TAKE 2

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

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INSIDE TAKE 2

Important Health Plan Changes For 2016

Each year the Trustees review the Health Plan's comprehensive package of benefits with the goal of ensuring that it remains both available and affordable to the largest number of participants. While Plan premiums and eligibility have remained constant over the last several years, a steady rise in health care costs and skyrocketing drug prices have caused the Trustees to implement the following changes to three areas: Eligibility, Premiums and Self-Pay.

Earned Eligibility – Increased Premiums and Earnings Requirements Effective April 1, 2016

Earnings Requirement for Eligibility and Earned Premium Amounts

	Plan I	Plan II	Plan II Alternative	Plan II Age and Service*
Earnings Requirement for eligibility commencing on or after April 1, 2016	$32,000	$16,000	78 Days	$11,600
Premiums				
Participant	$300/Quarter	$357/Quarter	$357/Quarter	$456/Quarter
Participant plus 1 Dependent	$348/Quarter	$408/Quarter	$408/Quarter	$525/Quarter
Participant plus 2+ Dependents	$375/Quarter	$447/Quarter	$447/Quarter	$570/Quarter

*Must be at least 40 years old with a minimum of 10 years of Earned Eligibility.

Please note that Earned Health Plan premiums have not changed since 2011 and the minimum requirements for Earned Eligibility have not changed since 2012.

Overall Network Out-of-Pocket Maximum Increase Effective January 1, 2016

Effective January 1, 2016, in accordance with the Affordable Care Act, the Plan will increase the overall out-of-pocket maximum for network services. The new maximums will be $6,850 per person and $13,700 per family; currently they are $6,600 per person and $13,200 per family. The maximums apply to covered prescription drugs and to network hospital and medical charges. In Plan I, network mental health and substance abuse treatment charges also apply to the maximums as these amounts are included in the hospital and medical categories.

Network deductibles, copays and coinsurance amounts accumulate toward the overall network out-of-pocket maximum. So do your prescription drug deductibles, copays and coinsurance. Once the maximum is satisfied, your covered prescription drug and network hospital and medical claims will be paid at 100%.

Senior Performers
Increased Premiums Effective April 1, 2016

Senior Performers health coverage is generally available to participants who have retired with at least 15 Pension Credits and who are at least age 65. The premium for coverage differs based on the number of Pension Credits you have. Amounts for Senior Performers with at least 20 Pension Credits change with Trustee action. The amount for Senior Performers with 15-19 Pension Credits changes annually on January 1st based on projected Senior Performers costs.

Senior Performers who had at least 10 Pension Credits as of December 31, 2001 and were at least age 55 as of December 31, 2002, are currently paying the same amounts as Senior Performers with at least 20 Pension Credits. Effective April 1, 2016, these participants will pay the same amount as Senior Performers with 15-19 Pension Credits. The 2016 Senior Performer premium amounts, which also apply to dependents covered under the Extended Spousal benefit, are listed below:

2016 Senior Performer Premium Amounts

Senior Performers and Extended Spousal	With No Spouse or With Spouse Age 65 or Older*	With Spouse Under Age 65*
Jan. 1, 2016 to March 31, 2016		
20 or More Pension Credits	$50/Month	$100/Month
15-19 Pension Credits	$165/Month	$165/Month
At Least 10 Pension Credits as of Dec. 31, 2001 and at least age 55 as of Dec. 31, 2002	$50/Month	$100/Month
Effective April 1, 2016		
20 or More Pension Credits	$60/Month	$120/Month
15-19 Pension Credits	$165/Month	$165/Month
At Least 10 Pension Credits as of Dec. 31, 2001 and at least age 55 as of Dec. 31, 2002	$165/Month	$165/Month

*Includes coverage for dependent children.

