TAKE 2

The Newsletter of the Screen Actors Guild – Producers Pension and Health Plans

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INSIDE TAKE 2

Special Rules for Participant Premium

The new Health Plan premium for Earned eligible participants is effective January 1, 2003. If you will have Earned eligibility in 2003, you should have already received a billing statement and payment coupon from the Plan Office. If you have not received this billing statement, please contact the Plan Office.

The general rule is that if you fail to pay the premium by the due date, you will not be eligible to participate in the Health Plan until your next Benefit Period. However, there are two exceptions to this general rule.

1) Other Coverage

If you do not pay the premium because you have other health coverage, you may be allowed to participate in this Health Plan when your other coverage ends because of a reduction in employment, separation, divorce or death or, if the other coverage is under a COBRA provision, the exhaustion of your COBRA coverage.

2) New Dependents

If you do not pay the premium and subsequently acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be eligible to participate in this Health Plan prior to your next Benefit Period.

You must request the coverage within 30 days after your other coverage ends, or 30 days after the marriage, birth, adoption or placement for adoption.

Effective January 1, 2003

Special Rules for Health Plan Premium

Changes in the Plans' Claims and Appeals Procedures

See page 2.

Claims and Appeals Procedures

Effective January 1, 2003, the Plans' claims and appeals procedures will change to conform to new regulations issued by the Department of Labor. These changes affect health and disability claims and claims for disability pensions. Procedures for claims involving eligibility, life insurance, accidental death and dismemberment benefits and other pension benefits will not change and are described in your Summary Plan Descriptions (SPDs).

FILING A CLAIM FOR BENEFITS

How To File A Claim

A claim for benefits is a request for benefits made in accordance with the Plans' claims procedures. Complete descriptions of how to file health claims and requests for pension benefits appear in your SPDs.

Simple inquiries about the Plans' provisions that are unrelated to a specific claim are not treated as claims for benefits. Nor will requests for prior approval of benefits that do not require such an approval by the Plans. In addition, when you present a prescription to a pharmacy to be filled under the terms of the Health Plan, that request is not a claim under these procedures. However, if your prescription request is denied, in whole or in part, you may file an appeal of the denial by using these procedures.

Authorized Representatives

An authorized representative may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Plan Office to designate an authorized representative.

Complete descriptions of how to file health claims and requests for pension benefits appear in your SPDs.

Types of Claims

A **Pre-Service Claim** is a claim for a benefit for which the Health Plan requires approval **before** medical care is obtained. For hospital and medical benefits, prior approval is required for organ transplants, eyelid, nasal and breast surgeries, outpatient private duty nursing and sleep studies. For mental health and chemical dependency benefits, prior approval from United Behavioral Health (UBH) is required for all care.

An **Urgent Care Claim** is any claim for medical care or treatment where the application of the time period for making a Pre-Service Claim determination:

- could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
- in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether your claim is an Urgent Care Claim is generally determined by the Health Plan. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above, shall be treated as an Urgent Care Claim.

A **Post-Service Claim** is a claim submitted for payment **after** health treatment has been obtained.

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FILING A CLAIM FOR BENEFITS, cont. from page 2

Disability Claims are claims that require a finding of total disability as a condition of eligibility. Under the Health Plan, this would be claims for waiver of the life insurance premium or coverage under the Total Disability Extension. Under the Pension Plan, this would be a request for a Disability Pension. The Plans reserve the right to have a physician examine you (at the Plans' expense) as often as is reasonable while a Disability Claim is pending.

Initial Determination

When you submit a claim, the Plan has a certain amount of time to make a decision regarding payment of the claim. The time for response may be extended if necessary due to matters beyond the Plan's control. For example, an extension may be available if the Plan needs additional information from you or your doctor to make its decision. You will be notified of the circumstances requiring the extension. The table below outlines these time periods and any available extensions.

Notice of Decision

For Pre-Service and Urgent Care Claims, you will receive written notice of the Plan's decision. For Post-Service and Disability Claims, you will be provided with written notice for claim denials, including:

1. The specific reason(s) for the decision and reference to any specific Plan provision(s) on which the decision is based.
2. A description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary.
3. A description of the appeal procedures and applicable time limits.
4. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
5. If an internal rule, guideline or protocol was relied upon in deciding your claim, a statement that a copy of the rule is available upon request at no charge.
6. If the decision was based on the absence of medical necessity, or because the treatment was experimental or investigational, a statement that an explanation of the scientific or clinical judgment for the decision is available upon request at no charge.
7. For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. Urgent Care decisions may be provided orally and followed with written notification.

Claims Procedures	Health Claims			Disability Claims
	Pre-Service	Urgent	Post-Service	
How long does the Plan have to make a decision when you file a claim?	15 days.	72 hours.	30 days.	45 days.
Are there any extensions available?	Yes, one 15-day extension.	No.	Yes, one 15-day extension.	Yes, two 30-day extensions. You will be notified of the first extension within 45 days. You will be notified of the second extension within the first 30-day extension.
What happens if the Plan needs additional information?	The Plan will tell you what information is needed within 5 days of receipt of the claim. You have 90 days to respond.	The Plan will tell you what information is needed within 24 hours of receipt of the claim. You have 48 hours to respond.	The Plan will tell you what information is needed within 30 days of receipt of the claim. You have 90 days to respond.	The Plan will tell you what information is needed within the time periods outlined above. You have 90 days to respond.
If additional information is requested, when must the Plan make its decision?	Within 15 days of the earlier of: • the day you respond, or • the end of the 90-day response period.	Within 48 hours of the earlier of: • the time you respond, or • the end of the 48-hour response period.	Within 15 days of the earlier of: • the day you respond, or • the end of the 90-day response period.	Within 30 days of the earlier of: • the day you respond, or • the end of the 90-day response period.

