlement Class while avoiding the costs, risks, and delay of continued litigation. In addition to a Gross Settlement Amount with a value of $15,000,000, to be allocated to certain Class Members who are Senior Performers (after Administrative Expenses and Attorneys' Fees and Costs are subtracted therefrom), the Settlement also provides other valuable benefits to the Settlement Class. Class Members who are Qualifying Senior Performers will receive additional allocations to their HRA Accounts (which could total up to $5,600,000) and the Plan will institute various changes for a period of four years (including to disclose financial information about the Plan to the negotiators of collective bargaining agreements).

i. *Costs, Risks, and Delay.* If Plaintiffs were to proceed with this Action, they would face various risks at each stage of the litigation that could preclude any relief, such as losing on a motion for class certification, on a motion for summary judgment, at trial, or on appeal. Plaintiffs also face the risk that, even if they prevail on the merits of their claims, their desired relief (*e.g.*, amendments to the Plan) may be unavailable as a matter of law.

ii. *Distribution Method.* The Settlement provides for an effective method of distributing the relief to Class Members. Class Members entitled to monetary relief will not be required to file claims; rather, those with HRA Accounts will receive their Settlement Allocations in those accounts, and those without HRA Accounts will receive a check from a Settlement Administrator.

iii. *Proposed Award of Attorneys' Fees.* As discussed further below, the Attorneys' Fees and Costs requested by Class Counsel are fair and reasonable and in line with Ninth Circuit authority.

iv. *Side Agreements.* Apart from the Settlement Agreement, there are no agreements made in connection with the Settlement to consider under Rule 23(e)(2)(C)(iv).

d. **Equitable Relief**. The Settlement treats Class Members equitably relative to each other insofar as it provides for a Settlement Administrator who has the final authority to determine the amount of each Class Member's Settlement Allocation, in accordance with a Plan of Allocation agreed upon by the Settling Parties.

ATTORNEYS' FEES AND COSTS AND SERVICE AWARDS

13. On [INSERT], Class Counsel filed a Motion for Attorneys' Fees and Costs and Service Awards (ECF No. ___). Having considered any opposition to and/or objections to Class Counsel's request [TBD], the Court hereby awards Class Counsel: (i) attorneys' fees in the amount of [INSERT] ([INSERT]% of the Gross Settlement Amount), and (ii) costs in the amount [INSERT], to be deducted from the Gross

Settlement Amount. The foregoing amounts of Attorneys' Fees and Costs are fair and reasonable in light of the substantial risks taken by Class Counsel to prosecute this Action on a contingency basis, Class Counsel's skill and experience in class action litigation of this type, and fee awards in comparable cases in this circuit.

14. The Court also hereby awards Service Awards to the Class Representatives in the amount of [INSERT] each, to be deducted from Class Counsel's Attorneys' Fees and Costs and not from the Gross Settlement Amount.

MISCELLANEOUS

15. **Implementation of Settlement**. The Settling Parties are hereby directed to consummate the Settlement in accordance with the Settlement Agreement and to comply with all of its terms and conditions.

16. **Binding Effect**. Upon entry of this Final Approval Order, Defendants (including the Plan) and the Class Members (including the Class Representatives) are hereby bound by this Order and by the Settlement Agreement, and may enforce the terms thereof.

17. **Enforcement of Settlement**. Nothing in this Final Approval Order shall preclude any action to enforce or interpret the terms of the Settlement. Any action to enforce or interpret the terms of the Settlement shall be brought solely in this Court.

18. **No Admission of Liability**. The Settlement shall not be deemed to constitute an admission or finding of liability or wrongdoing on the part of Defendants (including the Plan) or the Class Members (including the Class Representatives).

19. **Retention of Jurisdiction**. The Court expressly retains continuing jurisdiction as to all matters relating to the Settlement, and this Final Approval Order, and for any other necessary and appropriate purpose.

20. **Dismissal of Action with Prejudice**. All claims against Defendants in this Action are hereby dismissed on the merits and with prejudice, without an award of costs to any party, except as provided for in this Final Approval Order. For those

individual defendants who were dismissed without prejudice during the pendency of the litigation—namely Ann Calfas, Eryn Doherty, Gary Elliot, Mandy Fabian, Leigh French, Nicole Gustafson, Marla Johnson, Bob Kaliban (deceased), Shelley Landgraf, D.W. Moffett, Alan Raphael, John Rhone, David Silberman, John Sucke, and Kim Sykes (*see* ECF No. 43 ¶¶ 161, 169, 179, 187; ECF No. 71 at 5)—all claims in the Action are hereby dismissed with prejudice as to them as well.

RELEASES

21. **Released Claims**. Each Class Member (including each of the Class Representatives) is hereby deemed to have fully, finally, and forever settled, released, relinquished, waived, and discharged all Released Claims against the Released Parties, as set forth in the Settlement Agreement.

22. **Permanent Injunction**. Each Class Member (including each of the Class Representatives) is hereby permanently barred and enjoined from asserting, commencing, prosecuting, or continuing any of the Released Claims against the Released Parties, as set forth in the Settlement Agreement and consistent with Paragraph 21 above.

23. **Other Releases**. All other releases and covenants not to sue set forth in the Settlement Agreement, including but not limited to those in Section 12, are expressly incorporated herein in all respects.

IT IS SO ORDERED.

DATED: _____

_____
The Honorable Christina A. Snyder
United States District Judge

EXHIBIT 4

Proskauer Rose LLP Eleven Times Square New York, NY 10036-8299

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April __, 2023

By Certified Mail, Return Receipt Requested

Re: *Asner, et al. v. The SAG-AFTRA Health Fund, et al.*, No. 2:20-cv-10914-CAS-JEM (C.D. Cal.) – CAFA Notice Pursuant to 28 U.S.C. § 1715

Dear Sir/Madam:

Defendants the SAG-AFTRA Health Plan (the "Plan"), the Board of Trustees of the Screen Actors Guild-Producers Health Plan, the Board of Trustees of the SAG-AFTRA Health Plan, Daryl Anderson, Helayne Antler, Amy Aquino, Timothy Blake, Jim Bracchitta, John Carter Brown, Duncan Crabtree-Ireland, Barry Gordon, J. Keith Gorham, James Harrington, David Hartley-Margolin, Harry Isaacs, Robert W. Johnson, Sheldon Kasdan, Matthew Kimbrough, Lynne Lambert, Allan Linderman, Carol A. Lombardini, Stacy K. Marcus, Richard Masur, John T. McGuire, Diane P. Mirowski, Paul Muratore, Tracy Owen, Michael Pniewski, Ray Rodriguez, Marc Sandman, Sally Stevens, Gabriela Teissier, Lara Unger, Ned Vaughn, David Weissman, Russell Wetanson, David P. White, and Samuel P. Wolfson (collectively, the "Defendants"), through undersigned counsel, hereby provide this notice of a Proposed Class Action Settlement in the above-referenced matter pursuant to the Class Action Fairness Act of 2005 ("CAFA"), 28 U.S.C. § 1715. The proposed settlement will resolve this action.

On April __, 2023, Plaintiffs' Counsel filed a Motion for Preliminary Approval with the Court, which included the parties' Class Action Settlement Agreement ("Settlement Agreement"). These papers are included on the enclosed CD-ROM as **Exhibit A**. The Settlement Agreement contemplates that the Court will certify a class, for settlement purposes only, defined as: All individuals who (i) were enrolled in health coverage under the Plan at any time during the Class Period, (ii) were notified that they qualified for health coverage under the Plan for any time during the Class Period, and/or (iii) qualified or had qualified as a Senior Performer as of the beginning of or during the Class Period, but excluding the Trustee Defendants. The Class Period runs from January 1, 2017 through the date of the Court's Preliminary Approval Order.

In accordance with their obligations under CAFA, Defendants enclose the following:

(1) The Complaint, any materials filed with the Complaint, and any Amended Complaints.

Plaintiffs' Class Action Complaint (ECF No. 1) and First Amended Class Action Complaint (ECF No. 43) are included on the enclosed CD-ROM as **Exhibit B**.

(2) Notice of any scheduled judicial hearing in the class action.

There are no judicial hearings scheduled at this time. Once the Court schedules the fairness hearing, a copy of the Court's order will be posted on www.sagaftrahealthplansettlement.com.

(3) Any proposed or final notification to class members.

The proposed Notice of Proposed Class Action Settlement submitted to the Court is enclosed as Exhibit 2 to the Settlement Agreement, which is included in Exhibit A.

(4) Any proposed or final class action settlement.

The Settlement Agreement entered into by the parties and as submitted to the Court is included in Exhibit A.

(5) Any settlement or other agreement contemporaneously made between class counsel and counsel for the defendants.

There are no agreements other than the Settlement Agreement contemporaneously made between Class Counsel and counsel for the Defendants.

(6) Any final judgment or notice of dismissal.

Final judgment has not yet been entered. Once the Court issues its Final Approval Order and Judgment, a copy of the Court's orders will be posted on www.sagaftrahealthplansettlement.com.

(7) A reasonable estimate of the number of class members residing in each State and the estimated proportionate share of the claims of such members to the entire settlement.

A table with reasonable estimates of the number of Class Members residing in each State, according to the Plan's records, is included on the enclosed CD-ROM as **Exhibit C**. It is not possible to estimate each Class Member's proportionate share of the Settlement at this time because: (i) the portion of the Net Settlement Amount to be allocated to certain Class Members will be determined by a Settlement Administrator at a later date, and (ii) the component of the

Settlement that provides for up to eight years of additional allocations to the HRA Accounts of certain Class Members is variable and not yet quantifiable.

(8) Any written judicial opinion relating to the materials described in (3) through (6).

There are no written judicial opinions relating to the materials described in sections (3) through (6) at this time.

If you have questions about this notice, the lawsuit, or the enclosed materials, please do not hesitate to contact me.

Very truly yours,

Myron D. Rumeld

Enclosures

EXHIBIT 5

Cost Consultant RFP Process

A request for proposal ("RFP") will be sent to at least four of the following firms:

- Segal
- Horizon
- WTW
- Milliman
- Buck
- ClaimInformatics

The RFP will describe its purpose as seeking to identify a firm to review the SAG-AFTRA Plan's benefits, vendor agreements, and the cost-savings measures undertaken by the Plan over the last two to three years, as set forth in the attached memorandum, and then advise and make recommendations on potential additional measures to reduce the cost of providing the benefits currently available under the Plan without reducing the quality of coverage to participants.

Request for proposal will ask questions in the following categories:

- Organizational background
- Proposed service team
- Proposed conflicts of interest
- Investigations, litigation and audits
- Methodology
- Qualifications, including Taft-Hartley experience
- Reporting
- Fees
- Representative clients/references
- Distinguishing characteristics of consultant
- Cybersecurity

Responses to proposal will be summarized in comparative format for the Board's review.

The Board will review and select at least two finalists for interviews and then select the Cost Consultant.

EXHIBIT 6

PLAN OF ALLOCATION FOR NET SETTLEMENT AMOUNT

The Net Settlement Amount will be paid or allocated to Senior Performers and their age 65+ spouses (including surviving spouses) who lost active or secondary health coverage from the Plan in 2021 or 2022 solely due to the 2020 Amendments. (Each of the Senior Performers and their age 65+ spouses will receive the targeted amount.) The targeted amount of these payments or allocations are as follows:

- **$4,400** - For Senior Performers and their age 65+ spouses who received active health coverage from the Plan in December 2020 but did not qualify for active coverage in 2021 due to the elimination of the Dollar Sessional Rule in the 2020 Amendments.

- **$2,200** - For Senior Performers and their age 65+ spouses who received active health coverage from the Plan in December 2020 but did not qualify for active coverage in 2021 solely due to the elimination of the age and service rules and/or raising of the earnings eligibility thresholds to qualify for health coverage as part of the 2020 Amendments.

- **$1,100** - For Senior Performers and their age 65+ spouses who received active health coverage from the Plan in December 2020 and who qualified for active health coverage in 2021 but did not qualify for active coverage in 2022 solely due to the 2020 Amendments.

- **$400** - For Senior Performers and their age 65+ spouses who received secondary health coverage from the Plan in December 2020 but did not receive secondary coverage in 2021 solely due to the 2020 Amendments.

These target amounts have been set based on information provided by the Plan with respect to the number of Senior Performers and age 65+ spouses who are entitled to receive payment for the reasons set forth in each of the categories identified above. The Plan represents that it conducted a reasonable investigation and believes that the information it provided is accurate.

Within twenty-five (25) days after the later of the Settlement Effective Date or after the Court's award of Attorneys' Fees, Costs, and Service Awards becomes Final, and the amount available for distribution from the Net Settlement Amount can be quantified, Lead Class Counsel, with the assistance of the Settlement Administrator, shall evaluate whether there are sufficient funds to make an upward *pro rata*

adjustment to the targeted amount payments or allocations set forth above, or if a downward *pro rata* adjustment is necessary, given the amount of Administrative Expenses that remain unpaid or expect to be incurred in the future. Lead Class Counsel shall notify the Settlement Administrator and Counsel for Defendants of their decision regarding any *pro rata* adjustments to the targeted amounts for payment or allocation, who shall implement Lead Class Counsel's decision in a manner consistent with this Settlement Agreement. Any disagreements with Lead Class Counsel's decision shall be communicated within ten (10) days, and any unresolved disagreements shall be mediated before Robert Meyer, Esq. and, if no agreement is reached, submitted thereafter to the Court for resolution.

EXHIBIT 7

2021 AMENDED RESTATED AGREEMENT AND DECLARATION OF TRUST ESTABLISHING THE SAG-AFTRA HEALTH FUND

WHEREAS, certain employers of motion picture actors and extras and the Screen Actors Guild, Inc. ("SAG") entered into the Screen Actors Guild-Producers Health Plan Trust Agreement on February 1, 1960, as amended and restated from time to time ((the "SAG Trust"); and

WHEREAS, the SAG Trust established the Screen Actors Guild-Producers Health Fund (the "SAG Health Fund"); and

WHEREAS, certain employers and the American Federation of Television and Radio Artists ("AFTRA") entered into the Agreement and Declaration of Trust on November 16, 1954, as amended and restated from time to time (the "AFTRA Trust") (together with the SAG Trust, the "Trusts"); and

WHEREAS, the AFTRA Trust established the AFTRA Health Fund (the "AFTRA Health Fund"); and

WHEREAS, SAG and AFTRA merged and became "SAG-AFTRA" effective March 30, 2012; and

WHEREAS, the SAG Board and the AFTRA Board merged the SAG Health Fund and the AFTRA Health Fund pursuant to the authority vested in each of the Boards under their respective Trust Agreements, renamed the surviving SAG Health Fund the "SAG-AFTRA Health Fund" and adopted the Restated Agreement and Declaration of Trust Establishing the SAG-AFTRA Health Fund (the "2017 Agreement"), effective January 1, 2017;

WHEREAS, the Board of Trustees of the SAG-AFTRA Health Fund ("Board") continues to maintain the SAG-AFTRA Fund's plan of benefits and, in addition, has determined to create a new retiree-only health reimbursement account plan to be funded by the SAG-AFTRA Health Fund, as set forth herein; and

WHEREAS, the Board desires to amend and restate the 2017 Agreement to reflect the new retiree-only plan in addition to the plan of benefits for active participants and to reflect certain other agreed-upon changes.

NOW, THEREFORE, the Board hereby amends and restates the 2017 Agreement, respectively, as follows.

ARTICLE I.

DEFINITIONS

Whenever used in this Agreement, unless the context otherwise requires, the following words shall have the respective meanings set forth below:

Section 1. "Active Plan" shall mean the detailed rules and regulations of the SAG-AFTRA Health Fund plan of benefits, any amendments or modifications thereto from time to time adopted by the Board, setting forth the eligibility for medical, death, health and welfare benefits and related benefits and the nature, type, form, amount and duration of such benefits to be provided to Participants (other than Senior Performers (with the exception of life insurance) and Medicare-eligible Surviving Spouses), their dependents and Senior Performers' non-Medicare-eligible dependents, or Beneficiaries satisfying the eligibility rules of such plan. All such benefits under the Active Plan shall be funded under the SAG-AFTRA Health Fund. The name of the Active Plan is the SAG-AFTRA Health Plan.

Section 2. "Agreement" shall mean this 2021 Amended Restated Agreement and Declaration of Trust Establishing the SAG-AFTRA Health Fund, as may be amended from time to time.

Section 3. "AMPTP" shall mean the Alliance of Motion Picture and Television Producers, Inc.

Section 4. "Beneficiary" shall mean a person who is (i) legally entitled to receive life insurance and accidental death and dismemberment benefits under the SAG-AFTRA Health Fund because of his or her designation for such benefits, or (ii) legally entitled to, and receiving, or is entitled to receive such benefits by operation of law.

Section 5. "Benefit Consultant" shall mean the organization retained by the Board to provide day-to-day actuarial consulting services to the Health Fund.

Section 6. "Board" shall mean the individuals who, from time to time, acting collectively as the Board of Trustees under this Agreement, are appointed to control and manage the operation and overall administration of the SAG-AFTRA Health Fund and of the Plans. The Board shall also be the "named fiduciary" (as that term is defined in Section 402(a)(2) of ERISA) and the "administrator" (as that term is defined in Section 3(16)(A) of ERISA) of the Health Fund and the Plans.

Section 7. "Board Co-Chairs" shall mean the Chair and Co-Chair of the Board.

Section 8. "Code" shall mean the Internal Revenue Code of 1986, as from time to time amended, and all rules and regulations promulgated pursuant thereto.

Section 9. "Collective Bargaining Agreement" shall mean either (i) a

collective bargaining agreement between an Employer and SAG-AFTRA or any of its predecessor unions or (ii) a participation agreement or other written agreement if the Employer is SAG-AFTRA, the Screen Actors Guild-Producers Pension Plan for Motion Picture Actors (the "SAG Pension Plan"), the AFTRA Retirement Fund, or the SAG-AFTRA Foundation requiring such Employer to make contributions to the SAG-AFTRA Health Fund on behalf of its covered employees, which is in full force and effect and is acceptable to the Board in accordance with any requirements, standards, rules and regulations which may be adopted by the Board from time to time. Any such Collective Bargaining Agreement shall be deemed to incorporate, specifically, the terms and conditions of this Agreement, and by executing such Collective Bargaining Agreement, each Employer that is a party to such agreement thereby agrees to comply with, and be bound by, each and every provision of the SAG-AFTRA Health Fund and this Agreement (as such documents may be amended by the Board from time to time).

Section 10. "Collective Trust" shall mean any group, pooled, common, commingled or collective trust fund maintained by a bank, insurance company, trust company or broker-dealer, in which assets of employee benefit plans subject to ERISA and the Code may be invested. The trustees of such Collective Trust shall become trustees of the allocable share of the Health Fund assets transferred and deposited with such Collective Trust, and shall have sole and exclusive authority and discretion to manage and control (including the power to invest and reinvest) such Collective Trust assets. The Board shall not be liable for any act or omission of any trustee of a Collective Trust or be under any obligation to invest or otherwise manage any Health Fund assets that have been transferred thereto. The provisions of the agreement establishing such Collective Trust shall be deemed to be incorporated by reference in this Agreement (to the extent that the provisions thereof are not inconsistent with the terms of this Agreement and do not violate ERISA, the Code or other applicable law).

Section 11. "Commercials Collective Bargaining Agreement" shall mean the 2019 SAG-AFTRA Commercials Contract or a successor thereof.

Section 12. "Committee" shall mean the Administration Committee, the Appeals Committee, the Audit and Collections Committee, the Benefits Committee, the Investment Committee, the Legal Committee or any other committee duly appointed and authorized by the Board to act pursuant to this Agreement.

Section 13. "Committee Co-Chairs" shall mean the Chair and Co-Chair of a Committee.

Section 14. "Continuation Value" shall mean the number of future months of benefit and administrative expenses, as projected by the Benefit Consultant, that the Health Fund's reserves (net of claims incurred but not reported ("IBNR")) will fund the plans of benefits and their operations.

Section 15. "Covered Performer" shall mean an individual employed by an Employer to render services pursuant to the terms of a Collective Bargaining Agreement between an Employer and SAG-AFTRA requiring contributions to be made to the Health Fund.

Section 16. "Custodian" shall mean one or more banks, trust companies, insurance companies or broker-dealers selected by the Board.

Section 17. "Employer" shall mean any employer (including, without limitation, SAG-AFTRA, the SAG-AFTRA Foundation, the SAG Pension Plan and the AFTRA Retirement Fund) that satisfies the conditions for participation set forth in Article IX and that heretofore, or hereafter, is required to contribute to the SAG-AFTRA Health Fund on behalf of its Covered Performers, Plan Office Participants or SAG-AFTRA Participants pursuant to a Collective Bargaining Agreement, and/or on behalf of Non-Bargained Participants pursuant to a letter of agreement. Employers shall not include unincorporated, self-employed persons or sole proprietorships with no employees other than the sole proprietor, or partnerships that have no employees other than the partners.

Section 18. "Employer Appointer" shall mean the AMPTP, JPC, Network Appointers and Record Company Appointers, as applicable.

Section 19. "Employer Trustee" shall mean each individual designated as an Employer Trustee pursuant to Article III and his or her successor.

Section 20. "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as from time to time amended, and all rules and regulations promulgated thereunder.

Section 21. "HRA Account" shall mean the notional account established for an eligible Senior Performer, the Spouse of an Eligible Senior Performer, or the Surviving Spouse of a Senior Performer under the HRA Plan for the reimbursement of eligible medical expenses as set forth in the HRA Plan. HRA Accounts shall receive such allocations from the Health Fund as the Board may determine from time to time.

Section 22. "HRA Plan" shall mean the detailed rules and regulations of SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan, any amendments or modifications thereto from time to time adopted by the Board, setting forth the eligibility for HRA Accounts and the nature of such HRA Accounts and reimbursements to be made with respect to such Accounts to be provided to Senior Performers as defined in the HRA Plan.

Section 23. "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended, along with implementing regulations promulgated by the Secretary of the Department of Health and Human Services ("HHS"), including the "Privacy Rule" (45 CFR Parts 160 and 164, Subparts A and E) and the "Security Rule" (45 CFR Part 160 and 164, Subparts A and C), as amended.

Section 24. "JPC" shall mean the Joint Policy Committee on Broadcast Talent Union Relations.

Section 25. "Instructions" shall mean written communications signed by an authorized person (including, without limitation, communications received

electronically, by facsimile or by a similar system whereby the receiver of such communication is able to verify with a reasonable degree of certainty the identity of the sender of such communication).

Section 26. "Investment Consultant" shall mean any person or entity that has been retained by the Board or its delegate to advise the Investment Committee with respect to the Health Fund investments.

Section 27. "Investment Manager" shall mean any person or entity that has been appointed by the Investment Committee pursuant to this Agreement to manage, acquire or dispose of any securities or other property of the SAG-AFTRA Health Fund that is, and has acknowledged in writing to the Board that it is (i) a fiduciary (within the meaning of ERISA Sections 3(21) and 3(38) with respect to the assets held under its Investment Manager Agreement and (ii) either an investment manager registered in good standing under the Investment Advisers Act of 1940, a bank (as defined in said Act), located within the United States, or an insurance company qualified under the laws of more than one state to manage, acquire or dispose of employee benefit plan assets. The Board shall have the right, in its sole and absolute discretion, to appoint the Custodian as an Investment Manager for all, or a portion, of the Health Fund's Securities or other property.

Section 28. "Investment Manager Account" shall mean that portion of the Health Fund that has been segregated by the Board for investment management by one or more Investment Manager(s), each of which shall constitute a separate Investment Manager Account.

Section 29. "Merger Agreement" shall mean the AFTRA Health Fund and Screen Actors Guild—Producers Health Plan Merger Agreement providing for the merger of the SAG Health Fund and the AFTRA Health Fund, effective as of January 1, 2017.

Section 30. "Network Appointers" shall mean American Broadcasting Companies, Inc., NBC, Inc., CBS Broadcasting Inc. and Twentieth Century Fox Film Corporation.

Section 31. "Non-Bargained Participant" shall mean the following individuals who are eligible to participate in the Active Plan by virtue of a letter agreement and on whose behalf contributions are made to the Health Fund: (i) an individual who was a dancer and who qualified for health coverage as a dancer under the Active Plan (or the plan of benefits under the SAG Health Fund or AFTRA Health Fund) for at least five (5) years and who is currently engaged as a choreographer, but not as a dancer or in any other category covered by a collective bargaining agreement between SAG, AFTRA or SAG-AFTRA and Employers, (ii) an individual who had contributions made on his or her behalf to the Health Fund (or the SAG Health Fund or AFTRA Health Fund) in five (5) of the last ten (10) years as a dancer and who is currently engaged as an assistant choreographer, (iii) a warm-up performer, (iv) a pilot of an aircraft that is not photographed and (v) any other individual covered by a letter agreement between SAG-AFTRA and the AMPTP or

the JPC, or by a letter agreement between SAG-AFTRA and any other employer that is approved by the Board.

