TAKE 2

SPECIAL EDITION

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

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Important Health Plan Changes Effective January 1, 2011

This **Special Edition** of Take Two includes most of the Health Plan modifications that take effect January 1, 2011. Many of these changes were noted in the Summer 2010 edition of Take 2, and they are restated here as a reminder. The Special Edition also includes an update of the Plan II Prescription Drug Benefits for medications used to treat mental health or substance abuse disorders and information on how to obtain preventive services at no cost to you as required under the Patient Protection and Affordable Care Act of 2010 (ACA).

INSIDE TAKE 2
Special Edition

Minimum Earnings Requirement For Health Plan Eligibility Increased

The minimum earnings required for Health Plan eligibility will increase effective January 1, 2011. The days-of-employment requirement for Alternative Eligibility will also increase. The changes affect eligibilities commencing in 2011 as shown in the table below.

Eligibility Commencing:	Plan I	Plan II
January 1, April 1, July 1, or October 1, 2011	$30,150	$14,800; or 76 days of employment; or $10,700 if you are at least 40 years of age with 10 years of Earned Eligibility

New Prescription Drug Co-Pay Structure

Effective January 1, 2011, the Prescription Drug Benefit will change to incorporate different co-payments based on formulary status as illustrated in the table on the bottom of page 2. Generic medications will continue to be available at the lowest co-payment level while non-preferred brand-name prescriptions will require the highest co-payments. If you are taking a medication that is not on the Plan's preferred list, ask your doctor to consider prescribing a lower-cost generic or preferred brand-name drug.

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Reminder of Health Plan Changes, continued from page 1

To find out if a medication is preferred, as well as information about the new co-payment amounts, please visit www.medco.com/openenroll and use the applicable access code below when prompted.

Plan I Participants: SAG00002010
Plan II Participants: SAG20002010

After January 1, 2011, you can find out whether or not a medication is preferred by visiting Medco online at www.medco.com. After you log in, click "Learn about formularies" in the Planning and Reference section.

Lifetime Maximums Eliminated

The Plan's current hospital and major medical lifetime maximum is $2,000,000. Effective January 1, 2011, the lifetime maximum will be eliminated.

Plan II and Plan II Lower Cost Self-Pay Mental Health and Substance Abuse Benefits Eliminated

Effective January 1, 2011, Mental Health and Substance Abuse Benefits will be eliminated for Plan II participants and for Lower Cost Self-Pay participants who previously had Plan II Earned Eligibility. This change also affects Prescription Drug Benefits. See Coverage of Drugs article on page 7.

Hospital and Major Medical Co-Insurance Reductions

Co-insurance is the amount the Plan pays on your claim after your deductible and co-payment. Effective January 1, 2011, the hospital and major medical network co-insurance will be paid at 90% for all services except preventive care. On the back of your current Health Plan I.D. card, it states that network providers are paid at 100%. You will not receive an updated I.D. card until the start of your next Benefit Period. For some participants this will be January 1, 2011. Other participants will not receive their new cards until April 1st, July 1st or October 1st of 2011. Please be aware that until your new cards arrive, you will continue to have Health Plan I.D. cards that state network providers are paid at 100% even though, effective January 1, 2011, network benefits will be paid at 90%.

Plan I Hospital Coverage Limited to Network Hospitals Only

Effective January 1, 2011, non-network hospital coverage for Plan I will be eliminated. Plan I hospital coverage will be limited to network hospitals only. Over 90% of hospitals utilized are in the BlueCard network.

New Prescription Drug Co-Pay Structure

Plan I	Retail Pharmacy Program	Medco by Mail (includes Accredo Specialty Pharmacy)
Calendar Year Deductible	$150 per person/$300 per family	
Supply of Medication	Up to a 30-day supply per prescription and/or refill	Up to a 90-day supply per prescription and/or refill
Co-payments	The greater of: **Generic:** $10 or 10% **Preferred Brand:** $25 or 25% **Non-Preferred Brand:** $40 or 40% In addition, if you receive a brand-name drug when a generic exists, you will pay the difference in cost between the generic and brand-name medication.	The greater of: **Generic:** $20 or 10%; maximum co-pay is $50 per prescription **Preferred Brand:** $50 or 25%; maximum co-pay is $125 per prescription **Non-Preferred Brand:** $100 or 40%; maximum co-pay is $300 per prescription In addition, if you receive a brand-name drug when a generic exists, you will pay the difference in cost between the generic and brand-name medication.
Plan II	Same as Plan I except that prescription drugs used for mental health and substance abuse treatment are no longer covered effective January 1, 2011. See page 7.	