APPEALS PROCEDURES FOR DENIED CLAIMS

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request must be made in writing within 180 days after you receive notice of the denial. Appeals involving Urgent Care Claims for mental health or chemical dependency treatment may be made verbally by calling UBH at 800-562-2532. For other Urgent Care appeals, call the Plan Office at 818-954-9400, or from outside the Los Angeles area, 800-777-4013.

If your denied claim is a Disability Claim or for hospital or medical benefits, you may appeal one time to the Benefits Committee of the Board of Trustees. If your denied claim is for another type of health benefit, there are two levels of appeal. The first is to the appropriate carrier listed in the chart to the right. If the claim is denied after this first review, you may file a second appeal with the Plan Office.

Benefit	Company
Prescription Drug	Medco Health Solutions
Mental Health and Chemical Dependency	United Behavioral Health (UBH)
Dental	Delta Dental
Vision	Vision Service Plan
Life Insurance Premium Waiver	Metropolitan Life Insurance Company

Review Process

You have the right to review documents relevant to your claim. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

Your appeal will be reviewed by someone other than the person who originally denied the claim. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you. If your claim was denied on the basis of a medical judgment, such as lack of medical necessity, a health care professional with appropriate training and experience in a relevant field of medicine will be consulted.

Notice of Decision on Review

The table below outlines the timing for the appeal decision.

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Appeals Procedures for Denied Claims	Health Claims			Disability Claims
	Pre-Service	Urgent	Post-Service	
How much time do I have to appeal?	180 days.	180 days.	180 days.	180 days.
How long does the Plan have to make a decision on my appeal?	One level - 30 days. Two levels - 15 days for each level.	One level only - 72 hours.	One level - Usually appeals will be decided at the next Benefits Committee meeting.* You will be notified within 5 days of the decision. Two levels - 30 days for each level.	One level - Usually appeals will be decided at the next Benefits Committee meeting.* You will be notified within 5 days of the decision. Two levels - 30 days for each level.

* If your appeal is received within 30 days of the next regularly scheduled Benefits Committee meeting, it will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances a delay until the third regularly scheduled meeting following receipt of your appeal will be necessary.

APPEALS PROCEDURES FOR DENIED CLAIMS

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The decision on any review of your claim will be given to you in writing. If the appeal is denied, the notice will explain the reason for the decision as described in items 1, 4, 5 and 6 under "Notice of Decision" on page 3. It will also include a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.

See page 3 for detailed information on the Notice of Decision.

Limitation on When a Lawsuit may be Started

You may start a lawsuit to obtain benefits after you have filed an appeal and a final decision has been reached on the appeal. If two levels of appeal are required, you must receive a final decision on your second appeal. You may also file a lawsuit if the Plan does not reach a decision, or notify you that an extension is necessary within the appropriate time frames described above.

A lawsuit may not be started more than 90 days after the earlier of: (i) the date you receive the Plan's written decision on your appeal, or (ii) the end of the appeals and extension time frames described above.

Plans Take Steps To Protect Participant's Privacy

In an effort to protect your privacy and the threat of identity theft, the Plan Office has eliminated Social Security numbers on Health Plan ID cards and all Pension and Health Plan correspondence that we send to you beginning January 1, 2003. Although we will not be including Social Security numbers on your ID cards and correspondence in the future, Social Security numbers will remain a very important item in our internal record keeping system and for identification purposes.

Women's Health and Cancer Rights Act of 1998 Annual Notice

As required by the Women's Health and Cancer Rights Act of 1998, the Health Plan provides benefits for mastectomy-related service including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). For more information contact the Plan Office at (818) 954-9400 or (800) 777-4013.

***SCREEN ACTORS GUILD–
PRODUCERS PENSION
AND HEALTH PLANS***

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PO Box 7830
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Holiday Greetings

from

The Board of Trustees and Staff of the Screen Actors Guild - Producers Pension and Health Plans

PENSION AND HEALTH PLAN DIRECTORY

Burbank Plan Office: (818) 954-9400
From outside the Los Angeles area: (800) 777-4013
Fax: (818) 953-9880
New E-mail address: psd@sagph.org
Web site: www.sagph.org

IF YOU NEED:	ASK FOR:
Benefit and Eligibility Information	Participant Services
Pension Plan Information	Pension Department, Ext. 2020
Information on Medical Claims	Participant Services
Information on Dental Claims	
Delta Dental – Member Services	(800) 846-7418
– Directories	(800) 846-7418
Information on Prescription Drugs	
Medco Health	(800) 903-4728
Prescription Pre-Authorizations	(800) 753-2851
NEW YORK Plan Office 275 Madison Ave. #1819, New York, NY 10016	(212) 599-6010
SOUTHEASTERN Plan Office 7300 North Kendall Drive #620, Miami, FL 33156	(305) 670-9795