Section 32. "Participant" shall mean (i) a Covered Performer, Non-Bargained Participant, Plan Office Participant or a SAG-AFTRA Participant participating in the Active Plan and (ii) a Senior Performer, Spouse of a Senior Performer or Surviving Spouse of a Senior Performer participating in the HRA Plan.

Section 33. "Plan" shall mean the Active Plan or the HRA Plan.

Section 34. "Plan Office Participant" shall mean an employee of the SAG Pension Plan or the AFTRA Retirement Fund who has met the eligibility requirements of the Active Plan.

Section 35. "Real Property" shall mean, in general, all real property, and interests therein, of whatever nature and personal property, both tangible and intangible, directly or indirectly associated or connected with the use of real property (including, without limitation, direct or indirect equity or other investments in real estate, interest in general and limited partnerships, insurance contracts pertaining to real property investments, and other joint ventures having an interest in real property, participating or convertible mortgages or other debt instruments convertible into interest in real property by the terms thereof, options to purchase real estate, leaseholds, leasebacks, investments in group, collective or commingled real estate funds, and investments in securities issued by real estate investment trusts). For purposes of this definition, real property includes any property treated as real property either by local law or state law or for federal income tax purposes.

Section 36. "Record Company Appointers" shall mean Warner Bros. Records, Atlantic Recording Corporation, Sony Music Entertainment, UMG Recording, Inc., Capitol Records, LLC and Hollywood Records, Inc., all of which collectively appoint a Trustee.

Section 37. "Retiree" shall mean former Covered Performers, Non-Bargained Participants, Plan Office Participants and SAG-AFTRA Participants, or former participants in the Active Plan or the predecessor SAG Health Plan or AFTRA Health Plan, who are at least age 65 and who have commenced receiving their pension benefits under either the SAG Pension Plan or the AFTRA Retirement Fund.

Section 38. "SAG-AFTRA" shall mean Screen Actors Guild-American Federation of Television and Radio Artists.

Section 39. "SAG-AFTRA Health Fund" or "Health Fund" shall mean all cash, securities and other property owned by the Health Fund which, at the time of reference, shall have been deposited into the trust account maintained pursuant to Article II of this Agreement or held for the trust account by a Custodian, including any portion thereof which has been segregated in an Investment Manager Account or held under a group trust or Collective Trust and any Real Property at any time held by such trust account.

Section 40. "SAG-AFTRA Participant" shall mean an individual who is an employee of SAG-AFTRA and who has met the eligibility requirements of the Active

Plan. The term "SAG-AFTRA Participant" also includes a SAG-AFTRA Foundation Participant. The term "SAG-AFTRA Foundation Participant" means an employee of the SAG-AFTRA Foundation who has met the eligibility requirements of the Active Plan.

Section 41. "Securities" shall mean all Health Fund securities of any and every kind wherever situated and any rights or interests therein, including, but not limited to (i) common and preferred stocks, including the stock of an Employer (or any parent subsidiary or other person associated or affiliated therewith) to the extent permitted under ERISA, (ii) obligations of the United States Government or any government of a state of the United States (and any of their agencies or instrumentalities, (iii) bonds, debentures, notes and other evidences of indebtedness, including bonds, debentures or notes of an Employer (or any parent, or other person associated or affiliated therewith) to the extent permitted by ERISA, (iv) savings and time deposits (including, without limitation, any deposits bearing a reasonable rate of interest that the Custodian, or a bank or similar financial institution appointed as a trustee or custodian hereunder by the Board, makes in itself or in any parent, subsidiary or other person associated or affiliated therewith, to the extent permitted by law), (v) bankers' acceptances, (vi) commercial paper (including participation in polled commercial paper accounts), (vii) Collective Trusts, (viii) foreign securities (including, without limitation, American Depositary Receipts), (ix) participation units or certificates issued by investment companies or investment trusts, (x) collateral trust notes, (xi) equipment trust certificates, (xii) life insurance, retirement income, guaranteed investment, annuity and other forms of group or individual insurance policies, contracts or agreements, (xiii) bank investment contracts, (xiv) leaseholds, leasebacks, fee titles, mortgages and any other interests in Real Property, and (xv) any financial futures, forwards, options, warrants, repurchase and reverse-purchase agreements traded on a regulated securities exchange or other instruments representing rights to receive, purchase, or subscribe for the same or evidencing or representing any other rights or interest therein appurtenant to such Securities.

Section 42. "Senior Performer" shall mean an individual who meets the definition of Senior Performer in the Plans, as same may be amended from time to time.

Section 43. "Trustee(s)" shall mean collectively the individual Employer Trustees, the individual Union Trustees and their successors and assigns.

Section 44. "Union Trustee" shall mean any individual designated as a Union Trustee pursuant to Article III and his or her successor.

ARTICLE II.

NAME, PURPOSE AND OPERATION OF THE HEALTH FUND

Section 1. Name. There has been established, and there is hereby maintained, a trust known as the "SAG-AFTRA Health Fund."

Section 2. Purpose. The Health Fund is established for the exclusive purpose of providing certain health and welfare benefits (which may include medical, death, and other related benefits that may be provided by an organization exempt from income tax under Code Section 501(a) by virtue of being an organization described in Code Section 501(c)(9)) to Participants and their Beneficiaries, and shall further provide the means for financing and maintaining the operation and administration of the Health Fund and the Plans in accordance with this Agreement, the Plans, ERISA, the Code and other applicable law.

Section 3. Operation.

(a) It is intended that the Health Fund shall be established and operated in a manner that shall qualify it as an organization exempt from income taxation under Code Section 501(a). Notwithstanding anything to the contrary contained herein, the Health Fund shall be operated exclusively for such purposes as will comply with Code Section 501(a). To the extent that anything herein is inconsistent with the Code, this Agreement shall be deemed amended in such fashion as will implement the purposes of the Health Fund while continuing to comply with the requirements of the Code.

(b) It is further intended that the Health Fund shall be established and operated in a manner that complies with ERISA. To the extent that anything herein is inconsistent with ERISA, this Agreement shall be deemed amended in such fashion as will implement the purposes of the Health Fund while continuing to comply with the requirements of ERISA.

(c) The Health Fund has also been established as a "jointly administered" welfare fund within the meaning of, and in accordance with, Section 302(c) of the Labor Management Relations Act of 1947, as amended.

(d) Except as provided in Article V, Section 6, no part of the Health Fund, other than such part as is required to pay taxes, fees and expenses of the administration and operations of the Plans, shall, prior to the satisfaction of all liabilities with respect to the Participants and Beneficiaries, ever be used for or diverted to purposes other than for the exclusive benefit of Participants and Beneficiaries.

ARTICLE III.

TRUSTEES

Section 1. Administration by Trustees. The operation and administration of the Health Fund shall be the joint responsibility of forty (40) Trustees who shall constitute the Board. Of these, twenty (20) shall be Employer Trustees and twenty (20) shall be Union Trustees. Union Trustees shall be appointed by SAG-AFTRA. Employer Trustees shall be appointed by Employer Appointers as follows: ten (10) Employer Trustees shall be appointed by the AMPTP, five (5) Employer Trustees shall be appointed by the JPC, one (1) Employer Trustee shall be appointed by the Record Company Appointers jointly and four (4) Employer Trustees shall be appointed by the Networks Appointers (with one (1) appointee for each Network Appointer). The Board shall be the named fiduciary of the Plans.

Section 2. Acceptance of Trusteeship. By accepting trusteeship, any original, substitute or new Trustee agrees to act in such capacity in accordance with the provisions hereof.

Section 3. Term of Trustees. Each Trustee appointed hereunder shall continue to serve as such until his or her death, incapacity, resignation, or removal.

Section 4. Substitution and Appointment of Successor Trustees.

(a) SAG-AFTRA or an Employer Appointer responsible, in the first instance, for the appointment of any Trustee, may remove such Trustee and appoint a substitute Trustee at any time in its discretion, with or without cause, by written notice given to the Chief Executive Officer who, upon receipt of such notice, shall promptly notify all Trustees then in office of such removal and substitution. In addition, a Union Trustee who dies, resigns or becomes incapacitated may be replaced by SAG-AFTRA, and an Employer Trustee who dies, resigns or becomes incapacitated may be replaced by the Employer Appointer that appointed that Trustee, upon written notice to the Chief Executive Officer. Any substitute or successor Trustee under this Agreement shall immediately, upon his or her appointment as a Trustee and his or her acceptance of the trusteeship, become vested with all rights, powers, privileges and duties of a Trustee hereunder with like effect as if originally named a Trustee.

(b) Written notice required hereunder shall contain the name(s) of the Trustee(s) to be replaced or succeeded and the name(s) of the successor Trustee(s) appointed, and the effective date of such appointment or appointments.

Section 5. Resignations. A Trustee may resign by giving notice in writing to the Chief Executive Officer, who, upon receipt of such notice, shall

notify the remaining Trustees thereof. Such resignation shall become effective upon the date indicated by the Trustee (on or after the date of the notice), unless a successor Trustee shall have been appointed earlier, pursuant to Article III, Section 4, above. The resigning Trustee shall be fully discharged (to the extent permitted by law) from further duty or responsibility hereunder upon the effective date of the resignation.

Section 6. Use of Corporate Trustee.

(a) At any time and from time to time, the Board may appoint, as a Corporate Trustee or Custodian, a bank, insurance company, trust company or broker/dealer located within the United States to act on behalf of the Health Fund, and exercise the powers set forth in Article IV, Section 1, hereof.

(b) The Board may issue Instructions, delegating to the Corporate Trustee or Custodian:

(1) the power to hold the assets of the Health Fund as sole trustee of a trust separate from the Health Fund, created by this Agreement;

(2) the power to invest and reinvest such assets in the Corporate Trustee's sole discretion (as may be specifically delegated to it by the Board);

(3) the power to loan the Health Fund's Securities; and

(4) such other duties and powers consistent with this Agreement as the Board may deem advisable.

(c) The Board may enter into and execute a trust, custodial, insurance or other written agreement with the Corporate Trustee or Custodian of the Health Fund, which agreement shall contain such provisions as the Board may deem advisable. Upon the execution of such an agreement with the Corporate Trustee or Custodian, the Board may transfer and convey to the Corporate Trustee or Custodian, any part or all of the Securities, Real Property, or other property of the Health Fund acceptable to the Corporate Trustee or Custodian, and thereupon, to the extent permitted by law, the Board shall be forever released and discharged from any responsibility or liability with respect to such assets so transferred as to any period subsequent to such transfer and with respect to the investment and reinvestment thereof by the Corporate Trustee or Custodian. Notwithstanding such transfer, the Board shall continue to carry on its administrative and supervisory functions under the Plans, this Agreement and any other written agreement in accordance with

the provisions of the Plans, this Agreement and any other written agreement.

(d) The Board may, at any time, remove the Corporate Trustee or Custodian in the manner provided in this Agreement or the agreement between the Board and the Corporate Trustee or Custodian. The Corporate Trustee or Custodian shall, if and when removed by the Board, cause to be transferred to the Board any Securities, Real Property, personal or other property or records then in its possession, along with a final accounting of the Securities, Real Property, and personal or other property of the Health Fund held and/or managed by the Corporate Trustee or Custodian pursuant to said agreement.

Section 7. Indemnification and Fiduciary Insurance. Except as may otherwise be required by ERISA or other applicable law:

(a) The Trustees shall not be personally answerable for any liabilities or debts of the Plans or Health Fund incurred by them as Trustees, but said debts and liabilities shall be paid out of the Health Fund;

(b) No Trustee shall be personally liable for any error of judgment or for any Claims (as that term is defined in paragraph (e) below) arising out of any act or omission of such Trustee or for any acts or omissions of any other Trustee, or any agent elected or appointed by or acting for the Trustees, except as provided in paragraph (e) below;

(c) The Trustees shall not be personally liable for the proper application of any part of the Health Fund or for any other liabilities arising in connection with the administration of the Plans or Health Fund, except as provided in paragraph (e) below;

(d) The Trustees may from time to time consult with legal counsel and shall, to the extent permitted by ERISA or other applicable law, be fully protected in acting upon the advice of said counsel with respect to legal questions affecting the Plans or Trust; and

(e) In addition to provisions concerning Trustees' personal liability set forth elsewhere in this Section, and to the extent not covered by insurance and permitted (and subject to whatever conditions are imposed) by ERISA and other applicable law, the Board is authorized, in its sole and absolute discretion, to use the Health Fund's assets to protect, indemnify and hold harmless the Trustees, each individual Trustee, each Committee member, and the Chief Executive Officer and all other employees and other agents (and their respective spouses, estates, heirs and assigns), from and against

any and all liabilities, damages, taxes, judgments, debts, assessments, penalties, losses, expenses, costs and claims, including, without limitation, reasonable attorneys' fees; court costs; actuarial and related consulting costs; accounting and auditing costs; investment management, trustee and custodian costs; insurance premiums and related costs; and other professional fees (hereinafter collectively referred to as "Claims") incurred by any such person(s) as a result of any act, omission or conduct committed by said person(s) in connection with the performance of his or her powers, duties, responsibilities or obligations under the Health Fund, the Plans, this Agreement, ERISA, the Code or other applicable laws, except with respect to Claims brought against such person by the Health Fund (or by the Board on behalf of the Health Fund) for breach of fiduciary duty under ERISA and Claims arising from such person's own bad faith, fraud and/or willful misconduct; provided, however, that: (i) such person has first exhausted efforts to obtain reimbursement of such Claims from any available insurance coverage and assigned to the Health Fund the right to seek reimbursement from the insurance carrier of any expenses or liabilities incurred; and (ii) to the extent any such person is adjudged liable for any such Claims pursuant to a final, non-appealable order of a court of competent jurisdiction for a fiduciary breach under ERISA, bad faith, fraud and/or willful misconduct, the person shall promptly reimburse the Health Fund for all such liabilities, including the Claims and the cost of the legal fees advanced by the Health Fund in defense of such Claims, plus appropriate interest, to be determined by the Board (other than a Trustee adjudged liable for such Claims).

(f) Except as otherwise provided by law each Trustee shall be (i) fully protected in acting upon any instrument, certificate, or paper believed by him or her to be genuine and to be signed or represented by a duly authorized person or persons, and shall be under no duty to make any investigation or inquiry as to any statement contained in any such writing, but may accept the same as conclusive evidence of the truth and accuracy of the statements therein contained; and (ii) entitled to rely conclusively upon, and shall be fully protected in any action taken by him or her in good faith in relying upon any opinions or reports furnished to him or her by any actuaries, accountants, attorneys, consultants or specialists appointed or designated by the Board in connection with the administration of the Plans or the Health Fund or the investment of Health Fund assets.

Section 8. Bonding. Any person required to be bonded under the provisions of ERISA shall be bonded under a fidelity bond issued by an insurance carrier in the amount required by ERISA Section 412. The Board shall, in its sole discretion, have the authority to require the bonding of any other employee of the Health Fund and to require

bonds above the minimum amount. The cost of premiums for such bonds shall be paid out of the Health Fund.

Section 9. Fiduciary Insurance. The Board shall purchase with Health Fund assets and maintain a policy or policies of fiduciary liability (or errors and omissions) insurance covering the Health Fund, the Trustees, the Chief Executive Officer and, if the Board so determines, any other person to whom a fiduciary responsibility with respect to a Plan or the Health Fund has been allocated or delegated, to protect such persons against any and all Claims (as that term is defined in Article III, Section 7(e)) arising out of such individual's breach of his or her fiduciary or other responsibility to a Plan or the Health Fund. The insurance contemplated herein shall permit recourse by the insurer against the fiduciary in case of a breach of his or her fiduciary obligations or responsibilities to the Health Fund (although the insurer shall have the right to eliminate such recourse by the payment of an additional premium by such fiduciary or by an entity other than the Health Fund).

Section 10. Other Insurance. The Board may purchase, with Health Fund assets, and maintain a policy or policies of property, casualty, employment practices liability and other types of insurance covering the Health Fund (and its assets, including, without limitation, physical property), the Trustees, the Chief Executive Officer, Health Fund employees and/or any other individuals deemed appropriate by the Board, in such amounts, against such risks, and with such deductibles as, in the Board's judgment, shall be appropriate in connection with the operation or administration of the Health Fund.

ARTICLE IV.

POWERS AND DUTIES

Section 1. General. In addition to, and not by way of limitation of, such other powers as are set forth herein or otherwise conferred by law, in the administration of the Health Fund, the Board is authorized and empowered as follows:

(a) To invest and reinvest such part of the assets and the income of the Health Fund as in its sole judgment is advisable, in such Securities and other investments, including, without limitation, bonds, common and preferred stocks, notes, mortgages, trust deeds or other property (real, personal or mixed), tangible and intangible, as it may select in its sole discretion, whether or not the same be authorized by law for the investment of trust funds generally;

(b) To invest all or a portion of the Health Fund in, and to organize, trusts, corporations, general partnerships, limited partnerships, limited liability companies or corporations, investment companies, venture capital companies and partnerships and/or joint ventures to acquire and hold title to any Securities or real or personal property or interests in such securities or property held in connection with the Plans or Health Fund;

(c) To sell, exchange, lease, convert, grant options on, redeem, convey or dispose of any property, whether real or personal, at any time forming a part of the Health Fund upon such terms as it may deem proper, and to execute and deliver any and all authorizations, instruments of conveyance and transfer in connection therewith;

(d) To vote in person or by proxy Securities held by the Health Fund, and to exercise, or cause to be exercised, any other rights of whatsoever nature pertaining to Securities or any other property held hereunder;

(e) To exercise options, conversion privileges, or subscription rights, in connection with Securities and to make payments therefor;

(f) To use or cause to be used the facilities of the Depository Trust Company or the Federal Reserve Book-Entry System, subject to such rules, regulations and orders as may be adopted by the Securities and Exchange Commission thereunder;

(g) To cause any Securities or real or other property at any time held by the Health Fund to be registered in the name of the

Board, or in the name of a Custodian, a trustee or nominee (with or without the disclosure of any fiduciary relationship), and to hold in bearer form any Securities or other property at any time held in the Health Fund so that they will pass by delivery;

(h) To release and deliver Health Fund Securities to the issuer thereof (or its agent) when such Securities are called, redeemed, retired or otherwise become payable;

(i) To exercise any conversion privileges, subscription rights and voting rights, as well as any other right to make an investment decision (including, without limitation the voting of proxies and exercise of all other rights appurtenant to Securities), either in person by limited or general power of attorney, or by proxy, with respect to all Securities or other property, and generally to exercise with respect to Health Fund assets all other rights, powers, and privileges as may be lawfully exercised by any person owning similar property in its own right, unless the responsibility for exercising such rights, powers, or privileges has been delegated to an Investment Manager pursuant to Article VII;

(j) To consent, join or participate in, or to dissent from or oppose, dissolutions, reorganizations, consolidations, mergers, sales, recapitalizations, liquidations, leases, mortgages, transfers, pledges or other changes affecting Securities or other property held by the Health Fund and in connection therewith, and to pay assessments, subscriptions or other charges;

(k) To deposit any Securities or other property with any protective, reorganization or similar committee, and to pay or agree to pay part of the expenses and compensation of any such committee and any assessments levied with respect to such Securities or property so deposited;

(l) To appoint and retain one or more bank, trust company, broker/dealer, or similar depository to be designated and to act as a trustee and/or Custodian for all or any part of the Health Fund assets, to define the scope and responsibilities of each trustee or Custodian, and to keep property or Securities in the custody of such trustee or Custodian;

(m) To invest all or part of the Health Fund in deposits in any bank, trust company, broker/dealer or similar financial institution supervised by the United States or any State (including deposits of a Custodian, to the extent permitted by ERISA);

(n) To appoint ancillary or subordinate trustees or custodians to hold title to or other indicia of ownership of foreign Securities or other property of a Plan or the Health Fund in foreign jurisdictions, and to define the scope of the responsibilities of each such ancillary or subordinate trustee or custodian; provided, however, that such ancillary or subordinate trustees or custodians shall comply with all requirements of ERISA Section 404(b), and the regulations promulgated pursuant thereto, in the event that Health Fund assets are invested or reinvested in foreign Securities;

(o) To enter into any and all contracts and agreements or to make, execute and deliver any and all conveyances, indemnities, waivers, releases or other instruments in writing to carry out the terms of this Agreement and for the administration of the Health Fund and Plans, and to do all acts it deems necessary or advisable. Such contracts, agreements and acts shall be binding and conclusive on the parties hereto and any Participant or Beneficiary. Without limiting the foregoing, the Board shall have the power to share administration and other expenses and disbursements with any other plan or fund on the basis established by the Board, in accordance with ERISA;

(p) To (i) compromise, settle, arbitrate and release any debts or obligations owing to or from the Health Fund or Plans or any claims or demands in favor of or against the Health Fund or Plans, (ii) enforce or abstain from enforcing any right, claim, debt or obligation, (iii) reduce or increase the rate of interest on extension or otherwise modify, foreclose upon default or enforce any such obligation, and (iv) sue or defend suits or legal or dispute resolution proceedings against the Health Fund, its employees, the Plans or the Trustees in connection with any matter in any court or before any arbitrator, mediator or administrative agency, body or tribunal, in all cases on such terms and conditions as the Board may deem advisable;

(q) To implement a funding policy and to establish, accumulate and maintain reserves in such amounts as are adequate in the opinion of the Board to carry out the purposes of the Plans;

(r) To borrow money in such amounts and upon such terms and conditions as shall be deemed advisable or proper by the Board to carry out the purposes of the Health Fund and Plans and to pledge any Securities or other property of the Health Fund for the repayment of any such loans;

(s) To hold part or all of the Health Fund assets uninvested;

(t) To pay out of the Health Fund assets, or provide for the payment of, all real and personal property taxes, income taxes and other taxes of any and all kinds levied and assessed under existing or future laws upon or with respect to the Health Fund or any money, property or Securities forming a part thereof;

(u) To do all acts, whether or not expressly authorized herein, which the Board may deem necessary or proper for the protection of the Health Fund;

(v) To lease or purchase such premises, supplies, materials and equipment and to hire, employ and retain such legal counsel, investment counsel, architects, engineers, contractors, consultants, property managers, insurance brokers and administrative, accounting, actuarial, clerical, and other experts, assistants or employees as in its discretion the Board may find necessary or appropriate in the performance of its duties, and to pay therefor such amounts as the Board deems proper;

(w) To pay all reasonable and necessary expenses of collecting Employer Contributions and administering the affairs of the Health Fund, including without limitation, all expenses which may be incurred in connection with the maintenance, operation and administration of the Plans and the Health Fund, including, but not limited to:

(i) the fees and compensation of actuaries, accountants, attorneys, auditors, consultants and any other professionals or persons retained by the Board or the Chief Executive Officer to render services to the Health Fund or Plans;

(ii) the fees, expenses and other costs of holding or investing the assets of the Health Fund;

(iii) the salary and expenses of the Chief Executive Officer and other Health Fund employees, and the fees and expenses of any Investment Manager, Investment Consultant or Custodian;

(iv) the expense of maintaining mailboxes, bank accounts and safety deposit boxes;

(v) the cost of implementing and maintaining any accounting, auditing, computer recordkeeping or any other systems which the Board or, pursuant to his or her authority, the Chief Executive Officer has determined to be necessary or appropriate for the establishment, operation or administration of the Health Fund or the Plans; and

(vi) reasonable and necessary expenses of the individual Trustees as set forth under Article W, Section 2.