Improvements to Plan I Mental Health and Substance Abuse Benefits

Benefit Design

In accordance with the provisions of the Mental Health Parity and Addiction Equity Act of 2008, Plan I coverage for mental health and substance abuse disorders will be provided at the same benefit levels as Plan I hospital and major medical coverage. If you are covered under the Lower Cost Self-Pay Plan and you previously had Plan I Earned Eligibility your mental health and substance abuse coverage will be at the same benefit levels as your Lower Cost Self-Pay hospital and major medical coverage.

You may choose a network or non-network professional as your mental health or substance abuse provider. Non-network providers will be reimbursed at 70% of the Plan's allowance. Coverage for facility charges is limited to network providers. The only exception to this rule is for emergency cases. Please see page 31 of the 2007 Health Plan Summary Plan Description for a definition of emergency treatment.

ValueOptions will continue to administer the Mental Health and Substance Abuse Benefits. The table below illustrates how they will be integrated with the Hospital and Major Medical Benefits.

When you use Plan I Mental Health and Substance Abuse Benefits as an:	Your calendar year deductible, co-payments, co-insurance and calendar year out-of-pocket maximum are the same as:
Inpatient	Plan I Hospital Benefits (network only)
Outpatient Facility Charges* Professional Charges	 Plan I Hospital Benefits (network only) Plan I Major Medical Benefits

* Facility charges include Residential, Partial Hospital and Intensive Outpatient programs.

The Mental Health and Substance Abuse Benefits no longer will have separate calendar year deductibles. For example, the Plan I Major Medical network deductible is $250 per person. That deductible can be satisfied with charges from a Blue Cross/BlueCard provider or a ValueOptions provider or a combination of the two. This same rule applies to the calendar year out-of-pocket maximums.

Alternative levels of care such as residential programs, partial hospital programs and intensive outpatient programs will continue to be covered under the inpatient benefit. This means coverage is limited to network providers only.

Treatment Pre-Authorization

Under the current Mental Health and Substance Abuse Benefits, you were required to have all treatment pre-authorized by ValueOptions. As of January 1, 2011, this requirement is being eliminated for services provided by a behavioral health provider for outpatient therapy. However, network facilities will continue to initiate the pre-authorization process as is currently done by Blue Cross/BlueCard hospitals under the Hospital Benefit.

Coordination of Benefits and Claims Submission

Beginning January 1, 2011, ValueOptions will process all mental health and substance abuse claims, even if the Health Plan is your secondary coverage. Network providers will submit your claims directly to ValueOptions. If you use a non-network professional, please contact ValueOptions at (866) 277-5383 for information on where to submit your claims.

The Plans' website: www.sagph.org is an excellent source of up-to-date information about both the Pension and Health Plans. Please check our website as we will be posting Frequently Asked Questions regarding these changes.

In-Network Preventive Services at No Cost to You

To comply with regulations in the Affordable Care Act (ACA), effective January 1, 2011, the Health Plan will cover certain preventive services at 100% with no deductible or co-pay. The tables on pages 5-6 outline the preventive-care services that will be covered at this level.

Most of these tests and screenings are already covered under the Plan's Wellness Benefits. Age-specific immunizations, routine physicals, gender-specific cancer screenings are, and will continue to be, an integral part of the Health Plan's benefit package.

Billing and Office Visits

The Plan will continue to cover preventive services whether they are performed separately or in the course of an annual physical. **However, to avoid cost sharing you must use a network provider, and the primary purpose of your office visit must be for preventive care.** Cost sharing is permitted for an office visit involving a preventive service if the office visit is billed separately or the primary purpose of the office visit is not the preventive service. For example, if you go to a network provider for a sore throat, and while there it is recommended that you have your cholesterol checked, the office visit is subject to the deductible/co-pay/coinsurance, and the cholesterol test is paid at 100%. Additionally, if you are diagnosed with a condition such as hyperlipidemia (high cholesterol) and your doctor performs a cholesterol test then that test is subject to cost sharing as it is in connection with a medical condition and not preventive services.

