TAKE 2

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

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Important Health Plan Modifications To Be Phased in Beginning January 1, 2002

You have probably read or heard that medical costs are skyrocketing in the United States, but if you have been fortunate enough to participate in the SAG – Producers Health Plan, it may have seemed like a distant problem. However, rising costs have hit our Plan just like every other plan. Therefore, at their July meetings, the Trustees acted to safeguard the Plan's future by increasing the eligibility requirements and reducing certain benefits.

Financial projections revealed a significant shortfall in the future funding of the Plan. To put it simply, health care costs continue to outpace employer contributions. The last time we changed the minimum Health Plan eligibility requirement was 1996. Since that time, the cost of providing the Health Plan benefits has risen 49% from $102 million to a projected $152 million in 2001. For example, in 1996 the Plan paid a total of $9.5 million for prescription drugs. In 2001, that cost is projected to be $23 million – an increase of 142%!

During the same period, the number of participants covered by the Plan has increased 17% from 34,259 to 40,156 while covered earnings have stopped growing. Last year earnings declined almost 5%. This means the Plan is spending more to provide health coverage to a greater number of people. However, at the same time, the Plan is receiving less in contributions to pay for those benefits.

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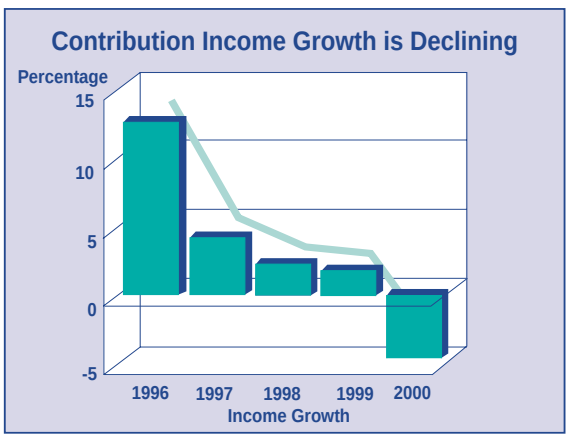
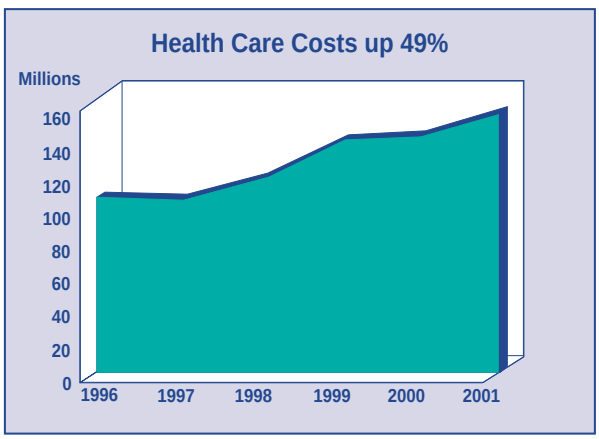
Health Plan Modifications





Important Health Plan Modifications, continued from page 1

Left unchecked, this deficit will put the Plan in an untenable position – it will not be able to pay its bills. By making modifications now and phasing them in over time, the Trustees preserve the financial integrity of the Plan and ensure that the benefits *currently* offered remain available to the largest number of actors and their families. Taking action now also allows us to phase these changes in gradually providing you with significant advance notice.

Why These Modifications and Not Others?

Questions such as, "Why these particular modifications and not others?", can seldom be answered in a manner that will satisfy 100 percent of the participants. The Trustees struggled with this difficult question. The modifications needed to be substantive; but they also needed to be fair. They spread the changes over several areas of the Plan – eligibility, benefits and self-pay – so that no one group of participants would bear the entire burden.

The Trustees also adopted a multi-year approach because they felt that a series of modifications spread out over several years would be easier for participants to handle than more drastic, immediate changes. No changes will take effect before January 2002. The eligibility changes will roll out over five years starting in **January 2003**, giving participants 15 months advance notice of the first increase.

The Self-Pay Program was restructured to more closely conform to the COBRA law, eliminating expensive options the Plan could no longer afford. It is important to note that the Extended Self-Pay Program was started at a time when private insurers were able to exclude new applicants based on pre-existing medical conditions. Changes in federal law now restrict an insurer's ability to have pre-existing exclusions and, in many cases, there are less expensive options than the Plan's self-pay available to participants who leave the Plan. The Trustees also provided generous run out and deferral provisions for the self-pay changes.

What are the changes?

Following is a brief description of the benefit modifications. More details will be provided to all Plan participants in the upcoming months.

Eligibility Modifications Effective January 1, 2003

Earnings and Days Requirement for Health Plan Benefits Increased

The new increases – the first in 7 years – go into effect for Earned Eligibility commencing on or after **January 1, 2003**. Eligibility commencing prior to December 31, 2002, will continue until the end of that eligibility period at which time you must meet the new earnings requirement detailed in the chart below. There are increases to the earnings requirement for both Plan I and Plan II as well as increases to the days of employment requirement for Plan II coverage.