(x) To construe the meaning of any provisions of the Plans, and any construction thereof adopted by the Trustees in good faith shall be binding upon SAG-AFTRA, the Employers, and all Participants and Beneficiaries and to delegate its construction authority under this subsection to the Claims Administrator of the HRA Plan;

(y) Generally to do all things, perform all acts (whether or not expressly authorized herein), execute all such instruments, adopt and promulgate all such reasonable rules and regulations, take all such actions and exercise all such rights and privileges as are necessary to carry out the terms of this Agreement or in the establishment, maintenance and administration of the Plans, and specifically but not limited to determining eligibility of, and delegating to the Claims Administrator of the HRA Plan its authority to determine eligibility of, Participants and their Beneficiaries for health and other benefits provided hereunder, requiring the payment of premiums by Participants, and determining the nature and extent of benefits to be provided by the Plans;

(z) To enter into such insurance contracts and policies and to pay or provide for the payment of premiums on such insurance contracts and policies, if any, as the Board may see fit to purchase to provide for the benefits to be provided hereunder; to assume and exercise all rights or privileges and benefits granted to the policy holder by the provisions of each such policy or allowed by the insurance carrier of such policy, and ownership thereof, and to agree with such insurance carrier to any alteration, modification or amendment of such policy, and to take any action with respect to such policy or the insurance provided thereunder which the Board in its discretion may deem necessary or advisable, and such insurance carrier shall not be required to inquire into the authority of the Trustees with respect to any such action;

(aa) To invest in units of any present or future common trusts or Collective Trusts (or otherwise deposit all or a portion of the Health Fund assets in such trusts) with respect to which the Health Fund is eligible to participate, and to withdraw any portion of the Health Fund assets so invested (provided that to the extent of the participation of the Health Fund in any Collective Trust, the provisions of the instrument or agreement establishing such trust shall be considered a part of this

Agreement to the extent not inconsistent with any provision of this Agreement);

(bb) To enter into agreements with other welfare benefit plans and trusts providing for the reciprocity or contributions and eligibility credit as between the Active Plan and such other plans and trusts or to merge the Health Fund and the Plans with other employee welfare benefit plans;

(cc) To allocate among the Trustees their responsibilities, obligations and duties with respect to the administration of the Health Fund and the management and control of the Health Fund's assets; provided, however, that the remaining Trustees shall not be liable for any loss resulting to the Health Fund resulting from the acts or omissions of those Trustees accepting the allocation of such specified fiduciary responsibilities (except as may otherwise be required by ERISA);

(dd) To (i) loan any Health Fund Securities to banks, trust companies, or nationally-recognized brokers or dealers and to employ agents and advisers in connection therewith; (ii) secure the same in any manner; (iii) cause the Health Fund to receive compensation therefor out of any amounts paid by or charged to the account of the borrower; (iii) cause any cash collateral to be invested in such a manner and at such times as the Board in its sole and absolute discretion deem appropriate; and (iv) during the term of any such loan, permit the loaned Securities to be transferred into the name of and voted by the borrower or others; provided, however, that such loans are fully consistent with ERISA and the Code; and

(ee) To retain one or more brokers, dealers or commission recapture agents.

Section 2. Compensation. The Trustees shall not receive compensation from the Plans or Health Fund for the performance of their duties hereunder, but shall be entitled to reimbursement for reasonable actual expenses incurred in the performance of their duties hereunder, including, in the discretion of the Trustees, traveling expenses to attend Board, Committee and educational meetings. Any other fiduciary shall be entitled to such compensation as may be agreed upon by the Board.

Section 3. Books of Account. The Board shall keep true and accurate books of account and records of all of its transactions, which shall be open to the inspection of each of the Trustees at all times and which shall be audited annually or more often, as the Board may determine, by a certified public accountant selected by the Board. A statement of the results of such audits shall be available at all times for inspection by SAG-AFTRA and the Employers at the principal office of the Health Fund.

Section 4. Execution of Documents. The Board Co-Chairs are authorized to jointly execute on behalf of the Board all documents, certificates, notices or other instruments necessary for the accomplishment of any action taken by the Board. The Board may authorize the Chief Executive Officer or any group of two or more Trustees composed equally of Employer Trustees and Union Trustees to jointly execute on behalf of the Board any certificate, notice, document or other instrument in writing. All persons, partnerships, corporations or associations may accept a document, certificate, notice or instrument signed in accordance with this Section as having been duly authorized by the Board and any such document, certificate, notice or other instrument so signed shall have the same force and effect as though signed by all of the Trustees.

Section 5. Deposits and Withdrawals. The Board (or such other person or entity acting on behalf of, and duly authorized by, the Board) is hereby designated as the entity authorized to receive Employer Contributions hereafter made to the Health Fund, and is hereby vested with all rights, title and interest in and to such monies and all interest accrued thereon and appreciation thereof. The Board agrees to receive all such payments, deposits, monies, policies or other properties and assets, and to hold the same in trust hereafter for the use and purposes of the Health Fund and the Plans, and may deposit all or a portion of such monies with such Custodians (or Corporate Trustee) as it may designate for this purpose. All deposits to, and withdrawals from, such account or accounts shall be made by any method necessary and convenient, including, but not limited to, wire transfers, electronic debits or checks. The Board may designate the Chief Executive Officer, or other individual, as the person or persons having the authority to make withdrawals from such account or accounts.

Section 6. Discretionary Authority.

(a) The Board (or, where applicable and duly authorized by the Board, the Chief Executive Officer, any Committee, or the HRA Claims Administrator to the extent of its authority) shall have the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply and interpret this Agreement, the Plans and any other Plan documents (including the AFTRA Trust and the AFTRA Plan and the SAG Trust and the SAG Plan) and to decide all matters arising in connection with the operation or administration of the Plans or the Health Fund and the investment of Health Fund assets.

(b) Without limiting the generality of the foregoing, the Board (or, where applicable and duly authorized by the Board, the Chief Executive Officer, any Committee, or the HRA Claims Administrator to the extent of its authority) shall have the sole and absolute discretionary authority to:

(i) take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plans to Participants or their Beneficiaries;

(ii) formulate, interpret and apply rules, regulations and policies necessary to administer this Agreement, the Plans or other Plan documents in accordance with their terms and to interpret and apply the provisions of the Collective Bargaining Agreements;

(iii) decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plans or other Plan documents;

(iv) resolve and/or clarify any ambiguities, inconsistencies and omissions arising under this Agreement, the Plans or other Plan documents;

(v) process, and approve or deny, benefit claims and rule on any benefit exclusions;

(vi) decide questions as to whether services rendered by Covered Performers, Non-Bargained Participants, Plan Office Participants and SAG-AFTRA Participants are services covered under the Health Fund and this Agreement; and

(vii) make decisions regarding whether contributions to the Health Fund made by Employers are properly payable to the Health Fund.

(c) All determinations made by the Board (or, where applicable and duly authorized by the Board, the Chief Executive Officer, any Committee, or the HRA Claims Administrator to the extent of its authority) with respect to any matter arising under the Plans, this Agreement and any other Plan documents shall be final and binding on all parties affected thereby.

ARTICLE V.

EMPLOYER CONTRIBUTIONS

Section 1. Rate of Employer Contributions. In order to carry out the purposes hereof, each Employer shall contribute to the Health Fund ("Employer Contributions"):

(a) The amount required by the Collective Bargaining Agreement with such Employer;

(b) With regard to an Employer that has a Collective Bargaining Agreement that provides for a single amount to be contributed to the AFTRA Health and Retirement Funds, the total amounts required to be paid to the Health Fund shall be determined by a resolution duly adopted by the Board in its settlor capacity;

(c) In addition, an Employer shall pay to the Active Plan Participant premiums, if any, deducted from the Participant's compensation (on a pre-or post- tax basis) pursuant to the Collective Bargaining Agreements or other agreements that provide for such deductions;

(d) The rate and amount of contributions on behalf of Covered Performers shall at all times be covered by said Collective Bargaining Agreements. Nothing in this Agreement shall be deemed to change, alter or amend any of said Collective Bargaining Agreements; and

(e) In addition, each Employer shall contribute to the Health Fund on behalf of Non-Bargained Participants in the amount and as specified in the respective letter of agreement or other participation agreement between Employers and the Producers or the AMPTP. Contributions on behalf of Plan Office Participants or Union Office Participants shall be made by Employers in the amount and as agreed to in the respective letter of agreement or other participation agreement. Nothing in this Agreement shall be deemed to require a contribution be made on behalf of a Non-Bargained Participant provided the applicable letter agreement does not require that the Employer make such contribution.

Section 2. Effective Rate of Employer Contributions. Employer Contributions to the Health Fund are due no later than:

(a) the due date for such Employer Contributions as set forth in the applicable Collective Bargaining Agreements (or related agreements);

(b) with respect to any such Collective Bargaining Agreements that do not specify a due date for Employer Contributions to the Health Fund, the last day of the calendar month immediately following the month in which the work for which the Employer Contributions are payable to the Health Fund was performed (except for Employer Contributions due in connection with residuals and reuse payments, which shall be due at the end of the calendar quarter following the calendar quarter in which the residual or reuse payment is due to the Covered Performer); or

(c) any other periodic basis that the Board determines (i) will be administratively convenient, and (ii) will not cause any material financial disadvantage to the Health Fund, and (iii) is not inconsistent with any applicable Collective Bargaining Agreement.

Section 3. Delinquent Employer Contributions.

(a) The failure of an Employer to pay the Employer Contributions required hereunder at the times and in the manner herein provided shall constitute a violation of such Employer's obligations hereunder. Non-payment by an Employer of any required Employer Contribution shall not relieve any other Employer of its obligation to make payment of its required Employer Contributions. It would be extremely difficult and impracticable to fix the actual expense and damage to the Fund which would result from the failure of an individual Employer to make the required payment in full within the time above provided in Section 2 above. Therefore, an Employer that fails to pay required Employer Contributions when due shall be liable for such Employer Contributions ("Delinquent Contributions") plus liquidated damages as follows:

Period of Delinquency	Liquidated Damages
Up to thirty (30) days	None
Thirty-one (31) to sixty (60) days	Ten percent (10%) of Employer Contributions due
Over sixty (60) days	Twenty percent (20%) of Employer Contributions due

(b) An Employer in default shall also be liable for reasonable attorney's fees and costs incurred in the collection of the Delinquent Contributions. The Board may take or cause to be taken any action deemed by it to be advisable or necessary to enforce payment of the Employer Contributions (including Delinquent Contributions) due hereunder, including actions in law or equity. In addition to all rights to

enforce payment of accrued obligations of an Employer anywhere in this Agreement provided or given by the law, in the event an Employer has been repeatedly delinquent or has otherwise willfully violated the provisions of this Agreement, the status of such Employer as a party hereto may be terminated by the Board in its discretion by a resolution duly adopted, and upon such termination such Employer shall forthwith cease to be an Employer under the provisions of this Agreement or a party hereto in any way thereafter. No Employer that has at any time defaulted hereunder and whose status as a party hereto has been so terminated shall be eligible to become a party hereto again, unless the Employer has paid in full all past obligations to the Health Fund as the Board may require. The provisions of this Article V, Section 3 shall be without prejudice to the rights of SAG-AFTRA, if any, under its Collective Bargaining Agreements, or otherwise, against the defaulting Employer by reason of such default.

Section 4. Remittance Reports and Audits.

(a) All Employers shall make Employer Contributions to the Health Fund, together with any remittance or other reports prescribed by the Health Fund. In addition, as required by ERISA, the Employer shall keep and supply to the Health Fund in connection with regular remittance reports, audits or upon request of the Health Fund, such records, including but not limited to Covered Performers', Non-Bargained Participants', SAG-AFTRA Participants' and Plan Office Participants' names, addresses, Social Security Numbers or taxpayer identification numbers, project title, engagement date(s), compensation, covered earnings, and, if the Employer is signatory to the Commercials Collective Bargaining Agreement, the information required in Article V, Section 7, below, as are necessary for the Health Fund to allocate Employer Contributions due or remitted with respect to the Covered Performers, Plan Office Participants, Union Participants or Non-Bargained Participants and to determine the Covered Performer's, Plan Office Participant's, Union Participant's or Non-Bargained Participant's eligibility for coverage and benefits under the Health Fund. If an Employer's reporting is materially deficient due to failure to provide required data, the Board may impose on the Employer liquidated damages in the amount of ten percent (10%), or if the material deficiency continues for 60 or more days from the due date of the report, twenty percent (20%), of the contribution amount for each individual with respect to whom the data provided is materially deficient. If such liquidated damages are imposed, the Employer shall be liable for the reasonable attorney's fees and

costs, if any, incurred in collection of the liquidated damages. The Board may take or cause to be taken any action it deems advisable or necessary to enforce payment of the liquidated damages described in this paragraph.

(b) The Health Fund may, at reasonable times, and during normal business hours of any Employer, audit or cause the audit or inspection ("Audit") of the records of any Employer with respect to the Employer Contributions and/or reports which the Employer is obligated to make insofar as the same may be necessary in order to accomplish the purpose of the Health Fund. Each Employer shall make available to the Health Fund's designated representative (the "Fund Representative") all records deemed necessary by such Fund Representative to determine the accuracy of such Employer's Employer Contributions and reports. The records referred to in this Article V, Section 4(b) shall include, but are not limited to, complete and updated payroll and wage records, employment tax returns, royalty statements, cost ledgers, general ledgers, accounts payable, cash disbursement journals, bank statements, personal service agreements; cast lists, production company agreements, license agreements, label copy, CD jackets, invoices and vouchers, cancelled checks, video tapes, session and use information, SAS 70 Reports or the Processing of Transactions by Service Organization, and any other documents or records that the Fund Representative deems necessary to determine the accuracy, completeness, and timeliness of the Employer Contributions and payments to the Health Fund (all of which are hereinafter collectively referred to as "Records").

(c) The Employer's Records shall be made available at the Employer's place of business at all reasonable times for the Audit. The Employer shall retain, for a minimum period of six (6) years (or such longer period as may be required by applicable law), all Records necessary for the conduct of the Audit contemplated in this Article. In addition, once notified by the Health Fund that an Audit has been authorized, the Employer shall retain all Records related to work performed and compensation paid under a Collective Bargaining Agreement, or other agreement, by and to Covered Performers, Non-Bargained Participants, Plan Office Participants and SAG-AFTRA Participants, until the conclusion of the Audit.

(d) The Employer shall promptly pay any additional Delinquent Contributions found due upon Audit. If the Employer disputes any additional Employer Contributions claimed to be due in the Health Fund's Audit report, the Employer shall respond to the Health Fund's Audit report in writing, and shall identify, with

supporting documentation, where applicable, the reasons that the additional claimed amounts are not due, in addition to supplying such documentation as may be requested by the Fund Representative, if available. If the Health Fund must take legal action to collect Delinquent Contributions found due upon Audit, in addition to any rights or remedies to which the Health Fund is entitled under Section 3(b), above, the Employer shall be liable for the costs of the Audit. The Trustees shall have the power to waive the Audit costs described in the previous sentence in a particular case upon good cause shown, such as, but not limited to, a case in which the Delinquent Contributions found are small in amount.

(e) In the event the Employer fails to make available records reasonably necessary to complete the Audit, the Board may take any action necessary, including taking legal action to compel the production of such Records. If litigation is required to compel an Audit, the Employer involved shall pay all attorney's fees, interest and court costs incurred by the Health Fund in connection with such litigation and Audit costs if the Trustees, in their discretion, choose to impose them, in addition to any Delinquent Contributions and liquidated damages, whether or not the Audit identifies Delinquent Contributions or other amounts due pursuant to this Agreement; and

(f) The Board may refuse future Employer Contributions from the Employer if the Board determines that adequate or reliable Records were unavailable and may deny eligibility to all individuals for whom Employer Contributions were due but were not contributed to the Health Fund.

Section 5. No Waiver of Other Rights. The provisions of this Section shall be without prejudice to any rights of SAG-AFTRA to enforce the payment of contributions or other amounts due hereunder.

Section 6. Mistaken Payments.

(a) An Employer shall be liable for the amount of any expenses incurred by the Health Fund and any benefits paid to, or on behalf of, an individual who was not eligible for coverage or benefits but with respect to whom the Health Fund mistakenly granted eligibility or benefits in reliance on improperly or erroneously reported contributions by the Employer, or incorrect information reported by the Employer, or on the absence of information that was required to be reported by the Employer. The individual who received such benefits or coverage shall be jointly and severally liable with the Employer for such erroneously provided benefits or coverage. The Board, in its sole and absolute

discretion, may offset any such amount from any refund of an overpayment or mistaken payment by an Employer if such amount was not otherwise recovered from the Employer or individual or otherwise. In addition, the Board may seek recovery of the amount of such overpayments (to the extent not offset pursuant to the preceding sentence) against the Employer, the individual who received the benefit or coverage or any other appropriate parties, jointly and severally and all expenses of collection thereof, costs, reasonable auditor's fees and attorney's fees.

(b) To the extent permitted by the Code, ERISA and other applicable law, in the event that any Employer Contribution or other payment to the Health Fund has been made by a mistake of fact or law, the Chief Executive Officer (or the Board, in cases referred to the Board by the Chief Executive Officer) may (but shall not be required to) in his or her sole and absolute discretion, return such Employer Contribution (or the value thereof, if less), without interest, to the Employer prior to the expiration of six (6) months after a determination by the Chief Executive Officer or, in cases referred to the Board by the Chief Executive Officer, the Board (or either of their designees). Alternatively, the Chief Executive Officer (or the Board, in cases referred to the Board by the Chief Executive Officer) may determine, in his or her or its sole and absolute discretion, that an Employer is entitled to offset from future Employer Contributions the amount of any mistaken payments (or the value thereof, if less), without interest. The determination as to whether an Employer has made an Employer Contribution or other payment to the Health Fund by a mistake of fact or law, and whether such Employer Contribution or payment should be returned to the Employer, shall be made in the sole and absolute discretion of the Chief Executive Officer or the Board (in cases referred to the Board by the Chief Executive Officer), as applicable, in accordance with ERISA and other applicable law, taking into account all of the evidence submitted by the Employer to demonstrate that the Employer Contribution or payment was made by mistake; provided, however, that the Employer shall have the burden of proving that an Employer Contribution or payment was made by mistake.

Section 7. Employer Contributions under Commercials Collective Bargaining Agreement. Employers signatory to the Commercials Collective Bargaining Agreement shall designate multi-service contract status on the contribution reports submitted to the Board and provide to the Health Fund unredacted copies of all contracts related to services provided under such multiple-service agreements at the time of submission of the contribution report to the Health Fund, except in instances where the Health Fund agrees to examine the underlying agreement in Los Angeles or New York.

Section 8. Effect of Remitting Contributions. By agreeing to remit Employer Contributions to the Health Fund, each Employer agrees to be bound by the terms of this Agreement.

Section 9. Participant Premiums. The Health Fund shall receive Participant premiums in such amounts as the Board may from time to time determine and the Board, in its discretion, may authorize the payment of such Participant premiums through any means it deems advisable, including, but not limited to, payment via the Health Fund's website, payroll deduction, automatic bank account debit, credit card charge, or telephone authorization.

ARTICLE VI.

DELEGATION OF AUTHORITY OF THE BOARD

Section 1. Delegation of Authority. The Board may delegate its authority under this Agreement as follows:

(a) To the Chief Executive Officer. The Board may delegate to a Chief Executive Officer the responsibility and authority to control the day-to-day administration of the Health Fund, subject to the terms of this Agreement, the Plans, any written agreement between the Board and the Chief Executive Officer, and any policies, procedures and other rules that may from time to time be adopted or established by the Board.

(b) To Committees: The Board may delegate its authority under this Agreement to the following committees:

(i) Standing Committees. The following shall be standing Committees: Administration Committee, Appeals Committee, Audit and Collections Committee, Benefits Committee, Investment Committee, and Legal Committee.

(ii) Ad Hoc Committees. Other Committees, or Subcommittees of Committees, for special purposes as may be created from time to time by the Board.

Section 2. Committee Membership, Governance and Authority:

(a) Committee Membership. The number of Trustees on each Committee shall be established by resolution duly adopted by the Board. The number of Trustees on Subcommittees may be determined by the applicable Committee. Each Committee shall have an equal number of members who are appointed by the Employer Trustees and who are appointed by the Union Trustees. Committee members serve until their successors are appointed, or, if earlier, when they cease serving as a Trustee. The Employer Trustees who will serve on each Committee shall be appointed, replaced and removed by the AMPTP and the JPC acting jointly. However, the Employer Trustees appointed to the Audit Committee will include at least one (1) Employer Trustee appointed as a Trustee by the JPC, one (1) Employer Trustee appointed by the AMPTP, one (1) Employer Trustee appointed by a Network Appointer and one (1) Employer Trustee jointly appointed by the Record Company Appointers. The Union Trustees who will serve on each Committee shall be appointed, replaced and removed by the Union Trustees.

(b) Committee Co-Chairs. Each Committee shall have a Chair and a Co-Chair. The Union Trustee Committee Chair or Co-Chair of each Committee shall be appointed by the Union Trustee Board Chair or Co-Chair. The Employer Trustee Committee Chair or Co-Chair of each Committee shall be appointed jointly by the AMPTP and the JPC. During odd-numbered calendar years, the Chair shall be an Employer Trustee and the Co-Chair shall be a Union Trustee. During even-numbered calendar years, the Chair shall be a Union Trustee and the Co-Chair shall be an Employer Trustee. The Chair or, in his or her absence, the Co-Chair, shall preside over meetings of the Committee.

(c) Committee Authority. The general purpose of a Committee is to study and debate issues that arise in the administration of the Health Fund and Plans and to make recommendations thereon to the Board for action by the Board. Notwithstanding this general rule, a Committee may, pursuant to paragraph (d) or by resolution adopted by the Board, be delegated the authority to take final action in specified areas; and in such instances the action of the Committee shall have the same binding effect as an action by the Board.

(d) Existing Delegations. The following delegations of authority to Committees are now in effect:

(i) To the Appeals Committee, the authority to render decisions on claims appeals under the Plans in accordance with ERISA Section 503.

(ii) To the Benefits Committee, the authority to review and make recommendations to the Board regarding plan design, including directing the Health Fund's consultants with respect to preparation of analyses and recommendations necessary for the Benefits Committee to exercise this authority, and the authority to make decisions regarding vendor selection and agreements related to the benefits provided under the Plans.

(iii) To the Administration Committee, the authority to make decisions regarding (i) utilization of building space used by Health Fund and (ii) vendor selection and agreements (other than those related to benefits provided under the Plans). In addition, the Administration Committee shall advise the Chief Executive Officer on matters relating to budget, operations, personnel issues, capital expenditures, executive performance and compensation (other than that of the Chief Executive Officer).

(iv) To the Audit and Collections Committee, the authority to act for the Board in those functions specified in Article V (other than those specified in Sections 1(b), 2(c) or (9)) and, in addition, the following authority:

a. to take, or refrain from taking, any legal action regarding any disputed issue of liability for Delinquent Contributions, liquidated damages, or overpayment of benefits;

b. in connection with an Audit, to decide how earnings related to Employer Contributions (including Delinquent Contributions) should be allocated to Covered Performers and Non-Bargained Participants in a manner consistent with any applicable Collective Bargaining Agreement;

c. to settle or otherwise resolve any matters within the authority of the Board specified in Article V; to monitor Employers to ensure that they are making all required Employer Contributions to the Health Fund with respect to Covered Performers and Non-Bargained Participants, and to establish and supervise a compliance monitoring program and employ auditors or other professionals to assist in such monitoring; and

d. to reject contributions made on behalf of individuals who are not engaged in employment requiring contributions pursuant to an applicable Collective Bargaining Agreement and to revoke eligibility or credit on such individuals.

(v) To the Investment Committee, the authority to appoint or remove Investment Managers, to determine the amount of Health Fund assets to be allocated to Investment Managers, to determine the amount of Health Fund assets to be allocated to various asset classes of investment, to adopt an investment policy and to take such other actions as described in Article VII and, to the extent of that authority, to function as a "named fiduciary" within the meaning of ERISA Section 402.

(vi) To the Legal Committee, the authority to retain legal counsel to protect Health Fund assets and to make all decisions regarding the institution, prosecution, defense and resolution of any legal action brought by or against the Health Fund, the Trustees or its employees, other than those legal actions that are within the authority of the Audit and Collections Committee.

(e) Voting. The unit voting rules of Article VIII of this Agreement shall be applicable to all votes of a Committee or Subcommittee; provided that, in the event of a deadlock, as defined in Article VIII, Section 6, no action shall be taken and the matter shall be reported to the Board by the Committee Co-Chairs for further consideration. In addition to decisions made at meetings, the Committees or Subcommittees may also make decisions by poll of the Trustees at the joint direction of the Committee or Subcommittee Co-Chairs. Such poll may be taken either in writing, by electronic mail or by telephone or video conference without the necessity of having a meeting; provided, however, that all Committee or Subcommittee members are notified of the poll and any action to be taken with respect to such issue must

be consented to in writing or electronic mail by at least seventy-five percent (75%) of the Union Trustees and at least seventy-five percent (75%) of the Employer Trustees serving on the Committee or Subcommittee. Any such action shall be reported at the next meeting.

(f) Quorum for Meetings. A quorum for the conduct of Committee business at a meeting will be decided by a resolution of the Board; however, a quorum must include at least one (1) Trustee appointed by the AMPTP, one (1) Trustee appointed by the JPC and two (2) Union Trustees. Notwithstanding the foregoing, the quorum requirement for the Legal Committee shall be two (2) Employer Trustees (one (1) of whom must have been appointed by the AMPTP and one (1) of whom must have been appointed by the JPC) and two (2) Union Trustees.

(g) Minutes. Each Committee and subcommittee shall keep written minutes of its proceedings, which minutes shall be distributed to all Trustees.

ARTICLE VII.