Effective January 1, 2011, the Plan will cover preventive services as illustrated in the table to the right. Age restrictions for Plan II and the Lower Cost Self-Pay Plan will no longer apply when services are received from network providers. Please note that the Plan will only pay for preventive services which are considered medically necessary. For example, a routine colonoscopy for an individual under the age of 50 would not be a covered expense as this test is performed routinely only for individuals age 50 and over.

See the tables on pages 5-6 that outline the covered preventive-care services. You can also visit www.healthcare.gov for even more information.

Preventive-Care Benefits	Network Provider	Non-Network Provider
Plan I	Health Plan pays 100% No deductible No co-pay	Health Plan pays 70% No deductible
Plan II and Lower Cost Self-Pay	Health Plan pays 100% No deductible No co-pay	Not covered except in certain limited circumstances. Refer to page 43 of the Health Plan SPD.

List of Covered Preventive Care Services

NETWORK ONLY

Children and Adolescents

Newborns

- Screening all newborns for
  - Hearing loss
  - Hypothyroidism
  - Sickle cell disease
  - Phenylketonuria (PKU)
- Gonorrhea preventive medication for eyes of all newborns

Childhood/Adolescent Immunizations

- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type B
- Hepatitis A and B
- Human Papillomavirus (HPV)
- Influenza (Flu)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal (pneumonia)
- Inactivated Poliovirus
- Rotavirus
- Varicella (chickenpox)

Childhood Screenings

- Medical history for all children throughout development
- Height, weight and Body Mass Index (BMI) measurements
- Developmental screening for children throughout childhood
- Autism screening for children at 18 and 24 months
- Behavioral assessment for children of all ages
- Vision screening
- Oral health risk assessment for young children
- Hematocrit or Hemoglobin screening
- Obesity screening and weight management counseling for children age 6 or older
- Iron supplements for children 6 to 12 months who are at higher risk for anemia
- Fluoride supplements for children without fluoride in their water
- Lead screening for children at risk of exposure
- Dyslipidemia screening for children at higher risk of lipid disorder
- Tuberculin testing for children at higher risk of tuberculosis

Additional Screenings for Adolescents

- Depression screening
- Alcohol and drug use assessment
- Counseling to prevent sexually transmitted infections (STIs) for sexually active adolescents
- Cervical dysplasia screening for sexually active young women
- HIV screening for adolescents at higher risk

See Adult Preventive Care Services *on page 6*

List of Covered Preventive Care Services

NETWORK ONLY

Health Screenings for Adults

- Blood pressure screening for all adults
- Cholesterol screening for men age 35 and older, women age 45 and older, and younger adults at higher risk
- Diabetes screening for type 2 diabetes for adults with high blood pressure
- HIV and sexually transmitted infection (STI) screenings for adults at higher risk

Cancer Screenings

- Breast cancer mammography every 1 to 2 years for women over age 40
- Breast cancer chemoprevention counseling for women at high risk for breast cancer
- Cervical cancer pap test for women
- Colorectal cancer screenings including fecal occult blood testing, sigmoidoscopy or colonoscopy from age 50 to 75
- Prostate cancer (PSA) screening for men

Health Counseling

- Doctors are encouraged to counsel patients about these health issues and refer them to appropriate resources as needed:
  - Healthy diet
  - Weight loss
  - Tobacco use
  - Alcohol misuse
  - Depression
  - Prevention of sexually transmitted infections (STIs)
  - Use of aspirin to prevent cardiovascular disease

Adult Immunizations

- Hepatitis A and B
- Herpes Zoster (Shingles)
- Human Papillomavirus (HPV)
- Influenza (Flu)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal (pneumonia)
- Tetanus, Diphtheria, Pertussis
- Varicella (chickenpox)