Plan I Eligibility Upgrade Eliminated

Under the current Plan rules, if you meet the Plan II earnings requirement of $7,500 and have 10 or more years of Earned Eligibility in the Health Plan, you are automatically upgraded to Plan I coverage. This provision is no longer available for Earned Eligibility commencing on or after January 1, 2003. If you are receiving Plan I eligibility under this upgrade provision, which commenced during calendar year 2002, your **Plan I coverage will continue until the end of that benefit period.** At that time you must satisfy the Plan I earnings requirement to receive Plan I coverage.

Minimum Health Plan Eligibility Requirements

Earned Eligibility Commencing:	Minimum Eligibility Requirements	
	Plan II	Plan I
January 1, 2002 thru December 31, 2002	$7,500 or 60 days of employment	$15,000 or $7,500/60 days with 10 years of Earned Eligibility
January 1, 2003 thru December 31, 2003	$9,000 or 61 days of employment	$20,000
January 1, 2004 thru December 31, 2004	$9,500 or 62 days of employment	$21,500
January 1, 2005 thru December 31, 2005	$10,000 or 63 days of employment	$23,000
January 1, 2006 thru December 31, 2006	$10,500 or 64 days of employment	$24,500
January 1, 2007 thru December 31, 2007	$11,000 or 65 days of employment	$26,000

Benefit Modifications Effective January 1, 2002

Office Visit Copay Increased To $20 For Plan II and Lower Cost Self-Pay

The current $15 copayment for office visits to network providers is being raised to $20 for Plan II and Lower Cost Self-Pay participants, effective January 1, 2002.

Network Major Medical Deductibles Increased For Plan II and Lower Cost Self-Pay

The current calendar year deductible for major medical services received from network providers is $100 per person/$200 per family. This is being raised for Plan II and Lower Cost Self-Pay participants, to $250 per person/$500 per family effective January 1, 2002. If you use The Industry Health Network (located in California but available to all participants), the major medical deductible is waived.

$100 Copayment Added For Outpatient Surgery at Network Facility

Currently, major medical charges for outpatient surgery performed at a network facility are covered at 100 percent, subject to deductibles. Effective January 1, 2002, a $100 copayment is added for outpatient surgery. After satisfaction of your major medical and hospital deductibles and the major medical copayment, network outpatient surgery is covered at 100 percent. This applies to surgery performed in 1) the outpatient department of a hospital, 2) a freestanding surgical center or 3) a physician's surgical suite.

Copayment Added For Surgery In A Network Doctor's Office

Currently, if you visit a network doctor for a surgical procedure, you are not charged a copayment. Effective January 1, 2002, you will be required to pay a copayment for such services ($15 for Plan I, $20 for Plan II and Lower Cost Self-Pay). If the surgery is performed during a scheduled office visit, you are not charged separate copayments for the office visit and the surgery – you are only responsible for one copayment.

4th Quarter Deductible Carry-Over Provision Eliminated

Currently, any dollar amounts that are applied to your hospital and major medical deductibles in the 4th quarter (October/November/December) of any given calendar year carry over as a credit to the following year's deductibles. Effective January 1, 2002, this carry over provision is eliminated and you must satisfy the deductibles in each calendar year separately.

Lifetime Major Medical Maximum Reinstatement Eliminated

In order to comply with federal law, the Plan provision for reinstatement of the $1 million major medical lifetime maximum is eliminated effective January 1, 2002. Any individual who exceeds the maximum will still be eligible to receive Plan benefits such as hospital, prescription drugs and dental. In addition, the $1,000 annual major medical reinstatement is still available.

Major Medical Coverage for Accidental Injury to Teeth Modified

The Plan currently covers dentist's charges for accidental injury to sound natural teeth provided you are covered by the Plan on the date of the accident and the repair is completed within six months of the accident. Effective January 1, 2002, the Plan covers these charges even if you were not covered by the Plan on the date of the accident. All other limitations continue to apply.

Self-Pay Modifications Effective January 1, 2002

New Maximum Length of Self-Pay Coverage

Effective January 1, 2002, the Plan's current 10-for-10 Extended Self-Pay Program is modified to reduce the maximum length of self-pay coverage offered by the Plan. Under the old rules, an individual who was younger than age 50 and had 10 or more years of Earned Health Plan coverage could self pay for up to 10 years. An individual who was age 50 or older with 10 or more years of Earned Health Plan coverage could self-pay until age 65. The following new periods of self-pay apply regardless of age:

- **18 months** –

  for participants (and their qualified dependents) with less than 17 years of Earned Eligibility in the Health Plan.

- **36 months** –

  for participants (and their qualified dependents) with at least 17 years of Earned Eligibility in the Health Plan.