INVESTMENT MANAGERS

Section 1. Appointment of Investment Managers. In its sole and absolute discretion, the Investment Committee may, from time to time, appoint one or more Investment Managers (including any manager of a Collective Trust, the assets of which constitute "plan assets" under ERISA) within the meaning of ERISA Section 3(38), to advise, manage and invest (including the power to acquire and dispose of) all or a portion of the assets of the Health Fund and, where applicable, to serve as a "named fiduciary" within the meaning of ERISA Section 402 for the limited purpose of designating and appointing other investment managers or sub-managers to serve as an investment manager within the meaning of ERISA Section 3(38) with respect to all or any portion of the allocable share of the Health Fund assets.

Section 2. Appointment of Investment Consultant. The Investment Committee may, in its sole and absolute discretion, from time to time, appoint an Investment Consultant to advise the Investment Committee with respect to the Health Fund's investments.

Section 3. Supervision of Investments. The Investment Committee may also supervise and direct the investment of any portions of the Health Fund that are not subject to the management and control of an Investment Manager, by exercising any of the powers set forth in Article IV or herein.

Section 4. Effective Date. The appointment of an Investment Manager or Investment Consultant shall be effective as of the date specified by the Investment Committee.

Section 5. Authority of Investment Manager. The Investment Manager shall have full discretion and authority, to the extent required, permitted or not prohibited by ERISA and other applicable law, to invest and reinvest the portion of the Health Fund's assets allocated to it by the Investment Committee, without further notice, consent or approval of any party, except as expressly provided to the contrary herein or in any agreement between the Health Fund and the Investment Manager, and subject to any directions or guidelines as may be delivered from time to time to the Investment Manager by the Investment Committee or its designee.

Section 6. Duties and Responsibilities of the Investment Manager and the Investment Consultant. The duties and responsibilities of each Investment Manager or Investment Consultant shall be expressed in a written agreement between the Health Fund and the Investment Manager or Investment Consultant. Each Investment Manager and Investment Consultant so employed shall be compensated in such manner as shall be mutually agreed upon in such agreement.

Section 7. Responsibilities for Acts or Omissions. Notwithstanding anything to the contrary contained in this Agreement, neither the Trustees, the Investment Committee nor the Chief Executive Officer shall be responsible or liable for any

acts or omissions of any Investment Manager or be under any obligation to invest or otherwise manage any assets contained in an Investment Manager Account, except those assets over which the Investment Committee has specifically assumed investment management duties.

Section 8. Instructions of the Investment Manager. Subject to the terms of the agreement between the Health Fund and each Investment Manager, (i) each Investment Manager shall have the power and authority, to be exercised in its sole discretion at any time and from time to time, to issue orders and Instructions for the purchase or sale of Securities or other property held in its Investment Manager Account directly to a broker-dealer, and (ii) all transactions by an Investment Manager shall be made upon such terms and conditions, and from or through such principals and agents, as the Investment Manager shall direct (consistent with the provisions of ERISA).

Section 9. Investment Guidelines. The investment powers of any Investment Manager shall be subject to any general or specific investment directions or guidelines that from time to time may be delivered to it by the Investment Committee or its designee, expressing the investment objectives, restrictions and policies of the Investment Committee with respect to the Securities and other property contained in an Investment Manager Account. Notwithstanding the preceding sentence, the issuance of any specific investment directions or guidelines by the Investment Committee shall not in any manner be construed as an acceptance by the Investment Committee of any investment management or supervisory powers in connection with the Health Fund's assets managed by an Investment Manager, and no Trustee shall, as a result of the issuance of such directions or guidelines, be liable for any acts or omissions of an Investment Manager with respect to such assets, or be under any obligation to invest or otherwise manage such assets.

Section 10. Proxies. The right to exercise (as it deems prudent and solely in the interest of the Participants) any proxies, conversion privilege or subscription right, and any other right to make an investment decision with respect to the Investment Manager Account assets (including, without limitation, the voting of proxies and exercise of all other rights of shareholders appurtenant to Investment Manager Account assets) shall be delegated to an Investment Manager, unless the Investment Committee takes affirmative action to exercise that authority itself, to issue Instructions regarding the exercise of that authority, or to delegate such right to another appropriate entity other than the Investment Committee.

ARTICLE VIII.

GOVERNANCE

Section 1. Officers.

(a) Prior to December 31, 2016 and prior to December 31 of each second year thereafter, the Board Co-Chairs shall be appointed from among the Trustees, one of whom shall be a Union Trustee and the other an Employer Trustee. The Union-appointed Board Co-Chair shall be appointed by the Union Trustees. The Employer-appointed Board Co-Chair shall be appointed jointly by the AMPTP and the JPC. The Board Co-Chairs shall alternate serving as Chair and Co-Chair, as provided below.

(b) The term of the Board Co-Chairs shall commence on the January 1 following their appointment and shall continue for a term of two (2) years (or, if later, the date their successors are appointed).

(c) During even-numbered calendar years, the Chair shall be an Employer Trustee and the Co-Chair shall be a Union Trustee. During odd-numbered calendar years, the Chair shall be a Union Trustee and the Co-Chair shall be an Employer Trustee. The Chair or, in his or her absence, the Co-Chair, shall preside over meetings of the Board.

Section 2. Calling of Meetings.

(a) The Board shall endeavor to meet at least three (3) times per year, and at such other times as the Board may reasonably decide.

(b) A meeting of the Board may be called at any time by four (4) Trustees, the Chair, the Co-Chair, or the Chief Executive Officer. At least ten (10) days' advance written notice of the time and place of any meeting of the Board must be given to the Trustees. Meetings may be held at any time without notice, in person or by video conference or telephone conference calls, provided that a majority of the Union Trustees and a majority of the Employer Trustees consent thereto. Neither notice nor consent shall be required if all Trustees are present at the meeting.

(c) Except as set forth in Article VIII, Section 2(d), meetings of the Board shall be held at the principal office of the Health Fund or at such other place or places as may be agreed upon by the Board Co-Chairs.

(d) Meetings of the Board may be held at any time, with proper advance notice (as prescribed by either paragraph (a) or (b) above), by telephone conference or video conference, consistent with any policy adopted by the Board.

Section 3. Quorum. Subject to the provisions of Article VIII, Section 4(a), at all meetings of the Board, at least ten (10) Employer Trustees (at least two (2) of whom were appointed by the AMPTP, at least one (1) of whom was appointed by the JPC, and at least one (1) of whom was appointed by a Network Appointer) and at least ten (10) Union Trustees shall constitute a quorum for the purpose of transacting business. For the purposes of quorum and voting, a Trustee is considered to be present and attending a meeting when connected by telephone or video conference.

Section 4. Vote of Trustees.

(a) Except as otherwise provided in this Article VIII, Section 4, all actions of the Board shall be taken by the concurring vote of (i) more than one-half of the Employer Trustees attending the meeting and not abstaining from the vote and (ii) more than one-half of the Union Trustees attending the meeting and not abstaining from the vote. Individual Union or Employer Trustees, or the Union Trustees or the Employer Trustees, as a group, may elect to recuse themselves from a vote because of actual or potential conflicts, in which case the individuals or group electing to recuse themselves or itself may, but shall not be required to, appoint an independent Trustee to act on their or its behalf. In the event that the individuals or the group electing to recuse themselves or itself does not appoint such an independent Trustee, action may be taken by concurring vote of (i) or (ii) above, as applicable.

(b) In addition to decisions made at meetings, the Board may also make decisions by poll of the Trustees at the joint direction of the Board Co-Chairs. Such poll may be taken either in writing, by electronic mail or by telephone or video conference without the necessity of having a meeting; provided, however, that all Trustees are notified of the poll and any action to be taken with respect to such issue must be consented to in writing or electronic mail by at least seventy-five percent (75%) of the Union Trustees and at least seventy-five percent (75%) of the Employer Trustees. Any such action shall be reported at the next Board meeting.

(c) In the event that any matter presented for decision by the Board cannot be decided due to a deadlock (as defined in Article VIII, Section 6(b), the matter shall then be resolved by arbitration (as provided by Article VIII, Section 6(b)).

Section 5. Minutes of Meetings. The Chief Executive Officer (or his or her duly authorized designee) shall maintain minutes of all Board and Committee meetings, but such minutes need not be verbatim. Copies of such minutes shall be provided to all Trustees.

Section 6. Deadlock and Arbitration.

(a) Whenever the Board is unable to decide a question during a meeting due to a deadlock among the Trustees (as defined in Article VIII, Section 6(b)), and provided that the question or resolution so deadlocked is presented for a second time at the next succeeding meeting of the Trustees and again the Trustees are deadlocked, either the Board Co-Chairs, or a majority of either the Employer Trustees or Union Trustees, may petition the American Arbitration Association (the "AAA") for the appointment of an arbitrator pursuant to the Impartial Umpire Rules for Arbitration of Impasses Between Trustees of Joint Employee Benefit Trust Funds of the AAA. If neither the Board Co-Chairs nor the Trustees petition for appointment of an arbitrator, then the majority of either the Union Trustees or the Employer Trustees may petition the United States District Court for the Central District of California for the appointment of an impartial umpire to resolve the deadlock.

(b) A deadlock for purposes of this Agreement shall mean that: (i) a majority of either the Employer Trustees or the Union Trustees votes for a motion, proposal, nomination or resolution while a majority of the other group of Trustees votes against it and the makers of the motion, proposal, nomination or resolution inform the other group of Trustees that a deadlock exists; or (ii) there exists an inability to take an action with respect to an issue presented due to the lack of a necessary quorum at two (2) successive Board meetings and at least six (6) Trustees from either group of Trustees notify the other group in writing that a deadlock exists by reason of such lack of a quorum.

(c) The failure of any Trustee to attend the arbitration hearing as scheduled and noticed by the AAA shall not delay the arbitration, and the arbitrator is authorized to proceed to take evidence and issue his or her decision as though such Trustee were present.

(d) In the event that such arbitrator, having been selected, shall resign or for whatever reason shall fail or refuse to act within a reasonable time after his or her selection, the AAA shall be requested to appoint another arbitrator; provided, however, that, should the AAA fail to act within fifteen (15) business days after the request, or should the Board be unable to agree on another

arbitrator within fifteen (15) business days after the AAA is requested to act, an arbitrator shall be appointed by the United States District Court for the Central District of California, upon the petition of a majority of either the Union Trustees or the Employer Trustees.

(e) The arbitrator, after hearings, of which all Trustees shall have due notice and opportunity to be heard, shall promptly announce his or her decision in writing to all Trustees and such decision shall be final and binding on all parties concerned as though it was embodied in a resolution duly adopted by the unanimous vote of the Board. All hearings of the arbitrator shall take place in Los Angeles, California, unless otherwise specifically mutually agreed upon.

(f) All reasonable fees and expenses of preparing for and conducting the arbitration (including, without limitation, the fees of the AAA, legal counsel, any expert witnesses and the arbitrator) shall be paid from the Health Fund.

(g) Notwithstanding anything herein to the contrary, a deadlock concerning an amendment to this sentence or Article XIII shall not be subject to resolution by arbitration pursuant to this Section.

ARTICLE IX.

BENEFITS

Section 1. Benefits.

(a) Subject to delegations of authority provided elsewhere in this Agreement, the Board shall have the full and exclusive right, power and authority, in its sole and absolute discretion, to determine the nature, type, form, amount, eligibility for and duration of benefits (including, without limitation, whether to enter into reciprocity and portability agreements with other funds and plans) to be provided to Participants and their Beneficiaries under the Plans and persons claiming benefits thereunder.

(b) The Board shall pay out of the Health Fund, at the time or times and in the manner specified in and in accordance with the Plans, the benefits provided for therein.

(c) Payment of benefits under the Plans shall be made directly from the Health Fund or may be provided for by the purchase and delivery of such insurance contracts, policies or certificates, to such persons, in such manner, and at such time as the Board shall decide.

(d) The Health Fund and the Trustees shall be fully protected in making, discontinuing or withholding benefit payments from the Health Fund, or purchasing or delivering insurance contracts, policies or certificates (or instructing the insurers with respect thereto), all in reliance upon information received from the Employer respecting the status of any Covered Performer, Non-Bargained Participant, Plan Office Participant or SAG-AFTRA Participant employed by such Employer.

Section 2. Written Plans of Benefits. The Board of Trustees shall specify the basis upon which eligibility for benefits under each Plan shall be determined, as well as the types, forms, nature and amount of benefits payable from each Plan (and any restrictions thereon). The terms of such plans of benefits shall be binding on all Participants, Beneficiaries, and persons claiming benefits thereunder.

Section 3. Insurance Contracts. The written plan of benefits comprising a Plan may (but need not necessarily) consist, in whole or in part, of contracts with one or more insurance companies.

Section 4. No Assignment of Benefits. Except as may otherwise be provided in a Plan, ERISA or the Code (including with respect to "qualified medical child support orders" as defined in ERISA Section 609(a)(2)):

(a) No benefit payable at any time under a Plan prior to receipt thereof by a Participant (or Beneficiary or estate) and no monies, Securities or other property of any nature whatsoever in the Health Fund or contracts, policies benefits, or monies payable therefrom shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, garnishment, mortgage, lien, charge or encumbrance of any kind, nor shall any benefit, until actually paid to the Participant (or Beneficiary or estate), be in any manner subject to the debts or liabilities of said Participant (or Beneficiary or estate);

(b) Benefit payments (or portions thereof) under a Plan or Health Fund shall not in any way be subject to any legal process, execution, attachment or garnishment, be used for the payment of any legal claim against any such person, or be subject to the jurisdiction of any bankruptcy court or insolvency proceedings by operation of law or otherwise;

(c) Any and all rights with respect to the Health Fund, including, without limitation, the right to receive benefits from the Health Fund and any and all rights to pursue a claim or cause of action of any kind, under any law, regulation or rule in any court, tribunal or otherwise, shall not be assignable by a Participant or Beneficiary (or anyone purporting to be a Participant or Beneficiary); and

(d) Any payment of benefits by the Active Plan directly to a medical provider pursuant to a written election or purported assignment submitted by a Participant or provider to the Active Plan is provided at the discretion of the Board as a convenience to Participants and does not imply an enforceable assignment of any benefits, the right to receive payment for benefits, any other right with respect to the Health Fund, or the right to pursue a cause of action therefor.

ARTICLE X.

PROTECTED HEALTH INFORMATION

Section 1. HIPAA. It is intended that the Health Fund shall at all times comply with the Privacy Rule and the Security Rule, respectively, regulations issued pursuant to 45 C.F.R. Parts 160, 12 and 164 as same may be amended from time to time. It is further intended that this Agreement constitutes the Plan document which under the Privacy and Security Rules must incorporate provisions governing the disclosure of protected health information, including electronic PHI ("PHI"), of individuals to the Trustees of the Health Fund.

Section 2. Permitted Disclosure. The Health Fund may use and disclose PHI for treatment, payment and operations, and such other uses and disclosures as are permitted under the Privacy Rule, and employees of the Health Fund shall have access to such PHI, as is necessary for them to perform their duties for the Health Fund. Specifically, PHI may be used for the following purposes:

(a) To the extent permitted by law, the Trustees of the Health Fund may receive, use and disclose PHI if, in the sole discretion of the Trustees, such PHI is necessary for the Trustees to perform their duties as Trustees.

(b) In addition, Trustees may receive and use PHI if an individual requests the Trustee to assist the individual in: (i) the filing of any claim for benefits under the Health Fund, (ii) understanding the Health Fund's determination with respect to a claim filed by the individual, or (iii) perfecting any appeal from an adverse determination by the Health Fund of a claim by the individual. In all cases, a Trustee shall receive, use and disclose the minimum amount of PHI necessary for the Trustee to perform his or her functions under the Health Fund, and shall safeguard such PHI as required by the Privacy and Security Rules and this Agreement.

(c) The Trustees may also receive summary health information within the meaning of the Privacy Rule, for the purpose of obtaining premium bids for providing coverage or modifying or amending the Plans, and may also receive enrollment and disenrollment information that lists which individuals are participating in the Plans.

Section 3. Limits on Disclosure. Each Trustee who receives PHI from the Health Fund shall keep such information in strict confidence and shall not use or further disclose the PHI received from the Health Fund other than as permitted or required by law and this Agreement or upon the express written permission of the individual who is the subject of the PHI.

Section 4. Administrative Safeguards. Except when the only electronic protected health information disclosed to the Trustees is disclosed pursuant to 45 CFR § 164.504(f)(1)(ii) or (iii), or as authorized under 45 CFR § 164.508, the Trustees will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that they create, receive, maintain or transmit on behalf of the Health Fund, and will ensure that the "adequate separation" required by 45 C.F.R. §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures.

(a) Each Trustee who receives PHI from the Health Fund shall ensure that the Trustee's agents to whom the Trustee provides such PHI, if any, shall conform to the same restrictions on the agent's use or disclosure of the information as govern the Trustee's use or disclosure.

(b) Each Trustee who receives electronic PHI shall ensure that the Trustee's agents to whom the Trustees provide such electronic PHI, if any, shall implement reasonable and appropriate security measures to protect electronic PHI.

(c) Each Trustee who receives PHI from the Health Fund shall not use or disclose such PHI for any employment-related actions or decisions, or with respect to any other benefit plan sponsored by the Trustees.

(d) Each Trustee who receives PHI from the Health Fund shall report to the Health Fund's Privacy Officer any use or disclosure of such PHI that is inconsistent with the provisions set forth in this Agreement or otherwise required by law, of which the Trustee becomes aware.

Section 5. Incident Reports. If any Trustee becomes aware of any security incident, the Trustee will promptly report the incident to the Security Officer of the Health Fund and will cooperate with the Health Fund to correct the violation and to impose appropriate sanctions.

Section 6. Required Disclosure. The Trustees shall, to the extent required by HIPAA, (i) make PHI that a Trustee has received from the Health Fund or created available to the individual about whom such PHI pertains for inspection and copying, as required by law, (ii) make available any PHI that it has received from the Health Fund for amendment and incorporate any amendments to PHI the Trustee has received from the Health Fund as required by law, and (iii) make available the information required to provide an accounting of disclosures as required by law.

Section 7. Reporting of Breach. The Trustees and their staff, assistants and clerical employees may obtain PHI in the course of performing the duties of their job with or for the Trustee who obtained such information. If any Trustee becomes aware of any such violations, the Trustee will promptly report the violation to the Health Fund and will

cooperate with the Health Fund to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the affected individuals.

Section 8. Destruction of PHI. Each Trustee who receives PHI (including ePHI) from the Health Fund shall return to the Health Fund or destroy all such PHI received from the Health Fund when there is no longer a need for the information.

Section 9. Internal Practices. The Trustees shall make available to the HHS internal practices, books and records relating to the use and disclosure of PHI received from the Health Fund to determine the Health Fund's compliance with the Privacy Rule.

ARTICLE XI.

EMPLOYER PARTIES TO THIS AGREEMENT

Section 1. By executing or complying with the terms of a Collective Bargaining Agreement, each Employer shall be deemed (without any further action) to have: (i) reviewed, understood, adopted and agreed to all provisions of this Agreement (and any amendments to such Agreement), which documents shall be deemed to have been incorporated by reference into such Collective Bargaining Agreement; (ii) agreed to comply with and be bound unconditionally to the Plans, any amendments thereto, as well as all of the decisions of the Board, duly authorized Committees and the Chief Executive Officer; and (iii) agreed to pay any additional payments to the Health Fund required pursuant to the terms of this Agreement or the Plans.

ARTICLE XII.

AMENDMENT AND TERMINATION

Section 1. Amendment. This Agreement may be amended in writing, at any time and in any manner, by the affirmative vote of not less than seventy-five percent (75%) of the full complement of Trustees in office, and the provisions of any such amendment may be made applicable to the Health Fund as constituted at the time of such amendment, as well as to the Chief Executive Officer, all Trustees, all Employers, SAG-AFTRA, any Investment Manager or Custodian, and all others whosoever; provided that the amendment (i) is consistent with the purposes for which the such Health Fund was established; and (ii) will not cause such Health Fund to lose its tax-exemption under Code Section 501(a).

Section 2. Limitation of Amendments. Notwithstanding anything to the contrary contained in this Agreement, no amendment shall be made to this Agreement or the Plan, which shall result in the impermissible return or diversion of any part of such Health Fund to any of the Employers or to SAG-AFTRA.

Section 3. Termination.

(a) The Health Fund established hereunder may be terminated and this Agreement may be terminated: (i) at any time, by the affirmative vote of not less than seventy-five percent (75%) of the full complement of Trustees then in office; or (ii) by an instrument in writing duly executed by SAG-AFTRA and by Employers which, in the aggregate, were responsible for at least two-thirds or more of the Employer Contributions paid to the Health Fund by Employers during the last complete calendar year immediately preceding the submission of such instrument. The Health Fund and this Agreement shall be terminated automatically in the event that the obligation of all Employers to make Employer Contributions to the Health Fund shall terminate or there shall be no assets remaining in the Health Fund.

(b) In the event of the termination of the Health Fund, the Board shall apply the assets of the Health Fund to pay or to provide for the payment of any and all obligations of the Health Fund and distribute or apply any remaining surplus in a manner consistent, in their opinion, with this Agreement, the Plans, ERISA, the Code and any other applicable law; provided, however, that except as provided by this Agreement, under no circumstances shall any portion of the corpus or income of the Health Fund, directly or indirectly, revert or accrue to the benefit of any Employer or SAG-AFTRA.

(c) Upon termination of the Health Fund, the Board shall forthwith notify all necessary parties, including SAG-AFTRA, the Chief

Executive Officer, and any insurance carriers, Investment Managers, Custodians and other service providers, and as many Employers and Participants (and their Beneficiaries) as possible, and the Board shall continue to act hereunder for the purpose of concluding the affairs of the Health Fund. The Board may take any action with regard to insurance policies or group contracts that may be required by an insurance carrier and which the Board, in its discretion, may deem appropriate.

Section 4. Transfer of Assets. Nothing herein contained shall be deemed to prohibit the Board, to the extent permitted by ERISA and other applicable laws, from transferring any assets of the Health Fund following its termination to another health and welfare fund, as applicable, established, maintained or contributed to by any Employer(s) for employees or former employees of the Employer(s) who were Participants or Beneficiaries on such terms and under such conditions as the Board may determine.

ARTICLE XIII.

BENEFIT DESIGN PROVISIONS

Section 1. Continuation Value. The Board shall at all times endeavor to maintain twelve (12) months of Continuation Value. To achieve this twelve (12) month target level of Continuation Value, the Board may adopt changes to the Plans' eligibility thresholds, Participant premiums or benefits at any time. The Board shall comply with the protocols set forth in the following Sections of this Article XIII.

Section 2. Required Projections. The Board shall require the Benefit Consultant to provide the Board projections at every Board meeting, using the assumptions set forth in Article XIII, Section 5.

Section 3. Insufficient Continuation Value. If the projections presented by Benefit Consultant to the Board at its first meeting of the year, which shall take place no later than the end of the first calendar quarter, show that the Health Fund's Continuation Value as of December 31 of the following year will be less than nine (9) months (eight (8) months with respect to the projections presented at the first meeting of 2021 or 2022), then:

(a) Within thirty (30) days of the meeting, the Benefit Consultant shall suggest proposed modifications to the Plans in Participant premiums, eligibility thresholds or benefits, or any combination thereof, to be effective on January 1 of the following year, that would increase the Continuation Value to at least nine (9) months (eight (8) months with respect to modifications to be effective January 1, 2022 or January 1, 2023) within two (2) years of such Plan modifications. The Trustees may also suggest proposed modifications for consideration. By the second Board meeting of the year, the Union Trustees shall propose one (1) or more of the suggested modifications for adoption by the Board at its second meeting of the year to achieve the nine (9) month (eight (8) month with respect to suggested modifications for adoption at the second meeting of 2021 or 2022) target Continuation Value within two (2) years of the January 1 effective date of such modifications, except as provided in Article XIII, Section 3(b). The Employer Trustees will not unreasonably object to the Union Trustees' proposed modifications.

(b) Notwithstanding the foregoing provision, if the updated projections presented by the Benefit Consultant at the second Board meeting of the year show a Continuation Value of at least nine (9) months (eight (8) months with respect to updated projections provided at the second meeting of 2021 or 2022) as of December 31 of the following year, no action shall be required.

(c) Examples:

(i) *Example 1:* At the first Board meeting in 2021, the Benefit Consultant's projections show that the Continuation Value as of December 31, 2022 will be seven (7) months. The Benefit Consultant will prepare a list of suggested modifications to be effective January 1, 2022 that are projected to raise the

Continuation Value to at least eight (8) months by December 31, 2023. The Union Trustees shall recommend, by the second Board meeting of the year, some or all of the suggested modifications to achieve the eight (8) month Continuation Value as of December 31, 2023, and the suggested modifications, to be effective January 1, 2022, will be adopted by the Board at the second Board meeting in 2021. If, however, at the second Board meeting in 2021, the projections from the Benefit Consultant show that the Continuation Value as of December 31, 2022 will be at least eight (8) months, no action will be necessary.