Screenings for Men

- Abdominal aortic aneurysm one-time screening for men age 65 to 75 who have smoked

Screenings for Women

- Osteoporosis screening for women age 60 and older, depending on risk factors
- BRCA counseling about genetic testing for women at higher risk

Specifically for Pregnant Women

- Folic acid supplements for women who may become pregnant
- Anemia screening for iron deficiency
- Tobacco cessation counseling for all pregnant women who smoke
- Syphilis screening for all pregnant women
- Hepatitis B screening during the first prenatal visit
- Rh incompatibility blood type testing at first prenatal visit and at 24-28 weeks
- Bacteriuria urinary tract infection screening at 12 to 16 weeks
- Breastfeeding education to promote breastfeeding

Coverage of Drugs Used to Treat Mental Health and Substance Abuse Conditions Eliminated for Plan II – Update

Under provisions of the Mental Health Parity legislation, a plan that eliminates facility and professional fees for mental health and substance abuse treatment must eliminate prescription drug coverage for these conditions as well. Using guidelines established by the National Institute of Mental Health, there are five psychotherapeutic medication categories for which the Plan will no longer provide prescription drug benefits for Plan II participants and for Lower Cost Self-Pay participants who previously had Plan II Earned Eligibility, effective January 1, 2011.

- **Antidepressants**
- **Antipsychotics**
- **Anxiolytics (drugs used to treat anxiety)**
- **Lithium compounds (mood stabilizers)**
- **Medications used for treating substance abuse**

Although the Plan will no longer pay for these drugs, you are still eligible to receive the Plan's discounted rates from Medco-participating retail pharmacies. Simply fill your prescription using your Medco prescription drug card. In addition, many medications used in mental health and substance abuse treatment are available in generic form. If you are currently taking a prescription for a drug that will no longer be covered, you may wish to talk to your doctor about transitioning to a generic and lowering your out-of-pocket costs.

The Plan recognizes that some drugs in an excluded category can be used for non-mental health purposes. For example, antipsychotic drugs such as chlorpromazine, haloperidol, and pimoside are used to treat Tourette's syndrome. Certain medications in the mood stabilizer category are anti-seizure drugs used in the treatment of epilepsy, while some anxiolytics are used to treat cardiovascular conditions. The Plan will consider medications that fall under an excluded category only if it is medically established that its use is primarily for non-mental health purposes. All drugs in the excluded categories will require prior authorization from the Health Plan.

How To Receive Prior Authorization

If you need an excluded medication for a non-mental health or substance abuse reason, fill your first prescription at a participating pharmacy with your Medco prescription drug card and pay 100% of the discounted price for the prescription. Send your original pharmacy receipt and a completed medical claim form to the Plan Office. Include a letter from your doctor confirming your underlying medical condition warranting treatment, and your medical records for review. If the prescription is determined to be medically necessary for a non-mental health or substance abuse purpose, the claim will be reimbursed at the Plan's normal benefit level.

If you use a non-participating pharmacy, your first claim should be filed with the Plan Office as outlined above. If the prescription is determined to be medically necessary, you will be reimbursed only the amount that would have been paid if you had used a participating pharmacy.

After medical necessity is determined, subsequent prescriptions may be filled in the usual way by paying the prescription drug co-payment at participating pharmacies. For non-participating pharmacies, claims should be submitted to Medco as described on page 75 of the Health Plan SPD.

Update on ADHD Medications

In the Summer 2010 edition of Take Two, we reported that medication used to treat attention-deficit hyperactivity disorder (ADHD) would not be covered under the Plan II Prescription Drug Benefit. After review by the Plan's medical consultant; it was determined that the Plan will continue to provide Plan II Prescription Drug coverage of medications used to treat ADHD.

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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

The Screen Actors Guild is a separate entity from the Pension and Health Plans and requires a separate notice for change of address.

PENSION AND HEALTH PLANS DIRECTORY

Burbank Plan Office: (818) 954-9400 or (800) 777-4013
Fax: (818) 953-2525
E-mail 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 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
24/7 Toll-Free Nurseline	(866) 670-0691
NEW YORK Plan Office	(212) 599-6010
275 Madison Ave. #1819, New York, NY 10016	