Elimination of Extended Self-Pay Benefit for Early Retirement and Disability Pensioners Effective January 1, 2016

For years the Health Plan's self-pay coverage provided a much more generous benefit than required under federal COBRA law. The Health Plan began offering extended self-pay through its early retiree and extended spousal programs in an effort to give participants and their families a way to bridge the gap between retirement and eligibility for Medicare and Senior Performers coverage at age 65.

The benefit also provided a safety net to those with pre-existing conditions who might not have been able to buy individual insurance policies.

Now that high-quality, affordable coverage is offered to everyone through the Affordable Care Act Marketplace, protection is in place for those with pre-existing conditions and this extended coverage safety net is no longer necessary.

The extended self-pay benefit for early retirement and disability pensioners will be eliminated effective January 1, 2016. Coverage will terminate on December 31, 2015 for all retirees and their dependents who are enrolled in the benefit except in the following circumstances:

- You have less than 17 years of Earned Eligibility and you are within 18 months of the loss of your Earned Eligibility; or
- You have at least 17 years of Earned Eligibility and you are within 36 months of the loss of your Earned Eligibility.

If you qualify for one of these exceptions, your self-pay coverage will terminate at the end of the applicable 18 or 36 month period.

Beginning January 1, 2016, early or disability retirement will not be a Qualifying Event for self-pay coverage. Self-pay coverage will only be offered to participants upon the loss of Earned Eligibility due to a reduction in Covered Earnings or Days of Employment or the change from Plan I to Plan II due to a reduction in Covered Earnings.

The extended self-pay benefit is also being eliminated for dependents qualifying for the Extended Spousal benefit due to the death of a participant. Coverage will terminate for these dependents on the latter of: (i) December 31, 2015; or (ii) 36 months from the loss of Earned Eligibility.

Individuals affected by this change will be personally notified by mail. If you have any questions, please contact our Participant Services Department at (800) 777-4013.

This change does not affect the Health Plan's Senior Performers health coverage, including the Extended Spousal benefit for qualifying dependents of deceased retirees.

Switching Doctors or Midwives During Pregnancy: Understanding How the Plan Pays

Obstetrical services provided during pregnancy include pre-natal care, delivery, and postpartum care. This package of services is known as global maternity care.

If you switch from one doctor or midwife to another during your pregnancy, the Plan will cover up to the maximum global maternity allowance between the two providers combined. The amount will be divided based on which provider submits claims first. If the first doctor to submit a claim bills for the entire allowance, the second doctor may be left with no payment from the Plan.

If you move during your pregnancy and switch providers, the Plan determines the amount it will pay based on the geographic area of the providers involved.

For example, if you are receiving care from an obstetrician or midwife in Chicago, Illinois where the global allowance is $5,400 and you move to Los Angeles, California where the allowance is $5,900, the Plan will allow up to the higher amount of $5,900 between the two providers and the $5,900 will be allocated based on which provider submits claims first.

Diagnostic tests such as ultrasounds and lab tests are not part of the global maternity package and are covered separately when medically necessary.

Genetic Testing

The Health Plan covers genetic testing only when medically appropriate and required for the diagnosis or treatment of a medical condition. If your doctor recommends that you have genetic testing, contact Participant Services at (800) 777-4013. You may also ask that the Plan preauthorize benefits before you undergo testing so you will know what to expect from your coverage.

There are hundreds of genetic tests on the market today and the field of genetic research is quickly growing.

Genetic testing is medical testing that looks for changes in genes or abnormalities in chromosomes. Genetic tests are used for many different reasons such as in prenatal screening to determine if a fetus has certain diseases or chromosomal disorders. Testing can also be used to screen prospective parents to see if they are carriers of inheritable conditions such as cystic fibrosis or Tay-Sachs disease. Genetic testing is sometimes used to diagnose illness or to help doctors choose the best treatment for a patient who has already been diagnosed with a disease such as cancer.

Regardless of the reason for your tests, check with the Plan to find out what will be covered.