(ii) *Example 2:* At the first Board meeting in 2023, the Benefit Consultant's projections show that the Continuation Value as of December 31, 2024 will be seven (7) months. The Benefit Consultant will prepare a list of suggested modifications to be effective January 1, 2024 that are projected to raise the Continuation Value to at least nine (9) months by December 31, 2025. The Union Trustees shall recommend, by the second Board meeting of the year, some or all of the suggested modifications to achieve the nine (9) month Continuation Value as of December 31, 2025, and the suggested modifications, to be effective January 1, 2024, will be adopted by the Board at the second Board meeting in 2023. If, however, at the second Board meeting in 2023, the projections from the Benefit Consultant show that the Continuation Value as of December 31, 2024 will be at least nine (9) months, no action will be necessary.

(d) If the Trustees fail to reach agreement at the second Board meeting of the year regarding the modifications to be made, the following modifications shall become effective January 1 of the following year:

(i) Active Plan eligibility thresholds, including the alternative days and age and service eligibility rules, shall be increased by an amount determined by the Benefit Consultant that would increase the Continuation Value to at least nine (9) months (eight (8) months with respect to modifications to become effective January 1, 2022 or January 1, 2023) within two (2) years of the effective date of the change, but not by more than ten percent (10%);

(ii) If the increase in the Active Plan eligibility thresholds as provided in Article XIII, Section 3(d)(i) is not sufficient to achieve the nine (9) month (or eight (8) month, as applicable) Continuation Value target within two (2) years of the effective date of the change, all Participant premiums, including Participant premiums for Senior Performers' non-Medicare eligible dependents and surviving dependents of deceased Senior Performers, shall be increased by an amount determined by the Benefit Consultant that would increase the Continuation Value to at least nine (9) months (eight (8) months with respect to modifications to become effective January 1, 2022 or January 1, 2023) within two (2) years of the effective date of the change, but not by more than ten percent (10%);

(iii) If the increases in the Active Plan eligibility thresholds and Participant premiums as provided in Article XIII, Section 3(d)(i) and (ii) are not sufficient to achieve the nine (9) month (or eight (8) month, as applicable) Continuation Value target within two (2) years of the effective date of the

change, the co-insurance payable by the Health Fund under the Active Plan for in-network and out-of-network benefits shall be decreased by an amount, in increments of ten percent (10%), determined by the Benefit Consultant that would increase the Continuation Value to at least nine (9) months (eight (8) months with respect to modifications to become effective January 1, 2022 or January 1, 2023) within two (2) years of the effective date of the change.

Section 4. Excessive Continuation Value. If the projections presented by the Benefit Consultant to the Board at its first meeting of the year show that the Continuation Value as of December 31 of the following year will be above fifteen (15) months (sixteen (16) months with respect to the projections presented at the first meeting of 2021 or 2022), then:

(a) Within thirty (30) days of the meeting, the Benefit Consultant shall prepare a list of suggested Plan improvements to be effective January 1 of the following year, or as soon as practicable thereafter, each of which would not decrease the Continuation Value to less than fifteen (15) months (sixteen (16) months with respect to modifications to be effective January 1, 2022 or January 1, 2023) within two (2) years of the effective date of the modifications. The Trustees may also suggest proposed improvements for consideration. The Union Trustees shall recommend one (1) or more of such suggested improvements for adoption by the Board at its second meeting of the year, except as provided in Article XIII, Section 4(c).

(b) At the second Board meeting of the year, if the updated projections presented by the Benefit Consultant continue to show a Continuation Value above fifteen (15) months (sixteen (16) months with respect to updated projections provided at the second meeting of 2021 or 2022), as of December 31 of the following year, the Board shall consider and vote on the Union Trustees' recommendations for improvements. The Employer Trustees will not unreasonably object to the Union Trustees' recommendations.

(c) Notwithstanding the foregoing provision, if the updated projections presented by the Benefit Consultant at the second Board meeting of the year show a Continuation Value of fifteen (15) or fewer months (sixteen (16) months with respect to updated projections provided at the second meeting of 2021 or 2022) as of December 31 of the following year, no action shall be taken.

(d) If the Trustees fail to reach agreement at the second Board meeting of the year regarding the improvements to be made, the following improvements shall become effective January 1 of the following year:

(i) Increases in Active Plan Participant premiums, including premiums for Senior Performers' non-Medicare eligible dependents and surviving dependents of deceased Senior Performers, scheduled to become effective January 1 of the following year, shall not be implemented, provided that the Benefit Consultant certifies that the Continuation Value would not fall below fifteen (15) months (sixteen (16) months with respect to modifications to become

effective January 1, 2022 or January 1, 2023) within two (2) years of the date the increases were scheduled to become effective.

(ii) If there are any remaining excess assets above the fifteen (15) month (or sixteen (16) month, as applicable) Continuation Value target after the suspension of any scheduled increases in Participant premiums as provided in item Article XIII, Section 4(d)(i), increases in the Active Plan's eligibility thresholds, including the alternative days and age and service eligibility rules, scheduled to become effective January 1 of the following year, shall not be implemented, provided that the Benefit Consultant certifies that the Continuation Value would not fall below fifteen (15) months (sixteen (16) months with respect to modifications to become effective January 1, 2022 or January 1, 2023) within two (2) years of the date the increases were scheduled to become effective.

(iii) If there are any remaining assets above the fifteen (15) month (or sixteen (16) month, as applicable) Continuation Value target after the suspension of any scheduled increases in Participant premiums and eligibility thresholds under the Active Plan as provided in Article XIII, Sections 4(d)(i) and (ii), the co-insurance payable by the Health Fund under the Active Plan for in-network and out-of-network benefits shall be increased proportionately by an amount, in increments of five percent (5%), determined by the Benefit Consultant that would not cause the Continuation Value to fall below fifteen (15) months (sixteen (16) months with respect to modifications to become effective January 1, 2022 or January 1, 2023) within two (2) years of the effective date of the modifications.

Section 5. Projection Assumptions. The assumptions to be used for the projections described in this Article shall be those recommended by the Benefit Consultant, the Investment Consultant, the Health Fund staff, and/or other sources mutually agreed upon by the Trustees.

Section 6. Excise Tax Trigger. If at any point, the projections presented by Benefit Consultant to the Board indicate that the Health Fund will be subject to the excise tax under Code Section 4980I in the following Health Fund year, then within thirty (30) days of the determination, the Benefit Consultant shall suggest proposed modifications to the Plans with respect to Participant premiums, eligibility thresholds, benefits, deductibles or copays, or any combination thereof, to be effective on January 1 of the following year, in order to prevent the Health Fund from being subject to such excise tax, and the Trustees shall meet promptly thereafter to agree on the modifications to be made to avoid the imposition of the tax. The Trustees may also suggest proposed modifications for consideration. Neither the Union Trustees nor the Management Trustees shall unreasonably object to the modifications proposed by the Benefit Consultant. If the Union Trustees, on the one hand, and the Management Trustees, on the other hand, are unable to agree on a benefit design for the Health Fund so as to avoid the imposition of the excise tax, the proposed benefit design of the Benefit Consultant shall go into effect on January 1 of the following year so that the excise tax can be avoided.

ARTICLE XIV.

MISCELLANEOUS

Section 1. Situs. This Agreement shall be deemed to have been executed and validly delivered in the City of Burbank and the State of California. The Board and the Health Fund shall have and maintain offices in the cities of Burbank and New York. The principal office will be located in the City of Burbank.

Section 2. Choice of Law. This Agreement and the Health Fund created hereby shall be construed, regulated, enforced and administered in accordance with the internal laws of the State of California applicable to contracts made and to be performed within the County of Los Angeles (without regard to any conflict of laws provisions), to the extent that such laws are not preempted by the provisions of ERISA (or any other applicable laws of the United States).

Section 3. Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which shall be considered the same instrument. The signature of a party on any counterpart shall be sufficient evidence of his or her execution thereof.

Section 4. Titles: Plurals: and Gender. Titles, headings, and subheadings for sections and paragraphs are inserted for the convenience of reference only, and this Agreement shall not be construed by reference to them. Wherever required by context, the singular of any word used in this Agreement shall include the plural and the plural maybe read in the singular. Words used in the masculine shall be read and construed in the feminine where they would so apply.

Section 5. Service of Process. The Trustees and the Chief Executive Officer are hereby designated as agents for service of legal process on the Health Fund or Plans.

Section 6. Validity of Trustees' Accounts and Instruments. No person, partnership, corporation or association dealing with the Health Fund shall be obliged to see to the application of any funds or property of the Health Fund, to see that the terms of this Agreement have been complied with, or be obliged to inquire into the necessity or expediency of any act of the Trustees. Every Certificate or other instrument executed by the Board Co-Chairs or the Chief Executive Officer shall be conclusive in favor of any person, partnership, corporation or association relying thereon that: (i) at the time of the delivery of said instrument, the Health Fund was in full force and effect; (ii) said instrument was effected in accordance with the terms and conditions of this Agreement; and (iii) the signatory was duly authorized and empowered to execute such instrument.

Section 7. Notices. Unless otherwise specified herein, all notices, instructions and advice with respect to Securities transactions, or any other matters contemplated by this Agreement, shall be deemed duly given when either delivered in writing, or sent by electronic mail or facsimile, to the addresses below or when deposited by first class mail addressed as follows:

(a) To the Board:

Board of Trustees
SAG-AFTRA Health Fund
3601 West Olive Blvd.
Burbank, CA 91505

(b) To the Chief Executive Officer:

Chief Executive Officer
SAG-AFTRA Health Fund
3601 West Olive Blvd.
Burbank, CA 91505

or to such other addresses as any of the foregoing parties, or individual Trustees, shall subsequently instruct the other parties. Any notice or other communication shall be deemed to have been given to, or received by, the appropriate party as of the date on which it is personally or electronically delivered or, if mailed, on the fifth business day after the date of the postmark applied by the United States Postal Service.

Section 8. Severability. If anyone or more of the covenants, agreements, provisions or terms of this Agreement (or any amendment hereto) shall be held contrary to any provision of law, or shall for any reason whatsoever be held invalid, then such covenants, agreements, provisions or terms (or amendments) shall: (i) be enforced only to the extent not contrary to law or invalid; (ii) be deemed severable from the remaining covenants, agreements, provisions or terms of this Agreement; and (c) shall in no way affect the validity or enforceability of the other provisions of this Agreement or the rights of the parties hereto.

Section 9. Successor Provisions of Law. Any references to a section of ERISA or the Code, or to any regulations or administrative pronouncements there under, shall be deemed to include a reference to any successor provision of ERISA or the Code (or of any successor federal law) or to any successor regulations or administrative pronouncements there under.

Section 10. Entire Agreement. This Agreement sets forth the entire agreement of the parties hereto with respect to the subject matter hereof, is intended to be the complete and exclusive statement of the terms hereof, and may not be modified or amended except pursuant to the procedure set forth in Article XII, Section 1.

Section 11. Construction. Anything in this Agreement, or any amendment hereof, to the contrary notwithstanding, no provision of this Agreement shall be construed so as to violate the requirements of ERISA, the Code, or other applicable law.

Section 12. Inurement. This Agreement shall inure to the benefit of the

Board and its successors and assigns, and the Participants (or their Beneficiaries).

Section 13. Rights in the Health Fund. No Covered Performer, Non-Bargained Participant, Plan Office Participant, SAG-AFTRA Participant, Retiree, Senior Performer or other person, or group of persons, nor any organization (other than the Trustees), nor any person claiming through them, shall have any right, title or interest in any of the income or property of any character received or held by or for the account of the Health Fund (by reason of having been named a Beneficiary or otherwise), and no person shall have any right to any benefit provided by the Plans, nor shall any person be entitled to any payment or other equity in the assets of the Health Fund unless and until the Board (or its designee) determines that he or she fulfills all the requirements for a benefit in accordance with the specific provisions of the Plans.

Section 14. No Interest to Participants. Neither the creation of this Health Fund nor anything contained in this Agreement or a Plan shall be construed as giving any Covered Performer, Non-Bargained Participant, Plan Office Participant, SAG-AFTRA Participant, Retiree or Senior Performer entitled to benefits hereunder or under the Plans (or any other individual on whose behalf contributions are made to the Health Fund), any right to be continued in the employ of any Employer or any equity or other interest in the assets of the Health Fund, except as set forth in the Plans.

Section 15. Duration of Agreement. This Agreement shall continue in effect without limit as to time; subject, however, to the provisions of this Agreement relating to amendment, modification and termination thereof set forth in Article XII.

Section 16. Effective Date. The terms contained in this Agreement, as amended and restated, shall generally be effective as of January 1, 2021, and as of such date the Board shall have such rights, title, interests, authority and discretion of the SAG Board and the AFTRA Board as set forth in the Merger Agreement. For clarity, (a) all claims, appeals or benefits due with respect to services rendered prior to January 1, 2017, shall be governed by the rules and procedures set forth in the governing documents of the SAG Health Fund or the AFTRA Health Fund, as applicable, in effect at the time the claim was incurred, (b) all Employer Contributions payable prior to January 1, 2017, including Delinquent Contributions and any liquidated damages, interest or other amounts payable, shall be payable pursuant to the terms set forth under the governing documents of the SAG Health Fund or the AFTRA Health Fund, as applicable, in effect at the time the Employer Contribution first became payable (except with respect to the allocation of Employer Contributions set forth in Article V, Section 1(b) which shall be as set forth in the Merger Agreement), and (c) any purportedly mistaken payments made prior to January 1, 2017 shall be governed by the governing documents of the SAG Health Fund or the AFTRA Health Fund, as applicable, in effect at the time the payment was made.

Union Trustees

Daryl Anderson

Amy Aquino

Timothy Blake

Jim Bracchitta

John Carter Brown

Duncan Crabtree-Ireland

Barry Gordon

David Hartley-Margolin

Matthew Kimbrough

Lynne Lambert

Richard Masur

Employer Trustees

Helayne Antler

J. Keith Gorham

James Harrington

Harry Isaacs

Robert Johnson

Sheldon Kasdan

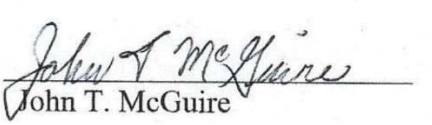
Allan Linderman

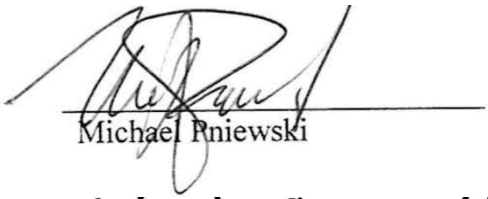
Carol A. Lombardini

Stacy K. Marcus

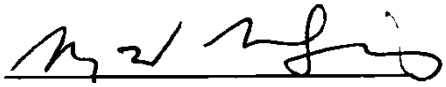
Diane P. Mirowski

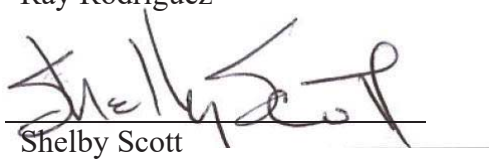
Paul Muratore


John T. McGuire

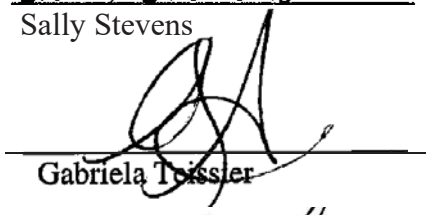

Michael Pniewski

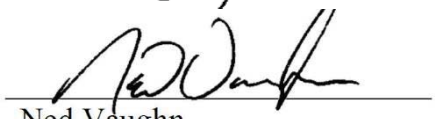

Linda Powell


Ray Rodriguez


Shelby Scott


Sally Stevens

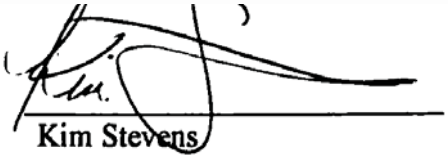

Gabriela Teissier

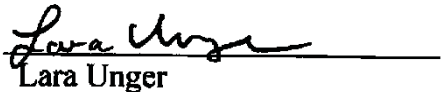

Ned Vaughn

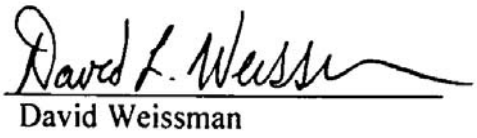

David White


Tracy Owen


Marc Sandman


Kim Stevens


Lara Unger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Russell Wetanson

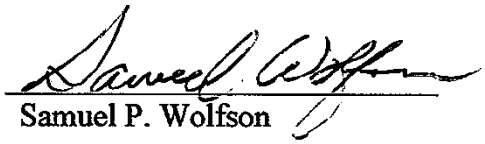
Samuel P. Wolfson

EXHIBIT 8

SAG-AFTRA HEALTH PLAN

SENIOR PERFORMERS

HEALTH REIMBURSEMENT ACCOUNT PLAN

SUMMARY PLAN DESCRIPTION

PLAN DOCUMENT

SAG-AFTRA HEALTH PLAN

SENIOR PERFORMERS

HEALTH REIMBURSEMENT ACCOUNT PLAN

SUMMARY PLAN DESCRIPTION

Effective January 1, 2021

TABLE OF CONTENTS

INTRODUCTION

A Letter from the SAG-AFTRA Health Fund Board of Trustees

In August 2020, the Board of Trustees of the SAG-AFTRA Health Fund decided to change the way in which the Fund offers benefits to our Senior Performer participants and their spouses, including through the adoption of the SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan (the "HRA Plan").

As Trustees, we are proud to provide you with this inaugural Summary Plan Description ("SPD") of the HRA Plan, which describes the benefits available to former participants in the SAG-AFTRA Health Plan (and its predecessor plans) who qualify as Senior Performers and their Spouses and Surviving Spouses, as defined herein, to obtain reimbursement of their Eligible Medical Expenses incurred on and after January 1, 2021.

The HRA Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. This HRA Plan is also intended to be exempt from the Affordable Care Act as a separate "retiree-only" plan pursuant to ERISA Section 732(a) and IRC Section 9831(a)(2). The HRA Plan will be interpreted at all times consistent with these intents.

The material provisions of the HRA Plan as of the January 1, 2021 Effective Date are summarized below, but this SPD is qualified in its entirety by reference to the full text of the formal HRA Plan document, a copy of which is included in this document behind the SPD, starting at page 32. In the event of any conflict between the terms of this SPD and the terms of the HRA Plan document, the terms of the HRA Plan document will control.

Note that capitalized terms used in this SPD are defined the first time they are used or are defined in the "HRA Plan Terms" section at the end of this booklet. Please note that "you," "your" and "my" when used in this SPD refer to you, the Participant, as defined herein. This HRA Plan uses gender-neutral personal pronouns. The singular shall include the plural, and vice versa.

It's important to note that the Board of Trustees may (with or without notice) reduce, modify or discontinue benefits or the qualification rules for benefits at any time, with respect to any individual who is covered, or who may become covered, under the HRA Plan. Rights to future benefits, including but not limited to, Senior Performer benefits, are not promised, vested or guaranteed. The Board of Trustees has the sole and exclusive power and responsibility to make all decisions regarding the HRA Plan and what it provides. The Board of Trustees' decisions regarding this HRA Plan are binding upon SAG-AFTRA, employers and Participants and anyone else purporting to be entitled to a benefit under the HRA Plan. Neither Plan employees nor employees of the Claims Administrator, currently Via Benefits, can alter benefits or eligibility or

other rules, and their opinions or interpretations cannot amend what is set forth in this SPD or the plan document and are not binding upon the Board of Trustees.

Please advise Via Benefits at 1-833-981-1280 if you change your address or marital status. If you have any questions, please contact Via Benefits at 1-833-981-1280 or contact the Plan at 1-800-777-4013.

We look forward to continuing to provide HRA Plan Participants with a high level of benefits and service as we start this new chapter together.

SAG-AFTRA Health Plan Board of Trustees

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PART I
GENERAL INFORMATION ABOUT THE HRA PLAN

What is the purpose of the HRA Plan?

The purpose of the HRA Plan is to reimburse Participants for Eligible Medical Expenses that are not otherwise reimbursed by any other plan or program. Reimbursements for Eligible Medical Expenses paid by the HRA Plan generally are excludable from the Participant's taxable income. Eligible Medical Expenses are defined below.

Who can participate in the HRA Plan?

A Senior Performer, Spouse or Surviving Spouse shall be eligible to participate in the HRA Plan if they meet all requirements to be a Participant as defined the Plan Terms at the end of this SPD, and are not eligible for coverage under the Active Plan. Senior Performers, Spouses or Surviving Spouses who become covered under the HRA Plan are called "Participants."

Can my dependents participate in the HRA Plan?

Only a Spouse or a Surviving Spouse who is eligible for Medicare can participate in the HRA Plan and have their Eligible Medical Expenses reimbursed.

When do I or my Spouse or a Surviving Spouse become a Participant in the HRA Plan?

A Senior Performer (see below for a special rule for Occupational Disability Pensioners), Spouse or Surviving Spouse becomes a Participant in the HRA Plan on the later of the Effective Date of the HRA Plan (January 1, 2021) or the date that they have attained age 65, or for a Spouse or Surviving Spouse otherwise become eligible for Medicare, and have satisfied all of the following requirements:

- They have satisfied the requirements to become a Senior Performer, Spouse or Surviving Spouse, as set forth in the HRA Plan Terms at the end of this SPD, as applicable;
- They have obtained an individual health insurance policy through Via Benefits or have provided satisfactory evidence to the Plan Administrator (or its delegate) that:
    - they obtained an individual health insurance policy through Entertainment Health Insurance Solutions (EHIS) or Artists Health Insurance Resource Center (AHIRC), both joint programs of the Actors Fund and the Motion Picture and Television Fund;
    - they have retiree coverage under another group health plan;
    - they have health coverage under TRICARE; or
    - they reside outside of the United States; and
- They have completed any enrollment forms (which may be electronic) or procedures as specified by the Plan Administrator (or its delegate) from time to time;

provided that the Senior Performer, Spouse or Surviving Spouse is not eligible for coverage under the Active Plan as a Participant or a dependent as a result of current employment status.

A Spouse who meets the above requirements may become a Participant regardless of whether the Senior Performer is a Participant, provided that:

- the Spouse has attained age 65 or is otherwise eligible for Medicare; and
- neither the Senior Performer nor the Spouse is eligible to be covered under the Active Plan as a result of current employment status.

A Surviving Spouse who meets the above requirements may become a Participant only upon the later of:

- The date the deceased Senior Performer, participant or former participant would have turned age 65; or
- The date the Surviving Spouse has attained age 65 or is otherwise eligible for Medicare;

provided that the Surviving Spouse is not eligible for coverage under the Active Plan.

A Senior Performer who is an Occupational Disability Pensioner may become a Participant when they have satisfied all of the following requirements:

- They have satisfied the requirements to become a Senior Performer, Spouse or Surviving Spouse, as set forth in the HRA Plan Terms at the end of this SPD, as applicable;
- They have obtained an individual health insurance policy through Via Benefits or have provided satisfactory evidence to the Plan Administrator (or its delegate) that:
    - they obtained an individual health insurance policy through Entertainment Health Insurance Solutions (EHIS) or Artists Health Insurance Resource Center (AHIRC), both joint programs of the Actors Fund and the Motion Picture and Television Fund;
    - they have retiree coverage under another group health plan;
    - they have health coverage under TRICARE; or
    - they reside outside of the United States; and
- They have completed any enrollment forms (which may be electronic) or procedures as specified by the Plan Administrator (or its delegate) from time to time;

provided that the Surviving Spouse is not eligible for coverage under the Active Plan as a result of current employment status.

How does the HRA Plan work and how much is allocated to my HRA Account?

The HRA Plan will establish one combined HRA Account for the Senior Performer and their Spouse (a "Combined Account"). If, however, the Senior Performer's Spouse is also a Senior Performer, Allocations will be made to each Senior Performer's separate HRA Account.