- **Early Retirement and Disability Pensioners:**

  There is no change in the amount of self-pay coverage offered to individuals receiving an Early Retirement or Disability Pension. They continue to be entitled to self-pay until age 65.

- **Special Deferral Provision:**

  In an effort to provide participants with sufficient time to find insurance in the private market, the Trustees adopted a special **12-month deferral** provision for those individuals who are currently on the Plan's Extended 10-for-10 Self-Pay Program. If the new self-pay rules would result in your losing your coverage on December 31, 2001, you will be allowed to continue to self-pay for up to 12 additional months, unless your 10 years of self-pay coverage would otherwise expire prior to January 1, 2003. Participants on the 10-for-10 Self-Pay Program will receive additional information that will explain exactly how this deferral applies to them.

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Self-Pay Modifications, continued from page 6

Self-Pay Enrollment Options Modified

Current Rule:

Participants losing Plan I Earned Eligibility may enroll in Plan I Self-Pay, Plan II Self-Pay or Lower Cost Self-Pay.

New Rule:

Participants who lose Plan I Earned Eligibility on or after December 31, 2001 may enroll in Plan I Self-Pay or Lower Cost Self-Pay only. The option to enroll in Plan II Self-Pay is not available. If you are a former Plan I participant who is currently receiving Plan II Self-Pay, you will be allowed to continue the Plan II coverage until the end of your current self-pay period. Participants who lose Plan II Earned Eligibility will continue to have the option to enroll in Plan II Self-Pay or Lower Cost Self-Pay.

Self-Pay Dental Options Modified

Current Rules:

- Participants losing Earned Eligibility that included dental may decline to self-pay for the dental coverage. In addition, dental selection may be changed one time for any reason, or immediately following a change in family status.
- Participants eligible for an extension of earned coverage due to Total Disability can self-pay for dental coverage alone.

New Rules:

- Participants who lose Earned Eligibility that included dental on or after December 31, 2001, must self-pay for dental coverage. For participants presently covered under the Self-Pay Program, changes to their dental selection will only be allowed through December 31, 2001.
- Participants who become eligible for the Total Disability Extension on or after January 1, 2002 may not self-pay for dental coverage alone.

Self-Pay Enrollment Options Effective 1/1/2002

Prior Earned Eligibility	Hospital/Medical	Dental	Mental Health and Chemical Dependency-UBH	Vision
Plan I	Plan I Basic	Included	Included	Exam Plus Plan
	Lower Cost	Included	Not Available	Access Plan
Plan II	Plan II Basic	Included only if participant has three years of Earned Eligibility	Included only if participant has three years of Earned Eligibility	Access Plan
	Lower Cost	Included only if participant has three years of Earned Eligibility	Not Available	Access Plan

Dental may not be excluded from your Basic or Lower Cost Self-Pay coverage if you qualified for these benefits as a participant with Earned Eligibility. UBH may not be excluded from your Basic Self-Pay coverage if you qualify for these benefits as a participant with Earned Eligibility. The level of self-pay coverage for UBH and dental is the same as the level of coverage you had under your Earned coverage.

Where Can I Get More Information and Assistance?

The Plan Office can help you understand the many changes to the Plan and how these changes affect you and your dependents. The Participant Services Department will be able to answer your questions, and the Plan's Web site at **www.sagph.org** will have complete details on all of these changes.

In addition, the Plan Office is prepared to assist participants who may be losing eligibility. We can refer you to industry assistance organizations for financial help.

We also have a resource guide with information that should help you find private insurance when your Plan coverage ends. This guide, which you can get from the Plan Office or on the Plan's Web site, can help you locate the private insurers in your area, including those who provide plans without pre-existing condition exclusions and those who provide special programs for lower income earners, as well as government programs. The U.S. Department of Health and Human Services, of which Medicaid is a part, also offers health programs that protect and assist needy families. Their national toll free number is (877) 696-6775 and their Web site is **www.hhs.gov.** The Plan's Web site will have direct links to several health insurance quote sites, such as:

www.ehealthinsurance.com **www.quickquote.com** **www.insure.com**

If you do not have access to the Internet in your home, most public libraries offer free computer/Internet access. In addition, many cities have "cyber cafes" which charge a small fee for use.

SCREEN ACTORS GUILD–PRODUCERS PENSION AND HEALTH PLANS

3601 West Olive
PO Box 7830
Burbank, CA 91510-7830

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

- **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 PLAN DIRECTORY

Burbank Plan Office: (818) 954-9400
From outside the Los Angeles area: (800) 777-4013
E-mail address: sagph@sagph.org
Home Page: http://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	
Merck-Medco	(800) 903-4728
Prescription Pre-Authorizations	(800) 841-5345
NEW YORK Plan Office 1500 Broadway #1705, New York, NY 10036	(212) 382-1020
SOUTHEASTERN Plan Office 7300 North Kendall Drive #620, Miami, FL 33156	(305) 670-9795