Alere's Quit for Life® Program Can Help You Quit Smoking

All participants and dependents who are at least 18 years old have access to the innovative Quit For Life® Program brought to you by the American Cancer Society and Alere Wellbeing.

Quit For Life® is the nation's leading tobacco cessation program and is available at no cost to you. With access to Alere's Quit for Life® Program, quitting smoking has never been easier.

Alere's Quit for Life® Program includes:

- Advice on quitting aids, such as the nicotine patch or gum
- Access to the Web Coach website, filled with online resources
- Unlimited access to the Quit Coach staff throughout the process

We encourage participants to enroll in the Quit for Life® Program and take advantage of this opportunity to achieve a smoke-free future.

Learn more at www.quitnow.net/sagphp or call (866) QUIT-4-LIFE (866-784-8454) to get started.

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 services 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 (800) 777-4013.

Notice of Availability of HIPAA Privacy Notice

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires periodic reminders of your right to receive a copy of the Plan's HIPAA Privacy Notice. This notice explains how your private health insurance information is used by the Plan and your rights under HIPAA. You can find the Plan's HIPAA Privacy Notice on our website www.sagph.org or you may request a copy by contacting the Plan Office at (800) 777-4013.

Prescription Drug Coverage for Medicare Eligible Participants Notice of Creditable Coverage

This Notice contains important information about your current prescription drug coverage with the SAG-Producers Health Plan and your options under Medicare's prescription drug coverage. Please read it carefully and keep it in a safe place with your important papers.

This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

Key Information

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare Prescription Drug Plans and Medicare Advantage plans that offer prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher premium.
2. The SAG-Producers Health Plan's existing prescription drug benefits have been determined to be "creditable coverage" which means that the Health Plan is expected to pay as much in claims for all participants as standard Medicare prescription drug coverage. Because your Health Plan drug coverage is comparable to the standard Medicare drug benefits, you do not need to join a Medicare drug plan as long as you have coverage under the Health Plan.
3. You do not need to enroll in a Medicare drug plan as long as you have coverage under the SAG-Producers Health Plan. If you do enroll in a Medicare drug plan, you will not be eligible for any prescription drug coverage from the SAG-Producers Health Plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. In addition, if you lose your Health Plan prescription drug coverage you may be eligible for a two-month Special Enrollment Period to sign up for a Medicare drug plan.

Your Choices and the Consequences

If you do not enroll in a Medicare drug plan, you will continue to receive your current prescription drug benefits from the Health Plan as long as you are otherwise eligible for Plan coverage. Remember that the Health Plan also covers hospital and medical benefits. There is no separate premium for prescription drug coverage under the Health Plan.

If you enroll in a Medicare drug plan, you will no longer receive any prescription drug coverage from the Health Plan. However, you will continue to receive medical and hospital benefits from the Health Plan as long as you continue to pay the Health Plan premium and are otherwise eligible for Plan coverage. If you enroll in a Medicare drug plan and later drop that coverage, you can again receive your prescription drug coverage from the Health Plan, provided you are still otherwise eligible. Your Health Plan prescription drug coverage will be effective the first of the month after your Medicare drug plan coverage ends.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

If you drop or lose coverage with the SAG-Producers Health Plan and do not enroll in a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 days or longer without prescription drug coverage that is as good as

Notice of Creditable Coverage

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Medicare's drug coverage, your monthly Medicare Part D premium may increase by at least 1% for each month that you did not have that coverage. For example, if you go 19 months without coverage, your premium for Medicare drug coverage may be at least 19% higher than what you would have paid had you enrolled as soon as you lost your Health Plan coverage. You may have to pay this higher premium for as long as you have Medicare drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or the Health Plan's Prescription Drug Coverage