The amount of your Allocation depends upon what category of Participant you are, the number of Retiree Health Credits you have, and certain other factors set forth in the chart below:

Type of Participant	Maximum Amount Allocated to HRA Account
Senior Performers with at least 20 Retiree Health Credits and their Spouses	Fixed Dollar Amount of $1,140 each
Surviving Spouses of Senior Performers with at least 20 Retiree Health Credits	Fixed Dollar Amount of $1,140
Surviving Spouses of a deceased participant or former participant in the Active Plan, the AFTRA Health Plan or the SAG-Producers Health Plan, who was at least age 50 at death, had at least 20 Retiree Health Credits, and whose age plus Retiree Health Credits equaled at least 75	Fixed Dollar Amount of $1,140
Senior Performers with less than 20 Retiree Health Credits and their Spouses, provided, however, that if the Senior Performer's Spouse is also a Senior Performer and has at least 20 Retiree Health Credits, the Spouse and the Senior Performer will instead each receive an allocation of $1,140 to their separate HRA Accounts	Fixed Dollar Amount of $240 each
Surviving Spouses of Senior Performers with less than 20 Retiree Health Credits	Fixed Dollar Amount of $240
Surviving Spouses of a deceased participant or former participant in the Active Plan, the SAG-Producers Health Plan or the AFTRA Health Plan with less than 20 Retiree Health Credits	Fixed Dollar Amount of $240

Allocations will be credited to HRA Accounts on or about the first business day of each Plan Year, or, if the Senior Performer or Surviving Spouse becomes a Participant after the first day of a Plan Year, on or about the first business day of their participation in the HRA Plan. The amounts allocated to your HRA Account will be prorated for the number of months of participation in your first year of participation.

HRA Accounts will be reduced by the amount of any Eligible Medical Expenses for which the Participant is reimbursed under the HRA Plan. At any time, the Participant may receive reimbursement for Eligible Medical Expenses up to the amount in their HRA Account. Note that the law does not permit Participants to make any contributions to their HRA Accounts other than under the COBRA rules described below.

An HRA Account is merely a bookkeeping account on the HRA Plan's records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the HRA Plan are paid entirely from the SAG-AFTRA Health Fund's general trust assets.

What is an "Eligible Medical Expense"?

An Eligible Medical Expense is generally an expense incurred by a Participant for medical care, as that term is defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease), but not everything that is medical care is reimbursable under this Plan. Some common examples of Eligible Medical Expenses include:

- Medications (in reasonable quantities);
- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Chiropractor treatments;
- Hearing aids;
- Wheelchairs;
- Premiums for individual long-term care insurance coverage; and
- Premiums for individual health insurance purchased through Via Benefits or an affiliate, or through Entertainment Health Insurance Solutions (EHIS) or Artists Health Insurance Resource Center (AHIRC), both joint programs of the Actors Fund and the Motion Picture and Television Fund.

Some examples of common items that are <u>not</u> Eligible Medical Expenses include:

- Baby-sitting and childcare;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues (unless specific requirements are satisfied); and
- Cosmetics, toiletries, toothpaste, etc.

If you need information regarding whether an expense is an Eligible Medical Expense under the HRA Plan, contact Via Benefits at 1-833-981-1280. Solely the Plan Administrator (and its delegates) determine what is an Eligible Medical Expense.

Only Eligible Medical Expenses incurred while you and your Spouse are Participants in the HRA Plan may be reimbursed from your HRA Account or Combined HRA Account.

Eligible Medical Expenses are "incurred" when the medical care is provided not when you or your Spouse is billed, charged or pay for the expense. Health insurance premiums are incurred for the coverage period to which they apply. An expense that has been paid but not incurred (e.g., pre-payment to a physician or for premiums) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may not be reimbursed from an HRA Account:

- expenses incurred for qualified long-term care services;
-
- expenses incurred prior to the date that you became a Participant;
- expenses incurred after the date that you cease to be a Participant;
- premiums under an employer's group health plan that are subsidized by the employer;
- expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan; and
- expenses for which you or your spouse claim as a deduction on your federal income tax return.

When do I cease participation in the HRA Plan?

If you are a Senior Performer, you will cease being a Participant in the HRA Plan on the earliest of:

- the date you regain eligibility in the Active Plan;
- the date of your death;
- the date you do not re-enroll in any individual health insurance policy;
- the effective date of any amendment terminating your eligibility under the HRA Plan; or
- the date the HRA Plan is terminated.

If you are a Spouse, you will cease being a Participant in the HRA Plan on the earliest of:

- the date the Senior Performer to whom you are married regains eligibility in the Active Plan;
- the date you do not enroll in any individual health insurance policy;
- the date you divorce the Senior Performer;
- the date of your death;
- the effective date of any amendment terminating your eligibility under the HRA Plan; or
- the date the HRA Plan is terminated.

If you are a Surviving Spouse, you will cease being a Participant in the HRA Plan on the earliest of:

- the date you do not re-enroll in any individual health insurance policy;
- the date of your death;
- the date of your remarriage;
- the effective date of any amendment terminating your eligibility under the HRA Plan; or

- the date the HRA Plan is terminated.

You may not obtain reimbursement of any Eligible Medical Expenses incurred after the date your eligibility ceases. However, you, your surviving spouse or your estate, as applicable, have 180 days after your eligibility ceases to request reimbursement of Eligible Medical Expenses you incurred before your eligibility ceased.

In addition, if you are a Senior Performer participating in the Plan, your Spouse or former Spouse may be eligible to continue coverage under the HRA Plan beyond the date that their coverage would otherwise end if coverage is lost for certain reasons under COBRA. Their continuation of coverage rights and responsibilities are described below.

What happens if I do not use all of the amounts allocated to my HRA Account during the Plan Year?

If you do not use all of the amounts allocated to your HRA Account during a Plan Year, those amounts will be carried over to subsequent Plan Years. If you do not use all of the amounts credited to your HRA Account before your coverage under the HRA Plan ceases, you will not be eligible to receive any reimbursements for Eligible Medical Expenses incurred after your coverage ceases, even if you continue to have a balance in your HRA Account, although you can continue to submit claims for Eligible Medical Expenses incurred prior to your cessation of coverage for up to 180 days, as described above.

How do I receive reimbursement under the HRA Plan?

If you have a claim for premiums for your individual health insurance, you may be able to take advantage of automatic claims substantiation procedures that Via Benefits has in place with most of the insurance carriers. If that applies to the carrier of your insurance, Via Benefits will explain those procedures.

For all other claims, you must complete a reimbursement form and mail or fax it, along with a copy of your insurance premium bill, an explanation of benefits ("EOB") or, if no EOB is provided, a written statement from the service provider, to the Claims Administrator:

Via Benefits
P.O. Box 25181
Lehigh Valley, PA 18002-5181
Phone: 1-833-981-1280
Fax: 1-866-886-0878

The written statement from the service provider must contain the following information regarding the health expenses for which you are requesting reimbursement:

- the name of the Participant;
- the date service or treatment was provided/incurred;
- a brief description of the health care expense;

- the amount of the health expenses incurred;
- the name of the provider to whom the health care expense was paid; and
- a written bill from an independent third party stating that the health care expense has been incurred and the amount of such expense and, at the discretion of the Plan Administrator, a receipt showing payment has been made.

You can obtain a reimbursement form from by calling Via Benefits or by logging into your account. Your claim is deemed filed when it is received by Via Benefits. Your claim for reimbursement must include a statement that you have not been and will not be reimbursed for the claimed expense by insurance or otherwise, and have not been allowed a tax deduction in a prior year (and will not claim a tax deduction) for the expense under Code Section 213.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably practicable following the determination. Claims are generally paid in the order in which they are received by Via Benefits. Claims will be reimbursed for the amount determined by Via Benefits to be Eligible Medical Expenses under the Plan up to the balance in your HRA Account. The Plan Administrator and its delegates, including Via Benefits, reserve the right to verify, to their satisfaction, all claimed medical expenses prior to making reimbursement payments.

Via Benefits will determine the method or mode of reimbursement payments, including whether by direct deposit, written check or otherwise.

Any HRA Account payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) will automatically forfeit twelve (12) months after the check was mailed or the payment was otherwise attempted.

What happens if my claim for benefits is denied?

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after Via Benefits receives your claim. If Via Benefits determines that an extension of this time period is necessary due to matters beyond the control of the HRA Plan, Via Benefits will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified of the additional information required and you will have at least 45 days to provide the additional information.

The notice of denial will contain:

- the reason(s) for the denial and the HRA Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a copy of any internal rule, guideline, protocol or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to the claimant free of charge upon request; and

- a description of the HRA Plan's appeal procedures and the time limits applicable to such procedures.

If your request for reimbursement under the HRA Plan is denied in whole or in part and you do not agree with the initial notice of denial of Via Benefits, you or your authorized representative may file a written appeal with Via Benefits. You must file your appeal with the Via Benefits at the following address no later than 180 days after receipt of the denial notice:

Via Benefits
P.O. Box 25181
Lehigh Valley, PA 18002-5181
Phone: 1-833-981-1280
Fax: 1-866-886-0878

You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim. You or your authorized representative may, upon request and free of charge, have reasonable access to records and other information relevant to your claim for benefits.

If you wish to designate an authorized representative to act on your behalf with respect to your claim for benefits and/or appeal, you must complete Via Benefits Authorization to Release Protected Information Form. Please contact Via Benefits at the number shown above to request this form or download the current version from https://documents.ViaBenefits.com/website/sagaftrahp/Via-Benefits-Authorization-to-Release-Protected-Information-Form.pdf. If you designate an individual to act as your authorized representative, they may complete the reimbursement form for you if you are unable to complete it yourself.

You will be notified in writing of the decision on appeal no later than 60 days after Via Benefits receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by Via Benefits. It will also advise you of your right to a voluntary appeal to the Appeals Committee of the Board of Trustees (described below), as well as your right to bring a civil action under ERISA Section 502(a) if you wish to challenge Via Benefit's denial of your appeal.

If Via Benefits denies your appeal, you may (but you are not required to) file an appeal with the Appeals Committee of the Board of Trustees at the following address no later than 60 days after receipt of ViaBenefit's appeal denial notice:

SAG-AFTRA Health Fund
3601 West Olive Avenue
Burbank, CA 91505
Phone: 1-800-777-4013
Fax: 1-818-953-9880

You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

If you wish to designate an authorized representative to act on your behalf with respect to your appeal, you must complete the SAG-AFTRA Health Plan's Authorization for Release of Health Information Form. Please contact the Plan at the address shown above to request this form or download the current version from the forms section of www.sagaftraplans.org/health.

Your appeal will be considered at the next regularly scheduled meeting of the Appeals Committee of the Board of Trustees. If the request for voluntary appeal to the Appeals Committee is received within thirty (30) days of the next scheduled Appeals Committee meeting, the voluntary appeal will be considered at the second regularly scheduled meeting following receipt of the request. In special circumstances, consideration of the voluntary appeal may be delayed until the third regularly scheduled meeting following the Appeals Committee's receipt of the voluntary appeal.

You will be notified in writing of the decision on your voluntary appeal within five (5) days of the Appeals Committee's determination of your appeal. The notice will contain the same type of information provided in the appeal denial provided by Via Benefits.

Note that you cannot file suit in federal court to claim any benefits due under the HRA Plan, to enforce your rights under the terms of the HRA Plan, or clarify your rights to future benefits under the terms of the HRA Plan unless and until you have exhausted these appeals procedures, other than the voluntary appeal to the Appeals Committee.

The decision of the Board of Trustees or its delegate (the Appeals Committee or Via Benefits) shall be final and binding, subject to applicable law. The Board of Trustees (or its delegate) has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret this HRA Plan and to decide all matters arising in connection with the operation or administration of the HRA Plan. Without limiting the generality of the foregoing, the Board of Trustees (or its delegate) has the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the HRA Plan to Participants;
- Formulate, interpret and apply rules, regulations and policies necessary to administer the HRA Plan or other plan documents in accordance with their terms;
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the HRA Plan or other plan documents;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the HRA Plan or other plan documents;
- Process and approve or deny benefit claims and rule on any benefit exclusions; and
- Decide questions as to whether expenses are eligible for reimbursement from the HRA Plan.

Any claim or action that is filed in a court or other tribunal against or with respect to the HRA Plan and/or the Board of Trustees must be brought within 90 days of the denial of a benefit claims, or with respect to any other matter, within 90 days of the action or inaction giving rise to the claim.

What happens if I die?

Combined Accounts and Surviving Spouse Accounts

If a Senior Performer with a Combined HRA Account dies with no Surviving Spouse, their HRA Account is immediately forfeited upon death, but the deceased Senior Performer's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Senior Performer and their Spouse prior to their death, so long as such claims are submitted within 180 days of the Senior Performer's death.

If the Senior Performer with a Combined HRA Account dies with a Surviving Spouse, the Senior Performer's HRA Account shall continue and the Surviving Spouse can continue to submit Eligible Medical Expenses for reimbursement so long as the Surviving Spouse remains entitled to receive allocations to the HRA Account.

Once the Surviving Spouse dies, the HRA Account will be immediately forfeited, but the deceased Surviving Spouse's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Surviving Spouse prior to their death, so long as such claims are submitted within 180 days of the Surviving Spouse's death.

Separate Accounts

If a Senior Performer who is married to another Senior Performer dies, the HRA Account of the deceased Senior Performer is immediately forfeited upon death, but the deceased Senior Performer's estate or representatives may submit claims for Eligible Medical Expenses incurred by the deceased Senior Performer before their death. Any remaining amounts in the deceased Senior Performer's HRA Account, after payment of any claims for reimbursement made on behalf of the Senior Performer, shall be credited to the surviving Senior Performer spouse's HRA Account in a one-time allocation.

If a Surviving Spouse dies their HRA Account shall be immediately forfeited, but the Surviving Spouse's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Surviving Spouse before the Surviving Spouse's death within 180 days of their death.

Are my benefits taxable?

The HRA Plan is intended to meet the requirements of existing federal tax laws, under which the benefits you receive under the HRA Plan generally are not taxable to you. However, the tax treatment to any given Participant is not guaranteed, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

What happens if I receive an overpayment under the HRA Plan or a reimbursement is made in error from my HRA Account?

If it is determined that a Participant received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that was paid by another medical plan or for an expense that is not in fact an Eligible Medical Expense, or if you miscalculated your true out-of-pocket prescription drug expenses for purposes of the

Catastrophic Coverage Reimbursement), will be required to refund the overpayment or erroneous reimbursement to the Plan Administrator.

If you do not refund the overpayment or erroneous payment, the Plan Administrator reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any allocations due to you or take other actions to recoup the overpayment/erroneous payment.

How long will the HRA Plan remain in effect?

Although the Board of Trustees expects to maintain the HRA Plan indefinitely, it has the right to modify or terminate the program at any time for any reason, including the right to change the classes of persons eligible for participation, and to reduce or eliminate the amounts that will be credited to HRA Accounts in the future.

How does the HRA Plan interact with other medical plans?

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied).

What Is Catastrophic Coverage Reimbursement?

Catastrophic Coverage Reimbursement begins after you have accumulated covered qualifying Medicare Part D prescription drug expenses equal to the true out-of-pocket (TrOOP) limit set by the Centers for Medicare and Medicaid Services (CMS) for the applicable Plan Year.

Catastrophic Coverage Reimbursement can be obtained by contacting Via Benefits and requesting a claim form.

Once you have accumulated sufficient covered qualifying Medicare Part D prescription drug expenses for Catastrophic Coverage Reimbursement, all further eligible claims for qualifying Medicare Part D prescription drug expenses incurred during that Plan Year will be reimbursed by the HRA Plan without any dollar limits. Claims must be incurred during the applicable Plan Year and submitted within the time frame set forth in this SPD for other qualifying HRA claims. All other HRA Account provisions set forth in this SPD continue to apply.

What is "continuation coverage" and how does it work?

Under the federal law called "COBRA," a Spouse or former Spouse of a Senior Performer may elect to continue coverage under the HRA Plan for a limited time after the date they would otherwise lose coverage because of a divorce or legal separation from the Senior Performer, or the death of the Senior Performer under certain circumstances. These are called "qualifying events."

Note that the Spouse or former Spouse is required to notify the Plan Administrator in writing of a divorce or legal separation from the Senior Performer within 60 days of the event or they will lose the right to continue coverage under the HRA Plan. The Plan Administrator will notify the Spouse of a Senior Performer's death as soon as practicable following its determination of the Senior Performer's death, although the Spouse will not cease to be a Participant in the Plan unless they:

- fail to meet the definition of Surviving Spouse;
- fail to re-enroll in an individual insurance policy;
- remarry or
- die.

If a Spouse or former Spouse elects to continue coverage, they are entitled to the level of coverage under the HRA Plan in effect immediately preceding the qualifying event. They may also be entitled to an increase in their HRA Account equal to the amounts credited to the HRA Accounts of similarly situated Participants (subject to any restrictions applicable to similarly situated Participants) so long as they continue to pay the applicable premium, described below.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event. Payment will be due within 45 days of the Spouse's or former Spouse's election to continue coverage.

Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the HRA Account is exhausted;
- The date the Spouse or former Spouse notifies the Plan Administrator that they wishes to discontinue coverage;
- Any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the Spouse's or former Spouse's election to continue coverage, that they become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary; or
- The Plan Administrator ceases to provide any group health plan.

Who do I contact if I have questions about the HRA Plan?

If you have any questions about the HRA Plan, you should contact Via Benefits or the SAG-AFTRA Health Fund.

Via Benefits
P.O. Box 25181
Lehigh Valley, PA 18002-5181

Phone: 1-833-981-1280
Fax: 1-866-886-0878

SAG-AFTRA Health Fund
3601 West Olive Avenue
Burbank, CA 91505
Phone: 1-800-777-4013
Fax: 1-818-953-9880

PART II

ERISA RIGHTS

This HRA Plan is an employee welfare benefit plan as defined in ERISA. ERISA provides that you, as a Plan Participant, will be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the HRA Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the HRA Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the HRA Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.
- Receive a summary of the SAG-AFTRA Health Fund's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue HRA Plan Coverage

Continue HRA Plan coverage for your eligible spouse if there is a loss of coverage under the Plan as a result of a qualifying event. However, your spouse will have to pay for such coverage. Review this SPD and the documents governing the HRA Plan for the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for HRA Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your HRA Plan, called "fiduciaries" of the HRA Plan, have a duty to do so prudently and in the interest of the HRA Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the HRA Plan, or from exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a benefit under HRA Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the HRA Plan

review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the HRA Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the HRA Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the HRA Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the HRA Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PART III

NOTICE OF PRIVACY PRACTICES

The SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan (the "Plan") is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to that information. The Plan understands that your health information is personal and we are committed to protecting it. This Notice of Privacy Practices gives you information on how the Plan protects your health information, when we may use and disclose it, your rights to access and request restrictions to the information, and the Plan's obligation to notify you if there has been a breach of your health information.

Definitions

"Health information" generally means information: (i) about your physical or mental health or condition, health care provided to you, or the payment of health care provided to you, whether past, present, or future; (ii) that is created, received, transmitted or maintained by the Plan; and (iii) that identified you or could be used to identify you.

A "breach" is any access, use or disclosure of your unsecured health information in a manner not permitted by the Privacy Rule that compromises the security or privacy of your health information.

Uses and Disclosures

In many instances, the Plan requires a court order or your written authorization to disclose your health information. However, the Plan is permitted by law to disclose your health information without your authorization or court order, as follows:

- Treatment: The Plan does not provide medical care or services; rather, it reimburses for such care and services that are covered under the terms of the Plan.
- Payment: The Plan may use or disclose your health information for purposes of processing claims for reimbursement, verifying your eligibility, and other payment activities.

In some circumstances it may be necessary for the Plan to disclose your health information, including your eligibility for Plan benefits and specific claim information to other covered entities such as other health plans.

The Plan may also disclose your health information and your Dependents' health information on payment-related correspondence, such as information regarding Plan reimbursements which are sent to you.

- Health care operations: The Plan may use or disclose your health information for purposes of overall Plan operations. For example, the Plan may obtain proposals from vendors in an effort to select appropriate private exchanges or insurance arrangements for Plan Participants. It may be necessary to provide the companies with certain health information, particularly in regard to catastrophic illnesses.

The Plan is prohibited from using or disclosing health information that is your genetic information for purposes of: (i) determining your eligibility for benefits under the Plan; (ii) computing any premium or contribution amounts under the Plan; (iii) applying any pre-existing condition exclusion; and (iv) any other activities relating to the creation, renewal or replacement of a contract for health benefits. The Plan may, however, use genetic information for determining the medical appropriateness of providing a benefit you have requested under the Plan.

- Reminders: The Plan may use your health information to provide you with reminders.

- Business associates: The Plan may disclose your health information to business associates. Business associates are entities retained or contracted by the Plan, such as Via Benefits, to perform certain functions on our behalf or provide services to us that involve the use or disclosure of health information. The Plan has a contract with each business associate, whereby they agree to protect your health information and keep it confidential.

- Trustees, for purposes of fulfilling their fiduciary duties: The Plan may disclose your health information to the Plan's Trustees who serve on the Appeals Committee in connection with appeals that you file following a denial of a benefit Claim or a partial payment. Trustees may also receive your health information if necessary for them to fulfill their fiduciary duties with respect to the Plan. Such disclosures will be the minimum necessary to achieve the purpose of the use of disclosure. In accordance with the Plan documents, such Trustees must agree not to use or disclose your health information with respect to any employment-related actions or decisions, or with respect to any other benefit plan maintained by the Trustees.

- Personal representatives: Unless you object, the Plan will disclose your health information to personal representatives appointed by you, and, in certain cases, a family member, close friend or other person in an emergency situation when you cannot give your authorization. The Plan will disclose only health information that is directly relevant to your health care or payment related to your health care, or as necessary for notification purposes.

- Workers' Compensation: The Plan may disclose your health information to comply with laws relating to Workers' Compensation or other similar programs that provide benefits for work-related injuries and illnesses.
- Legal proceedings: The Plan may disclose your health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal. In addition, the Plan may disclose your health information under certain conditions in response to a subpoena, discovery request or other lawful process, in which case, reasonable efforts must be undertaken by the party seeking the health information to notify you and give you an opportunity to object to this disclosure.
- Secretary of Health and Human Services: The Plan will disclose your health information to the Secretary of Health and Human Services (HHS) or any other officer or employee of HHS to whom authority has been delegated for purposes of determining the Plan's compliance with required privacy practices.
- Health care oversight: The Plan may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and legal actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Military activity and national security: When the appropriate conditions apply, the Plan may use or disclose health information of individuals who are Armed Forces personnel for activities deemed necessary by military command authorities, or to a foreign military authority if you are a member of that foreign military service. The Plan may also disclose your health information to authorized federal officials conducting national security and intelligence activities including the protection of the President of the United States.
- Public health activities: The Plan may disclose your health information to a public health authority in connection with public health activities including, but not limited to: preventing or controlling disease, injury or disability; reporting disease or injury; reporting vital events such as births or deaths; conducting public health surveillance, public health investigations and public health interventions; at the direction of a public health authority, to an official of a foreign government agency acting in collaboration with a public health authority; or reporting child abuse or neglect.
- Coroners, funeral directors and organ donation: The Plan may disclose your health information to a coroner or medical examiner for identification purposes or other duties authorized by law. The Plan may also disclose your health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. The Plan may disclose such information in reasonable anticipation of death. Your health information may be used and disclosed for cadaveric organ, eye or tissue donation and for transplant purposes.
- Disaster relief: The Plan may disclose your health information to any authorized public or private entities assisting in disaster relief efforts.

• Food and Drug Administration (FDA): The Plan may disclose your health information to a person or company subject to the jurisdiction of the FDA with respect to an FDA-regulated product or activity for which that person has responsibility, or for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity.

• Abuse or neglect: The Plan may disclose your health information to any public health authority authorized by law to receive reports of child abuse or neglect. In addition, if the Plan reasonably believes that you have been a victim of abuse, neglect or domestic violence we may disclose your health information to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

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

• Criminal activity: Consistent with applicable federal and state laws, the Plan may disclose your health information if it believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan may also disclose your health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

• As required by law: The Plan will disclose your health information as required by law.

Use and Disclosure with Your Permission

The Plan may not use or disclose your health information for any purposes other than the ones outlined above without your written authorization. Types of uses and disclosures that require your written authorization include:

• Personal representatives: In situations where you wish to appoint a personal representative to act on your behalf or make medical decisions for you in situations where you are otherwise unable to do so, the Plan will require your written authorization before disclosing your health information to that individual. The Plan will recognize your previous written authorization designating such individual to act on your behalf and receive your health information until you revoke the authorization in writing.

• Trustee(s) as your representative: In some circumstances you may request that a Trustee receive your health information if you request the Trustee to assist you in your filing or perfecting of a Claim for benefits under the Plan. In these situations the Plan will first request that you complete a written authorization before disclosing the health information.

• Disclosure to others involved in your care or payment of your care: You may designate a manager, agent, accountant, personal assistant or other third party to receive written communications from the Plan with respect to you and your eligible Dependents. In such cases the Plan requires that you first file a written authorization with the Plan. The Plan will recognize your written authorization designating such individuals and will continue to send communications from the Plan to such parties. If you do not want the Plan to continue such communications, you must notify the Plan in writing to such effect and give us an alternate address or third party, if any, to whom you would like us to send your information.

• Psychotherapy notes: The Plan may not use or disclose the contents of psychotherapy notes without your written authorization.

• Marketing: Marketing means situations where the Plan receives financial compensation from a third party to communicate with you about a product or service and is only allowed if you give your written authorization. Marketing would include instances when an individual or entity tries to sell you something based on your health information. The Plan does not engage in marketing and will not use your health information for this purpose.

• Sale of health information: The sale of an individual's health information for financial compensation requires that individual's written authorization. The Plan does not sell health information.

In situations where your written authorization is required in order for the Plan to use or disclose your health information, you may revoke that authorization, in writing, at any time, except to the extent that the Plan has already taken action based upon the authorization. Thereafter, the Plan will no longer use or disclose your health information for the reasons covered by your written authorization.

Your Rights Regarding Your Health Information

As a Participant, you have the following rights with regard to your personal health information:

• Right to inspect and copy – You have the right to review and copy health information that the Plan has about you in a designated record set for as long as the Plan maintains the information. You have the right to request a copy of your health information in electronic form, including in an unencrypted or unsecured form if you so desire. You have the right to request that a copy of your health information be provided to a third party. You must send a written request to the Plan's Privacy Officer using the Plan's access request form. You may obtain a copy of the Plan's access form by contacting the Plan's Privacy Officer using the telephone number, email address or mailing address listed on the following page. The Plan may charge you a fee to provide you with copies of your health information. If the Plan will charge you a fee, it will notify you before it makes /the copies. The Plan is allowed to charge only a reasonable, cost-based fee for the labor and supplies associated with making the copy, whether on paper or in electronic form. The Plan may deny

your request to inspect and copy your health information in certain limited circumstances. If you are denied access to your health information, you will be provided written notice of the denial and may request the Plan to review the denial.

- Right to receive confidential communications – The Plan normally provides health information to Participants via U.S. mail. You may request that the Plan communicate your health information to you in a different way. Your request must be made in writing to the Plan's Privacy Officer and explain the reasons for your request. In certain cases, the Plan may deny your request.

- Right to request consideration of restrictions – You may request additional restrictions on how your health information is used and disclosed. You may also request that any part of your health information not be disclosed to family members, friends or others who may be involved in your care or for notification purposes as described in this Notice. Your request must be made in writing to the Plan's Privacy Officer and explain the reasons for your request. The Plan is not required to agree to the restrictions you request. If the Plan agrees, it must honor the restrictions you request.

- Right to amend –If you believe the health information the Plan maintains about you is incorrect, you have the right to request an amendment to it. Your request must be made in made in writing to the Plan's Privacy Officer and explain the reasons for your request. In certain cases, the Plan may deny your request. If the Plan denies your request for amendment, you have the right to file a statement of disagreement with the decision.

- Right to receive an accounting of disclosures – You have the right to request a listing of the disclosures the Plan has made of your health information without your authorization for purposes other than treatment, payment of Claims and health care operations (subject to exceptions, restrictions, and limitations noted in the Privacy Rule). Your request must be made in writing to the Plan's Privacy Officer and must specify the period for which you are requesting the disclosures (which cannot be for a period longer than six years prior to the date of your request). In certain cases, the Plan may charge a fee for this request. The Plan will notify you of the cost in advance and you may choose to withdraw or modify your request at that time.

- Right to notification in the event of breach – A breach occurs when there is an impermissible use or disclosure that compromises the security or privacy of your health information such that the use or disclosure poses a significant risk of financial, reputational or other harm to you. The Plan takes extensive measures to ensure the security of your health information; but in the event that a breach occurs, or if the Plan learns of a breach by a business associate, the Plan will promptly notify you of such breach.

- Right to obtain a paper copy of the Plan's Privacy Notice – If you received this Notice electronically (via email or the internet), you have the right to request a paper copy at any time.

Genetic Information

Genetic information is information about an individual's genetic tests, the genetic tests of family members of the individual, the manifestation of a disease or disorder in family members of the individual, or any request for or receipt of genetic services by the individual or a family member of the individual. The term genetic information also includes, with respect to a pregnant woman (or a family member of a pregnant woman), genetic information about the fetus and, with respect to an individual using assisted reproductive technology, genetic information about the embryo.

Federal law prohibits the Plan and health insurance issuers from discriminating based on genetic information. To the extent that the Plan uses your health information for underwriting purposes, federal law also prohibits the Plan from disclosing any of your genetic information. The Plan will not use or disclose any of your genetic information for this purpose.

Complaints

If you believe your privacy rights have been violated you have the right to file a formal complaint with the Plan's Privacy Officer and/or with the Secretary of the U.S. Department of Health and Human Services. You cannot be retaliated against for filing a complaint.

Effective Date

The effective date of this Notice of Privacy Practices is January 1, 2021. The Plan is required by law to abide by the terms of this Notice until replaced. The Plan reserves the right to make changes to this Notice and to make the new provisions effective for all health information the Plan maintains. If revised, a new Notice of Privacy Practices will be provided to all Participants eligible for or covered by the Plan at that time.

For Questions or Additional Information Regarding Privacy Practices and Complaints

To request additional copies of this Notice of Privacy Practices, to obtain further information regarding our

privacy practices and your rights, or to file a complaint, please contact the Plan's Privacy Officer. This Notice is also available online at www.sagaftraplans.org/health.

Part IV

GENERAL HRA PLAN INFORMATION

Name of Plan:	SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan
Effective Date:	January 1, 2021
Name, address, and telephone number of the Plan Sponsor:	Board of Trustees of the SAG-AFTRA Health Fund 3601 West Olive Avenue, Suite 200 Burbank, CA 91505 Phone: 1-800-777-4013 Fax: 1-818-953-9880
Name, address, and telephone number of the Plan Administrator: The Plan Administrator has the exclusive right to interpret the HRA Plan and to decide all matters arising under the HRA Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the HRA Plan and the SPD issued in connection with the HRA Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals or committees.	Board of Trustees of the SAG-AFTRA Health Fund 3601 West Olive Avenue, Suite 200 Burbank, CA 91505 Phone: 1-800-777-4013 Fax: 1-866-886-0878
Agent for Service of Legal Process:	Legal process may be served on the Trustees or theChief Executive Officer at: SAG-AFTRA Health Fund Street Address: 3601 West Olive Avenue Burbank, CA 91505 Mailing Address: P.O. Box 7830

	Burbank, CA 91510-7830
Sponsor's federal tax identification number:	95-6024160
Plan Number:	501
Plan Year:	January 1 through December 31
Claims Administrator: All reimbursement forms, and supporting documentation, must be provided to the Claims Administrator.	Via Benefits P.O. Box 25181 Lehigh Valley, PA 18002-5181 Phone: 1-833-981-1280 Fax: 1-866-886-0878
Funding:	Benefits are paid from the SAG-AFTRA Health Fund out of its general assets. No assets are segregated or earmarked for the purpose of providing benefits hereunder. No person shall have any right, title or claim to such assets prior to their payment pursuant to the terms of the HRA Plan.

PART V

HRA PLAN TERMS

Whenever used in this HRA Plan, the following terms shall have the meanings set forth below:

Active Plan	The SAG-AFTRA Health Plan
Allocation	The amount credited to a Participant's HRA Account for the provision of benefits under the Plan.
Board of Trustees	The joint labor-management Board of Trustees of the SAG-AFTRA Health Fund that has adopted the HRA Plan. The Board of Trustees is responsible for setting the benefits, rules and regulations of the HRA Plan and generally overseeing the HRA Plan's operations, with the assistance of its staff, professional consultants and advisors, the Claims Administrator, and other providers.
Catastrophic Coverage Reimbursement	Coverage provided under the HRA Plan for qualifying prescription drug expenses beginning only after the Participant accumulates covered Part D expenses in an amount equal to the true out of pocket (TrOOP) limit set by CMS for the applicable Plan Year. https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/catastrophic-coverage
Claims Administrator	The entity with which the Board of Trustees has entered into a contract for the purpose of processing claims under the HRA Plan. At the time this SPD is first effective, the Claims Administrator is ViaBenefits. References to Via Benefits include any successor to Via Benefits with whom the Board of Trustees may contract in the future.
CMS	The U.S. Center for Medicare and Medicaid Services.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.
Code	The Internal Revenue Code of 1986, as amended from time to time.

Committee	Any committee duly appointed and authorized by the Board of Trustees.
Effective Date	January 1, 2021
ERISA	The Employee Retirement Income Security Act of 1974, as amended from time to time.
Eligible Medical Expense	Certain expenses incurred by a Participant for medical care as defined in Code Section 213(d) and the rules, regulations and Internal Revenue Service interpretations thereunder, including premiums for health care insurance coverage and for long-term care insurance coverage. Eligible Medical Expenses shall not include expenses reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement or any amount claimed as a deduction on the federal income tax return of the Participant. Eligible Medical Expenses are incurred when the medical care is provided, not when the Participant is formally billed, charged for, or pays the expenses. Notwithstanding the above, the HRA Plan will pay for or reimburse individual health insurance premiums only if the coverage is purchased through the ViaBenefits Medicare Marketplace, or through Entertainment Health Insurance Solutions and Artists Health Insurance Resource Center (both joint programs of the Actors Fund and the Motion Picture and Television Fund), as determined by Via Benefits.
HIPAA	The Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including its regulations and other guidance promulgated thereunder, as of the applicable time that such regulations and guidance are effective.
HRA Account	The notional account established for a Participant to hold their Allocations. Each HRA Account is a notional account that merely reflects bookkeeping entries for any specific Participant. No earnings shall be credited at any time with respect to any HRA Account.
HRA Plan	The SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan, as same may be amended from time to time.

Participant	A Senior Performer, a Spouse, or a Surviving Spouse who has satisfied the eligibility requirements of the HRA Plan and has not, for any reason, become ineligible to participate in the HRA Plan.
Plan Administrator	The Board of Trustees
Plan Sponsor	The Board of Trustees
PHI	Protected health information as described under HIPAA, and generally includes individually identifiable health information held by or on behalf of the HRA Plan.
Retiree Health Credits	Credit toward eligibility for coverage under this HRA Plan as a Senior Performer as maintained in the records of the Plan Administrator. Retiree Health Credits are the Retiree Health Credits as recognized by Board of Trustees immediately prior to January 1, 2021 plus Retiree Health Credits earned on or after such date. Effective January 1, 2021, a participant in the Active Plan will earn a Retiree Health Credit if they earn at least $26,000 in covered earnings reported to the Active Plan during a calendar year. Effective January 1, 2022 the earnings threshold increases to $27,000.
Senior Performer	Anyone who satisfies the following eligibility requirements: • A former participant in the Active Plan who has satisfied the following requirements as of their attainment of age 65 or thereafter: o Completed 20 Retiree Health Credits; and o Started their pension from the SAG-Producers Pension Plan or the AFTRA Retirement Fund. • A former participant in the SAG-Producers Health Plan or the AFTRA Health Plan who has satisfied the following requirements as of their

attainment of age 65 or thereafter, and who, as of January 1, 2017:

- had attained age 55;
- started their pension from the SAG-Producers Pension Plan or AFTRA Retirement Fund; and
- had at least 15 qualifying years under the AFTRA Health Plan or at least 15 pension credits under the SAG-Producers Pension Plan.

- A former participant in the AFTRA Health Plan who has satisfied the following requirements as of their attainment of age 65:
  - was born on or before January 1, 1943; and
  - has at least 10 qualifying years under the AFTRA Health Plan.

- A former participant in the AFTRA Health Plan who has satisfied the following requirements as of their attainment of age 65:
  - was born before December 1, 1937 and, as of December 1, 1992;
    - was vested in a regular annuity based on at least 10 years of credit under the AFTRA Retirement Plan (including at least five base years in which covered earnings were at least $2,000 or more); or
    - met the requirements in effect at that time for retiree coverage under the AFTRA Health Plan.

- A former participant in the SAG-Producers Health Plan who has satisfied the following requirements as of their attainment of age 65:

- had at least 10 pension credits under the SAG-Producers Pension Plan as of December 31, 2001; and
- was at least age 55 as of December 31, 2002.

- An "Occupational Disability Pensioner" under the SAG-Producers Pension Plan who has at least 15 Retiree Health Credits earned under the SAG-AFTRA Health Plan and the SAG-Producers Health Plan. Occupational Disability Pensioners may not count any AFTRA Health Plan qualifying years as Retiree Health Credits for this purpose.

Spouse

The person who is legally married under any applicable state or foreign law to a Senior Performer determined as of the applicable time by Via Benefits and/or the Plan Administrator.

Surviving Spouse

The Spouse of

- A deceased Senior Performer; or
- A deceased participant or former participant in the Active Plan, the AFTRA Health Plan or the SAG-Producers Health Plan, who was at least age 50 at death, had at least 20 Retiree Health Credits, and whose age plus Retiree Health Credits equaled at least 75.

who was married to the Senior Performer, participant or former participant for the twelve months immediately preceding the death of the Senior Performer, participant or former participant.

SAG-AFTRA HEALTH PLAN
SENIOR PERFORMERS
HEALTH REIMBURSEMENT ACCOUNT
PLAN

TABLE OF CONTENTS

SAG-AFTRA HEALTH PLAN
SENIOR PERFORMERS
HEALTH REIMBURSEMENT ACCOUNT PLAN

INTRODUCTION

The Board of Trustees of the SAG-AFTRA Health Fund hereby adopts this SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan (the "Plan") for the purpose of allowing former participants in the SAG-AFTRA Health Plan (and its predecessor plans) who qualify as Senior Performers and their Spouses and Surviving Spouses, as defined herein, to obtain reimbursement of eligible medical expenses incurred by such Senior Performers, Spouses and Surviving Spouses. The Plan is intended to qualify as a "health reimbursement arrangement" as that term is defined under IRS Notice 2002-45 and a medical reimbursement plan under Code Sections 105 and 106. This Plan is also intended to be exempt from the Affordable Care Act as a separate "retiree-only" plan pursuant to ERISA Section 732(a) and Code Section 9831(a)(2). The Plan will be interpreted at all times in a manner consistent with such intent.

ARTICLE I
DEFINITION OF TERMS

1.1 Definitions. Whenever used in this Plan, the following terms shall have the meanings set forth below:

(a) "Active Plan" means the SAG-AFTRA Health Plan.

(b) "Allocation" means the amount credited to a Participant's HRA Account for the provision of benefits under the Plan as provided in Section 3.2.

(c) "Board of Trustees" means the joint labor-management Board of Trustees of the SAG-AFTRA Health Fund that has adopted the Plan. The Board of Trustees is responsible for setting the benefits, rules and regulations of the Plan and generally overseeing the Plan's operations, with the assistance of its staff, professional consultants and advisors, the Claims Administrator, and other providers.

(d) "Catastrophic Coverage Reimbursement" means coverage provided under the Plan under Section 4.5 for qualifying prescription drug expenses beginning only after the Participant accumulates covered Part D expenses in an amount equal to the true out of pocket (TrOOP) limit set by CMS for the applicable Plan Year.

(e) "Claims Administrator" means the entity with which the Board of Trustees has entered into a contract for the purpose of processing claims under the Plan. At the time this document is executed, the Claims Administrator is Via Benefits. References to Via Benefits shall include any successor Claims Administrator hired by the Board of Trustees.

(f) "CMS" means the United States Center for Medicare and Medicaid Services.

(g) "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

(h) "Code" means the Internal Revenue Code of 1986, as amended from time to time.

(i) "Committee" means any committee duly appointed and authorized by the Board of Trustees.

(j) "Effective Date" means January 1, 2021.

(k) "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

(l) "Health Care Expense" means an expense incurred by a Participant for medical care as defined in Code Section 213(d) and the rules, regulations and Internal Revenue Service interpretations thereunder. Health Care Expenses are incurred when the medical care is provided, not when the Participant is formally billed, charged for, or pays the expenses. Notwithstanding the foregoing, Health Care Expenses shall not include:

(1) expenses reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement or any amount claimed as a deduction on the federal income tax return of the Participant;

(2) premiums to an employer's group health plan that are subsidized by an employer; or

(3) individual health insurance premiums other than for insurance that is purchased through the Via Benefits Medicare Marketplace, or through Entertainment Health Insurance Solutions or Artists Health Insurance Resource Center (both joint programs of the Actors Fund and the Motion Picture and Television Fund), as determined by the Claims Administrator.

(4)

(m) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including its regulations and other guidance promulgated thereunder, as of the applicable time that such regulations and guidance are effective.

(n) "HRA Account" means the notional account established for a Participant to hold their Allocations. No earnings shall be credited at any time with respect to any HRA Account.

(o) "Participant" means a Senior Performer, a Spouse, or a Surviving Spouse who has satisfied the eligibility requirements of Article II hereof and has not, for any reason, become ineligible to participate in the Plan.

(p) "Plan" means the SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan, as set forth herein, and as same may be amended from time to time.

(q) "Plan Administrator" means the Board of Trustees.

(r) "Plan Sponsor" means the Board of Trustees.

(s) "Plan Year" means the calendar year.

(t) "PHI" means protected health information as described in 45 C.F.R. § 160.103, and generally includes individually identifiable health information held by or on behalf of the Plan.

(u) "Retiree Health Credits" means credit toward eligibility for coverage under this Plan as a Senior Performer as maintained in the records of the Plan Administrator. Retiree Health Credits shall be the Retiree Health Credits as recognized by the SAG-AFTRA Health Fund immediately prior to January 1, 2021 plus Retiree Health Credits earned on or after such date. Effective January 1, 2021, a participant in the Active Plan will earn a Retiree Health Credit if they earn at least $26,000 in covered earnings reported to the Active Plan during a calendar year. Effective January 1, 2022, the foregoing earnings threshold increases to $27,000.

(v) "Senior Performer" means any individual who satisfies the following eligibility requirements:

(1) A former participant in the Active Plan who has satisfied the following requirements as of their attainment of age 65 or thereafter:

(i) Completed 20 Retiree Health Credits; and

(ii) Commenced receipt of a pension from the SAG-Producers Pension Plan or the AFTRA Retirement Fund.

(2) A former participant in the SAG-Producers Health Plan or the AFTRA Health Plan who has satisfied the following requirements as of their attainment of age 65 or thereafter, and who, as of January 1, 2017:

(i) had attained age 55;

(ii) commenced receipt of a pension from the SAG-Producers Pension Plan or AFTRA Retirement Fund; and

(iii) had at least 15 qualifying years under the AFTRA Health Plan or at least 15 pension credits under the SAG-Producers Pension Plan.

(3) A former participant in the AFTRA Health Plan who has satisfied the following requirements as of their attainment of age 65:

(i) was born on or before January 1, 1943; and

(ii) has at least 10 qualifying years under the AFTRA Health Plan.

(4) A former participant in the AFTRA Health Plan who has satisfied the following requirements as of their attainment of age 65:

(i) was born before December 1, 1937 and, as of December 1, 1992;

(ii) was vested in a regular annuity based on at least 10 years of credit under the AFTRA Retirement Plan (including at least five base years in which covered earnings were at least $2,000 or more); or

(iii) met the requirements in effect at that time for retiree coverage under the AFTRA Health Plan.

(5) A former participant in the SAG-Producers Health Plan who has satisfied the following requirements as of their attainment of age 65:

(i) had at least 10 pension credits under the SAG-Producers Pension Plan as of December 31, 2001; and

(ii) was at least age 55 as of December 31, 2002.

(6) An Occupational Disability Pensioner under the SAG-Producers Pension Plan who has at least 15 Retiree Health Credits earned under the SAG-AFTRA Health Plan and/or the SAG-Producers Health Plan. Occupational Disability Pensioners may not count any AFTRA Health Plan qualifying years as Retiree Health Credits for this purpose.

(w) "Spouse" means the person who is legally married under any applicable state or foreign law to a Senior Performer determined as of the applicable time by the Claims Administrator and/or Plan Administrator.

(x) "Surviving Spouse" means (1) the Spouse of a deceased Senior Performer, or (2) the Spouse of a deceased participant or former participant in the Active Plan, the AFTRA Health Plan or the SAG-Producers Health Plan, who was at least age 50 at death, had at least 20 Retiree Health Credits, and whose age plus Retiree Health Credits equaled at least 75; provided, however, that a Surviving Spouse will not be eligible for benefits hereunder until the date on which the deceased Senior Performer or deceased participant or former participant would have attained their 65th birthday, and provided further, that the Surviving Spouse will be eligible for benefits hereunder only if they have attained their 65th birthday or otherwise are eligible for Medicare and were married to the Senior Performer, participant or former participant for the twelve months immediately preceding the death.

1.2 Gender and Number. This Plan uses gender-neutral person pronouns. The singular shall include the plural, and vice versa.

ARTICLE II
PARTICIPATION

2.1 Eligibility to Participate. A Senior Performer, Spouse, or Surviving Spouse shall become a Participant in this Plan when they meet the following requirements:

(a) For a Senior Performer other than an Occupational Disability Pensioner described in Section 1.1(v)(6), have reached age 65;

(b) For a Spouse or a Surviving Spouse, have reached age 65 or otherwise become eligible for Medicare;

(c) Have obtained an individual health insurance policy through Via Benefits or provided satisfactory evidence to the Plan Administrator or its delegate that:

(1) They have obtained an individual health insurance policy through Entertainment Health Insurance Solutions or Actors Health Insurance Resource Center, both joint programs of the Actors Fund and the Motion Picture and Television Fund;

(2) They have retiree coverage under another group health plan;

(3) They have health coverage under TRICARE; or

(4) They reside outside the United States; and

(d) Have completed any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator or its delegate from time to time;

provided that the Senior Performer, Spouse or Surviving Spouse is not eligible for coverage under the Active Plan as a Participant or a dependent as a result of current employment status.

2.2 Special Rule for Spouses. A Spouse may become a Participant regardless of whether the Senior Performer is a Participant, provided that the Spouse has attained age 65 or is otherwise eligible for Medicare and that neither the Senior Performer nor the Spouse is eligible for coverage under the Active Plan as a result of current employment status.

2.3 Cessation of Participation. A Participant shall cease to be a Participant on the earliest of:

(a) with respect to a Senior Performer and their Spouse, the date the Senior Performer regains eligibility in the Active Plan;

(b) with respect to a Senior Performer, the date of their death;

(c) the date a individual does not re-enroll in any individual health insurance policy, unless they satisfy one of the exceptions listed above;

(d) with respect to a Spouse, the date they divorce the Senior Performer or die;

(e) with respect to a Surviving Spouse, the date of their remarriage or death;

(f) the effective date of any Plan amendment that renders them ineligible to participate; or

(g) the termination of the Plan.

Reimbursement from the Participant's HRA Account after cessation of participation shall be governed by Article IV.

ARTICLE III
FUNDING

3.1 Funding. The benefits provided herein shall be provided by the SAG-AFTRA Health Fund out of its general assets, and no assets shall be segregated or earmarked for the purpose of providing benefits hereunder, nor shall any person have any right, title or claim to such assets prior to their payment hereunder. As such, each HRA Account established pursuant to the Plan shall be a notional account which merely reflects bookkeeping entries and does not represent assets that are actually set aside for the exclusive purpose of providing benefits to the Participant under the terms of the Plan. In no event may any benefits under the Plan be funded with Participant contributions, except with respect to COBRA Continuation Coverage.

3.2 Allocations. The following annual amounts will be credited on behalf of Participants; provided that allocations for Senior Performers and Spouses will be made to a combined HRA Account, unless the Spouse is also a Senior Performer, in which case the Senior Performer and the Spouse will each receive an allocation to their separate HRA Accounts. The amounts will be prorated for the number of months of participation in their first year of participation.

(a) Fixed Dollar Amount of $1,140, each, for Senior Performers with at least 20 Retiree Health Credits and their Spouses;

(b) Fixed Dollar Amount of $1,140 for Surviving Spouses of Senior Performers with at least 20 Retiree Health Credits;

(c) Fixed Dollar Amount of $1,140 for Surviving Spouses of a deceased participant or former participant in the Active Plan, the AFTRA Health Plan or the SAG-Producers Health Plan, who was at least age 50 at death, had at least 20 Retiree Health Credits, and whose age plus Retiree Health Credits equaled at least 75;

(d) Fixed Dollar Amount of $240, each, for Senior Performers with fewer than 20 Retiree Health Credits and their Spouses; provided, however, that if the Senior Performer's Spouse is also a Senior Performer and has at least 20 Retiree Health Credits, the Spouse and the Senior Performer will each instead receive an allocation of $1,140 to their separate HRA Accounts;

(e) Fixed Dollar Amount of $240 for Surviving Spouses of Senior Performers with fewer than 20 Retiree Health Credits;

(f) Fixed Dollar Amount of $240 for Surviving Spouses of a deceased participant or former participant in the Active Plan, the SAG-Producers Health Plan or the AFTRA Health Plan with fewer than 20 Retiree Credits.