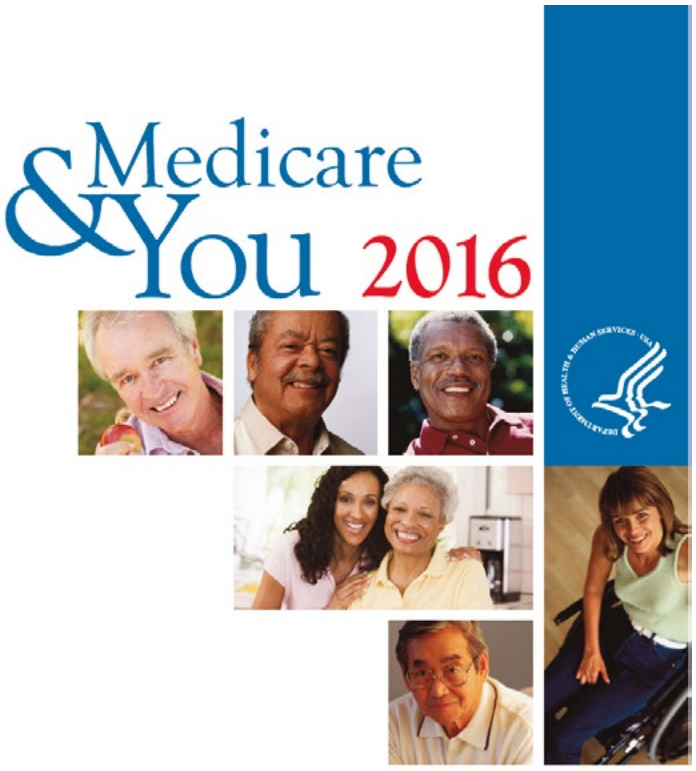
Contact the Plan Office at: (800) 777-4013 or (818) 954-9400.

An updated copy of this Notice will be provided annually. You will also get it before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the SAG-Producers Health Plan changes. You may also request a copy at any time by contacting the Plan Office.

Benefits under the SAG-Producers Health Plan are not vested or guaranteed. They may be modified, reduced or terminated at any time by the Board of Trustees.

For More Information About Your Options Under Medicare Prescription Drug Coverage

Detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.



To get more information, you can:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see "Medicare & You" or www.medicare.gov/contacts for phone number).
- Call 1-800-MEDICAR (800) 633-4227. TTY users should call (877) 486-2048.

If you have limited income and assets, extra help paying for Medicare prescription drug coverage is available. Information about this help is available from the Social Security Administration:

- Visit www.socialsecurity.gov.
- Call 1-800-772-1213 (TTY 1-800-325-0778).

Keep this Notice of Creditable Coverage

If you enroll in a Medicare drug plan, you may be required to provide a copy of this Notice when you enroll to avoid paying a higher premium. This Notice verifies that you have creditable coverage with the SAG-Producers Health Plan so that you are not required to pay the higher premium.

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Moving?

When you move, you must notify the Pension and Health Plan Office so that you will continue to receive information about your eligibility and benefits. This is especially important now that premium payment coupons are mailed every quarter to your address on file.

You can change your address with the Plan Office four different ways:

- Online at www.sagph.org
- Call the Plan Office
- File a Change of Address Card
- Write or FAX a letter to the Plan Office

SAG-AFTRA is a separate entity from the Pension and Health Plans and requires a separate notice for change of address.

Sign up for web access to all your information at sagph.org

PENSION AND HEALTH PLANS DIRECTORY

Burbank Plan Office: (818) 954-9400 or (800) 777-4013
Fax: (818) 953-9880 • Email address: psd@sagph.org
website: 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 Mental Health/Substance Abuse Coverage		
ValueOptions		(866) 277-5383
Information on Dental Claims		
Delta Dental	— Member Services	(800) 846-7418
	— Directories	(800) 846-7418
Information on Prescription Drugs		
Express Scripts		(800) 903-4728
Prescription Pre-Authorizations		(800) 753-2851
NEW YORK Plan Office		(212) 599-6010
275 Madison Ave. #1819, New York, NY 10016		