3.3 Timing of Allocation. Allocations will be credited to HRA Accounts on or about the first business day of each Plan Year, or, if the Senior Performer or Surviving Spouse becomes a Participant after the first day of a Plan Year, on or about the first business day of their participation in the Plan.

3.4 Carryover of Accounts. Allocations remaining in an HRA Account (after the expiration of the claims run-out period) at the end of a Plan Year shall be carried over to subsequent Plan Years.

ARTICLE IV
BENEFITS

4.1 Provision of Benefits. The Plan will reimburse Participants for Health Care Expenses, up to the unused amount in the Participant's HRA Account. A Participant shall be entitled to reimbursement under this Plan only for Health Care Expenses incurred after they become eligible to participate in the Plan and before their participation has ceased. In no event shall any benefits under this Plan be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Health Care Expenses.

4.2 Amount of Reimbursement. At all times during a Plan Year, a Participant shall be entitled to benefits under this Plan for payment of Health Care Expenses in an amount that does not exceed the balance of their HRA Account. Each reimbursement hereunder shall be a deduction to such HRA Account available to pay Health Care Expenses under the Plan.

4.3 Expense Reimbursement Procedure. Reimbursement for Health Care Expenses shall be made in accordance with this Section 4.3.

(a) *Timing:* A Participant desiring to receive reimbursement for Health Care Expenses under this Plan shall submit a written claim form to the Claims Administrator. Upon loss of eligibility as provided in Section 2.3, coverage under the Plan ceases, the Participant shall receive no further Allocations under the Plan, and their Health Care Expenses incurred after such date will not be reimbursed hereunder even if Allocations remain in the Participant's HRA Account. The Participant may submit claims for reimbursement for Health Care Expenses incurred prior to their loss of eligibility, provided the Participant files such claims within 180 days following such loss of eligibility.

(b) *Claims Substantiation:* The Plan Administrator may require the Participant to furnish a bill, receipt, cancelled check, and/or other written evidence or certification of payment or of obligation to pay Health Care Expenses. The Claims Administrator will reimburse the Participant from the Plan for expenses that it determines are Health Care Expenses up to the balance in the Participant's HRA Account at such intervals as the Plan Administrator may deem appropriate (but not less frequently than quarterly). The Plan Administrator or its delegate reserves the right to verify to its satisfaction all claimed Health Care Expenses prior to reimbursement. Each request for reimbursement shall include the following information, except where the Claims Administrator has in place with an insurance carrier an automatic substantiation procedure with respect to premium payments, in which case, the Claims Administrator will follow such procedures:

(1) the amount of the Health Care Expense for which reimbursement is requested;

(2) the date the Health Care Expense was incurred;

(3) a brief description and the purpose of the Health Care Expense;

(4) the name of the Participant for whom the Health Care Expense was incurred;

(5) the name of the person, organization or other health care provider to whom the Health Care Expense was or is to be paid;

(6) a statement that the Participant has not been and will not be reimbursed for the Health Care Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such Health Care Expense under Code Section 213; and

(7) a written bill from an independent third party stating that the Health Care Expense has been incurred and the amount of such expense and, at the discretion of the Plan Administrator, a receipt showing payment has been made.

Claims will be charged to the HRA Account of the Participant who submits the claim. The Plan Administrator may establish such other rules as it deems desirable regarding the frequency of reimbursement of expenses, the minimum dollar amount that may be requested for reimbursement and the maximum amount available for reimbursement during any single month.

(c) *Timing*: The Claims Administrator shall review such claim and respond thereto within thirty (30) days after receiving the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify the claimant within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review the claim. If such an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that the claimant will need to provide to the Claims Administrator. The claimant will have no less than 45 days from the date they receive the notice to provide the requested information. The Claims Administrator shall provide to every claimant who is denied a claim for benefits (in whole or in part) written or electronic notice setting forth in a manner calculated to be understood by the claimant:

(1) the specific reason or reasons for the denial;

(2) specific reference to pertinent plan provisions on which denial is based;

(3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and

(5) a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.

(d) *Claims Denied*: Claims that are partially or wholly denied may be appealed to the Plan Administrator as provided in Section 6.4.

(e) *Mode of Reimbursement*. The Claims Administrator shall determine the method or mode of reimbursement payments, including whether by direct deposit, written check or otherwise.

(f) *Forfeiture of Unclaimed Reimbursements.* Any HRA Account payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) shall automatically forfeit twelve months after the check was mailed or the payment was otherwise attempted.

4.4 Death.

(a) *Senior Performer with Combined HRA Account*.

(1) In the event a Senior Performer with a combined HRA Account dies with no Surviving Spouse, the Senior Performer's HRA Account shall be immediately forfeited upon their death; provided, however, that the Senior Performer's estate or representatives may submit claims for Health Care Expenses incurred by the Senior Performer and their Spouse prior to their death, as long as such claims are submitted no later than 180 days after the Senior Performer's death.

(2) In the event a Senior Performer with a combined HRA Account dies with a Surviving Spouse, the Senior Performer's HRA Account shall continue, and such Surviving Spouse may continue to submit Health Care Expenses for reimbursement in the normal course as long as the Surviving Spouse remains entitled to receive Allocations to the HRA Account after the Senior Performer's death. Following the death of the Surviving Spouse, the HRA Account shall be immediately forfeited; provided, however, that the estate or representatives of the Surviving Spouse may submit claims for Health Care Expenses incurred by the Surviving Spouse prior to the Surviving Spouse's death, as long as such claims are submitted no later than 180 days after the Spouse's death.

(b) *Separate HRA Accounts.*

In the event a Senior Performer who is married to another Senior Performer dies, the estate or representatives of the deceased Senior Performer may submit claims for Health Care Expenses incurred by the Senior Performer prior to their death, as long as such claims are submitted no later than 180 days after the deceased Senior Performer's death. The deceased Senior Performer's HRA Account shall be forfeited and a one-time allocation of the remaining amount in the deceased Senior Performer's HRA Account shall be made to the deceased Senior Performer's Surviving Spouse's separate HRA Account.

(c) *Surviving Spouses*.

In the event a Surviving Spouse dies, their HRA Account shall be immediately forfeited upon their death; provided, however, that the Surviving Spouse's estate or representatives may submit claims for Health Care Expenses incurred by the Surviving Spouse prior to

their death, as long as such claims are submitted no later than 180 days after the Surviving Spouse's death.

4.5 Catastrophic Coverage Reimbursement. Once a Participant has accumulated covered qualifying Part D prescription drug expenses equal to the true out of pocket (TrOOP) limit set by the CMS for the applicable Plan Year, all qualifying Part D prescription drug expenses incurred thereafter for the remainder of the Plan Year shall be reimbursed by the Claims Administrator with no dollar limit. Such Participant must apply for this reimbursement with the Claims Administrator by following the requirements established by the Claims Administrator for such purpose from time to time.

ARTICLE V
CONTINUATION COVERAGE

5.1 Definitions. For purposes of this Article, the following terms shall have the meanings set forth below:

(a) "COBRA Continuation Coverage" means the continuation of the Plan benefits being provided to a Qualified Beneficiary immediately prior to a Qualifying Event.

(b) "Election Period" means a period of at least 60 days' duration that begins not later than the date on which the Qualified Beneficiary's coverage under the Plan would otherwise terminate by reason of a Qualifying Event and that ends 60 days after the later of: (1) the date such coverage would otherwise end, or (2) the date that the Qualified Beneficiary receives notice of their right to continued coverage under the Plan pursuant to Section 5.4.

(c) "Qualified Benefits" means the HRA benefit under this Plan.

(d) "Qualified Beneficiary" means a Spouse, former Spouse.

(e) "Qualifying Event" means any of the following events which, but for this Article, would result in the loss of coverage of a Qualified Beneficiary:

(1) the death of a Participant; or

(2) the divorce or legal separation of a Participant and their Spouse.

(f) "Similarly Situated Beneficiary" means, in the case of any Qualified Beneficiary who has a Qualifying Event, an individual who has the same coverage options under the Plan that the Qualified Beneficiary would have had if the Qualifying Event had not occurred; provided that determinations of similar status shall be made by the Plan Administrator in accordance with and taking into account the factors permitted under Code Section 4980B and the regulations issued thereunder to the extent such law or regulations apply.

5.2 COBRA Continuation Coverage. The Spouse or former Spouse may elect COBRA Continuation Coverage under the Plan pursuant to this Article if the Spouse or former Spouse is no longer eligible for Qualified Benefits because of a Qualifying Event described in Section 5.1(e).

5.3 Period of Coverage. A Qualified Beneficiary who elects COBRA Continuation Coverage under the Plan shall be provided coverage identical to that being provided at that time to a Similarly Situated Beneficiary. COBRA Continuation Coverage under this Plan shall continue for up to 36 months, but shall be terminated earlier upon the occurrence of any of the following events:

(a) The date the Qualified Beneficiary's HRA Account is exhausted;

(b) The date the Qualified Beneficiary notifies the Plan Administrator that they wish to discontinue coverage;

(c) Any required monthly premium is not paid when due or during the applicable grace period;

(d) The date, after the date of the Qualified Beneficiary's COBRA election, that they become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the Qualified Beneficiary; or

(e) The Board of Trustees ceases to provide any group health plan to any participant.

5.4 Notices.

(a) Qualified Beneficiaries must notify the Plan Administrator in writing within 60 days of a Qualifying Event described in Section 5.1(e)(2) .

(b) Within 14 days of its receipt of any notice required by subsection (a) of this Section, or as soon as practicable following its determination that a Participant has died, the Plan Administrator shall notify the Qualified Beneficiary of their right to COBRA Continuation Coverage under the Plan. Any notification to a Spouse or former Spouse by the Plan Administrator shall also be treated as notification to all other Qualified Beneficiaries residing with said Spouse at the time such notification is made. Notice from the Plan Administrator shall be deemed complete upon placement of the notice of Election Period in the United States mail, provided there is sufficient postage for first class mailing and said notice is addressed to the Qualified Beneficiary's last known primary residence (any address other than the Qualified Beneficiary's last known primary residence shall only be known to the Plan Administrator if the Qualified Beneficiary specifically notifies the Plan Administrator of the change in address).

5.5 Election of Coverage. Upon notification by the Plan Administrator of their right to COBRA Continuation Coverage under the Plan, a Qualified Beneficiary must affirmatively elect COBRA Continuation Coverage before the expiration of the Election Period.

5.6 Contributions. A Qualified Beneficiary who elects COBRA Continuation Coverage under the Plan shall be required to pay a premium for any period of continued coverage, such premium to be 102% of the cost to the Plan of coverage for Similarly Situated Beneficiaries. The first required payment must be paid within 45 days of the date the COBRA Continuation Coverage is elected under Section 5.5.

ARTICLE VI
ADMINISTRATION

6.1 Plan Administrator. The Plan Administrator shall be responsible for the performance of all reporting and disclosure obligations under ERISA, and all other obligations required to be performed by the plan administrator under ERISA or the Code, except such obligations and responsibilities as may be delegated to such person or entity as the Plan Administrator designates. The Plan Administrator shall be the designated agent for service of legal process with respect to the Plan.

6.2 Duties of the Plan Administrator.

(a) The Plan Administrator shall have the sole discretion and authority to control and manage the operation and administration of the Plan.

(b) The Plan Administrator (or, where applicable and duly authorized by the Plan Administrator, the Chief Executive Officer of the SAG-AFTRA Health Fund or any Committee or the Claims Administrator) shall have the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply and interpret this Plan and to decide all matters arising in connection with the operation or administration of the Plan.

(c) Without limiting the generality of the foregoing, the Plan Administrator (or, where applicable and duly authorized by the Plan Administrator, the Chief Executive Officer or any Committee or the Claims Administrator) shall have the sole and absolute discretionary authority to:

(1) take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan to Participants;

(2) formulate, interpret and apply rules, regulations and policies necessary to administer this Plan in accordance with its terms;

(3) decide questions, including legal or factual questions relating to the calculation and payment of benefits under the Plan;

(4) resolve and/or clarify any ambiguities, inconsistencies and omissions arising under this Plan; and

(5) process, and approve or deny, benefit claims and rule on any benefit exclusions.

All determinations made by the Plan Administrator (or, where applicable and duly authorized by the Plan Administrator, the Chief Executive Officer or any Committee or the Claims Administrator) with respect to any matter arising under the Plan shall be final and binding on all parties affected thereby, subject to Section 6.4.

(d) The Plan Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:

(1) to prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;

(2) to prepare and distribute information explaining the Plan to Participants;

(3) to receive from Participants such information as shall be necessary for the proper administration of the Plan;

(4) to keep records of elections, claims, and disbursements for claims under the Plan, and any other information required by ERISA or the Code;

(5) to appoint individuals, third parties, or committees to assist in the administration of the Plan and to engage any other agents as it deems advisable;

(6) to promulgate election forms and claims forms to be used by Participants, which may be electronic in nature;

(7) to determine and enforce any limits on benefit elections hereunder; and

(8) to correct errors and make equitable adjustments for mistakes made in the administration of the Plan, specifically, and without limitation, to recover erroneous overpayments made by the Plan to a Participant, in whatever manner the Plan Administrator deems appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant.

6.3 Allocation and Delegation of Duties.

(a) The Plan Administrator shall have the authority to allocate, from time to time, by instrument in writing filed in its records, all or any part of its responsibilities under the Plan to one or more of its Trustees, Committees, employees, or officers, or to the Claims Administrator, as may be deemed advisable, and in the same manner to revoke such allocation of responsibilities. In event of such allocation, any and all discretionary authority or control vested in the Plan Administrator with respect to such allocated responsibility shall be delegated to such Trustees, Committees, employee, or officer, or to the Claims Administrator. In the exercise of such allocated responsibilities, any action of the Trustees, Committees, employees, officers, or the Claims Administrator to whom responsibilities are allocated shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of such Trustees, Committees, employees, or officers or the Claims Administrator with respect to such allocated responsibilities. The Trustees, Committees, employees, officers and Claims Administrator to whom responsibilities have been allocated shall periodically report to the Plan Administrator concerning the discharge of the allocated responsibilities.

(b) The Plan Administrator shall have the authority to delegate, from time to time, by written instrument filed in its records, all or any part of its responsibilities under the Plan to such person or persons other than those enumerated in Section 6.3(a) as it may deem advisable (and may authorize such person or persons to delegate such responsibilities to such other person or persons as the Plan Administrator shall authorize) and in the same manner to revoke any such delegation of responsibility. Any action of the delegate in the exercise of such delegated responsibilities shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall periodically report to the Plan Administrator concerning the discharge of the delegated responsibilities.

6.4 Appeal Procedure.

(a) Within 180 days of receipt by a claimant of a notice under Section 4.3 denying a claim in whole or in part, the claimant or their duly authorized representative may request in writing a full and fair review of the claim by the Claims Administrator, as delegate of the Plan Administrator. In connection with such review, the claimant or their duly authorized representative may, upon request and free of charge, have reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits, and may submit issues and comments in writing. The Claims Administrator shall make a decision promptly, but not later than 60 days after the Claims Administrator's receipt of a request for review. The decision on review shall be in writing, in a manner calculated to be understood by the claimant, and shall include:

(1) specific reasons for the decision;

(2) specific references to the pertinent Plan provisions on which the decision is based;

(3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;

(4) a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; information about the claimant's right to a voluntary appeal to the Plan Administrator, as set forth in 6.4(b), below; and

(5) a statement describing the voluntary appeal procedure under Section 6.4(b) and a statement of the claimant's right to bring a civil action under ERISA Section 502(a).

(b) A claimant may voluntarily take part in one more level of review of the denied appeal, to be completed by the Plan Administrator or its delegate. Any such review will be completed at the next scheduled meeting of the Plan Administrator or its delegate. If the request for voluntary appeal is received within 30 days of the next scheduled meeting of the Plan Administrator or its delegate, it will be considered at the second regularly scheduled meeting following receipt of the voluntary request for review. In special circumstances consideration of the appeal may be delayed until the third regularly scheduled meeting following the Plan Administrator's receipt of the voluntary appeal.

(c) The decision of the Plan Administrator, or its delegate, shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. The Plan Administrator, or its authorized delegate, shall be afforded such discretionary authority as set forth in the Restated Agreement and Declaration of Trust Establishing the SAG-AFTRA Health Fund. If claimant challenges the decision of the Plan Administrator, or its delegate, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before a claimant can pursue the claim in federal court. Facts and evidence that become known after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

(d) Any claim, suit or action relating to an alleged wrongful denial of Plan benefits (in whole or in part) or any other matter must be brought within 90 days of the date the appeal was denied or the date of the action or inaction complained of.

ARTICLE VII
GENERAL PROVISIONS

7.1 Amendment and Termination. The Board of Trustees reserves the right to amend, modify, or terminate this Plan at any time, including but not limited to the right to modify persons eligible for participation, benefits paid by the Plan, and the amount of Allocation to be credited, and the right to reduce or eliminate existing HRA Accounts.

7.2 Liability. Benefits under the Plan are paid by the SAG-AFTRA Health Fund out of its general assets.

7.3 Alienation of Benefits. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated and any attempt to do so shall be void and unenforceable.

7.4 Facility of Payment. If the Plan Administrator deems any person incapable of receiving benefits to which they are entitled by reason of minority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Plan Administrator to disburse it, whose receipt shall be complete acquittance therefor. Such payments shall, to the extent thereof, discharge all liability of the Plan Administrator, Plan Sponsor and the SAG-AFTRA Health Fund.

7.5 Status of Benefits. The Board of Trustees makes no commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable. Any Participant, by accepting a benefit under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

7.6 Applicable Law. The Plan shall be construed and enforced according to the laws of the California, to the extent not preempted by any Federal law.

7.7 Capitalized Terms. Capitalized terms shall have the meaning set forth in Article 1 (or, if not defined therein, as defined elsewhere in the Plan).

7.8 Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

EXHIBIT 9

SETTLEMENT REACHED IN LAWSUIT INVOLVING SAG-AFTRA HEALTH PLAN AND PLAN MEMBERS

LOS ANGELES–The SAG-AFTRA Health Plan (Plan) and a group of Plan participants announced today an amicable resolution of a class action lawsuit related to the 2017 merger of the SAG and AFTRA Health Plans and changes the Plan made to its benefit structure in July of 2020.

Under the terms of the settlement agreement, participants known as "Senior Performers," who no longer qualified in 2021 for the same health coverage from the Plan that was available to them before the 2020 changes will receive monetary relief worth $15 million, less any Court-approved attorneys' fees and costs. The Plan will also allocate an additional amount up to $700,000 per year for eight years (in 2023-2030 for a maximum of $5.6 million) into the Heath Reimbursement Accounts of certain Senior Performers who no longer qualify for active health coverage from the Plan. Those allocations will be based on the residual earnings of those Senior Performers.

In addition, the Plan has agreed to implement certain changes for the next four years that will inure to the benefit of all Plan participants. These changes include formalizing the process by which periodic disclosures to SAG-AFTRA are made concerning the Plan's projected financial condition for purposes of anticipating whether additional changes to the Plan will be needed as well as in advance of various collective bargaining negotiations; and the retention of an additional consultant to explore the prospects of cost-cutting measures, beyond those that the Plan has consistently implemented since its inception, while ensuring benefits are protected.

As reported to the Court, the attorneys for the class recommend the settlement because they believe it provides substantial monetary relief to Plan participants who were adversely affected by the 2020 Plan amendments as well as structural changes that will inure to the benefit of all Plan participants, and avoids the risk and costs of continued litigation. The Class Participants who brought this complaint, on behalf of performers who were negatively impacted by the 2020 benefit changes, feel this settlement is a beginning to reestablishing trust and benefits.

Defendants have similarly agreed to the settlement for the sake of avoiding the time and expense of litigation. They maintain that the 2020 changes, including those that affected Senior Performers, were necessary to preserve the financial health of the Plan and the Plan's continued ability to continue to provide high quality benefits to the greatest number of participants, and that the changes have achieved precisely that result.

Details about the settlement can be reviewed at www.sagaftrahealthplansettlement.com. The settlement is contingent on approval by the District Court. If the Court preliminarily approves the settlement, it will direct the parties to send formal notice of the settlement to all Plan participants and give them an opportunity to present their views in advance of a final hearing where the Court will decide whether to approve the settlement.

EXHIBIT 10

SAG·AFTRA HEALTH PLAN
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P (800) 777-4013 • F (818) 953-9880
www.sagaftraplans.org/health

Notice of Additional Credited Earnings Opportunity for Retirees (Including Senior Performers)

If you worked in Covered Employment during your Base Earnings Period (October 1 through September 30), and your sessional earnings are reported to the Plans on or before November 15, you can request to apply those covered sessional earnings to your previous Base Earnings Period if they will establish your coverage under the Health Plan starting the following January 1. To request this rule, email psd@sagaftraplans.org or send a secure message through Benefits Manager. If you use such sessional earnings to qualify for the next January 1, you cannot also apply them to qualify for the following Benefit Period.

You can use this rule twice in the next five years.

EXHIBIT 11

HRA NOTICE

TO: All individuals who qualified as a Senior Performer (as defined in the SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan ("HRA Plan")) and Surviving Spouses (as defined in the HRA Plan) as of January 1, 2017 or at any time from January 1, 2017 through [XXXPA date].

A Federal Court authorized this Notice. This is not a solicitation from a lawyer.

You are receiving this notice, along with the Notice of Proposed Class Action Settlement ("Notice"), because according to the records of the SAG-AFTRA Health Plan (the "Plan"), you qualified as a Senior Performer or a Surviving Spouse, as defined in the SAG-AFTRA Health Plan Senior Performers Health Reimbursement Account Plan ("HRA Plan") as of January 1, 2017 or at any time from January 1, 2017 through [XXXPA] and you are not a participant in the HRA Plan and do not have an HRA Account.

As set forth in the attached Notice, pursuant to the Settlement Agreement, the initial $15 million component of the Settlement, net of Attorneys' Fees and Costs and necessary Administrative Expenses, will be allocated to the HRA Accounts of certain Class Members who are Senior Performers (and their age 65+ spouses, if applicable) and Surviving Spouses, or otherwise paid in cash. In addition, the second monetary component of the Settlement will provide for additional allocations to the HRA Accounts of Qualifying Senior Performers (as defined in the Settlement Agreement) for up to eight years, from 2023 through 2030. A Qualifying Senior Performer who does not have an HRA Account will not receive this second component of monetary relief under the Settlement.

The purpose of this HRA Notice is to advise you that you have the opportunity to become a participant in the HRA Plan in order to receive settlement allocations to which you may be entitled in your HRA Account. Attached to this HRA Notice is a form you can complete and send back to [Settlement Administrator] within 60 days of the date on this notice indicating your intention to become a participant in the HRA Plan.

With respect to the initial allocation of the $15 million (net of Attorneys' Fees and Costs and Administrative Expenses), your allocation will be paid to you in cash if you do not notify the Plan of your intention to become a participant in the HRA Plan by the above deadline, or you notify the Plan of your intention and then fail to become a participant in the HRA Plan by May 1, 2024 regardless of the reason. Similarly, if you are a Qualifying Senior Performer and you do not become a participant in the HRA Plan and have an HRA Account by May 1, 2024, you will not receive any allocation of the additional HRA allocation for 2023. In subsequent years, Qualifying Senior Performers must be a participant in the HRA Plan with an HRA Account by January 1 of the relevant year to receive an additional allocation.

Keep in mind that in order to become a participant in the HRA Plan, you must have obtained a group Medicare Advantage Plan that has been approved by the Plan Administrator, or an individual health insurance policy (either a Medicare Advantage plan or a Medigap policy) through Via Benefits, unless you provide evidence that you have such a group Medicare

Advantage Plan or an individual health insurance policy (either a Medicare Advantage plan or a Medigap policy) through Entertainment Health Insurance Solutions or Actors Health Insurance Resource Center; have retiree coverage under another group health plan; have health coverage under TRICARE; or reside outside the United States, in addition to completing applicable enrollment forms. Enrolling in a group Medicare Advantage plan or an individual Medicare Advantage or Medigap insurance policy through these channels will require you to enroll in Medicare and to pay the required premiums.

There are also only limited periods during which a person can enroll in Medicare that depend on your current health coverage as well as other factors. Everyone's circumstances are different. You are therefore encouraged to contact Medicare and review your options with respect to the timing of your possible enrollment in Medicare and the amount of your Medicare premiums in order to make an informed choice about enrolling in the HRA Plan to receive any allocations under the Settlement Agreement to which you may be entitled. And you should also keep in mind that it can take on average up to 60 days for your Medicare enrollment to become effective and that you must have that Medicare enrollment before you can become a participant in the HRA Plan.

If you are enrolled in another group health plan as an employee or the spouse of an employee and are receiving active coverage, you will not be able to become a participant in the HRA Plan.

If you have any questions about this HRA Notice or about the Settlement, you may contact the following lawyers who have been appointed as Lead Class Counsel and you will not be charged:

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