TAKE 2

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

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INSIDE TAKE 2

A Message From The Board of Trustees

Dear Participant,

In this issue of Take 2, we discuss the funding issues facing the Health Plan, and the benefit modifications necessary to mitigate the financial impact of new federal healthcare legislation with which the Plan must comply effective January 1, 2011.

It has been almost two years since the collapse of the world's financial markets; the dust has yet to settle. In 2009 the Trustees voted to implement a comprehensive funding-improvement plan that included benefit accrual reductions in the Pension Plan and benefit modifications in the Health Plan. The goal was that the benefit changes, **in conjunction with** projected investment returns and employer contributions, would create a solid foundation on which the rebuilding of both Plans could begin. Unfortunately, while 2009 investment returns were encouraging, they were not enough to make up for the historic and unprecedented decline in employer contributions under the television agreement, or the 13% increase in the cost of healthcare. So far in 2010, investment returns have been very volatile, and contribution income remains down under the television agreement. As a result, the Health Plan faces a $30 million deficit for 2010, which is projected to grow to $50 million in 2011.

Complicating any deficit reduction strategy is the fact that the Health Plan must comply with a number of provisions in the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and the Affordable Care Act of 2010. These federal mandates, which by their very nature will increase Health Plan expenditures, must be integrated into the Plan effective January 1, 2011. The challenge facing the Trustees over the last several months has been to comply with the provisions of these acts while simultaneously reducing Health Plan expenses in a way that ensures the Plan's comprehensive package of benefits remains available *and affordable* to the largest number of participants. To achieve this, the Trustees have adjusted the cost-share required of participants by changing the amounts and structure of co-insurance and out-of-pocket maximums where applicable, or by completely eliminating coverage for certain benefits. The modifications adopted by the Trustees at their July Board meeting are noted and explained inside this issue of Take 2.

Please be advised that the deficit, the regulatory environment and continuing economic uncertainty are formidable obstacles that may require additional Health Plan modifications in 2011 and 2012. The first phase of changes, which are explained in the following pages, become effective January 1, 2011. The Trustees will provide updates in future editions of Take 2.

Sincerely,

The Board of Trustees

The Impact To The Health Plan Of New Federal Legislation

Affordable Care Act

In March of this year, President Obama signed both the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. Together these laws are referred to as the Affordable Care Act. The Act's provisions phase in over the next several years. Certain items, such as the extension of coverage to dependent children up to age 26 and the elimination of Hospital/Major Medical lifetime maximums, are effective for the Plan's participants on January 1, 2011. Additional provisions involving cost sharing for preventive care and claims appeals procedures, which also take effect on January 1, 2011, are still being evaluated. We will provide updated information as it becomes available.

Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) does not require health plans to provide benefits for mental health or substance addiction. However, if a plan does provide such benefits, they must be in *parity* with the plan's medical benefits. In other words, if a participant seeks the services of a mental health provider, the Health Plan's provisions for such things as deductibles, co-insurance, out-of-pocket maximums, visit limits and access to non-network providers among others, cannot be applied more stringently to Mental Health and Substance Abuse Benefits than to benefits offered in the Hospital and Major Medical portions of the Plan. For example, if a health plan offers non-network Hospital coverage, under the provisions of the MHPAEA, it must also offer non-network Hospital coverage for Mental Health and Substance Abuse. Accordingly, achieving parity required changes to the current Plan I Hospital, Major Medical, Mental Health and Substance Abuse Benefits.

With respect to Plan II, the Trustees regretfully determined that under current economic conditions the Health Plan could not support Mental Health and Substance Abuse Benefits at the parity levels required under the MHPAEA. As a result, these Benefits will be eliminated for Plan II participants effective January 1, 2011. The elimination of these Benefits will also affect coverage of certain prescription medications under the Plan II Prescription Drug Benefit. Please refer to page 4 for additional information. These and other changes are shown in the tables on pages 6 and 7.

While the provisions of the Affordable Care Act and the MHPAEA clearly include benefit improvements for most participants, achieving compliance is projected to increase Health Plan costs by up to $10 million annually.

While the provisions of the Affordable Care Act and Mental Health Parity clearly include benefit improvements for most participants, achieving compliance is projected to increase Health Plan costs by up to $10 million annually. In a healthy economy the Plan would have more options in absorbing this additional expense. But as economic uncertainty continues, and the federally mandated compliance date for the Affordable Care Act and Mental Health Parity nears, modifications to existing benefits were determined to be the only way to keep the Health Plan viable and still satisfy the new regulations.

Health Plan Modifications Effective January 1, 2011

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

Coverage Extended for Dependent Children Up To Age 26

As a result of the Affordable Care Act, the Plan is expanding its definition of eligible dependent children effective January 1, 2011, to include your children who are younger than 26 years of age. Dependent children will be eligible regardless of their student or marital status, although spouses of your married children will not be eligible for coverage under the Plan.

A complete description of the dependents eligible under this new provision as well as specific information on how to enroll additional dependents will be provided later this year.

Plan I Hospital Coverage Limited to Network Hospitals Only

Effective January 1, 2011, non-network hospital coverage for Plan I is eliminated. Plan I hospital coverage is limited to network hospitals only.

Hospital and Major Medical Co-Insurance Reductions

To help manage Health Plan expenditures, the Trustees have increased the share participants contribute to the cost of their benefits. Co-insurance is the amount the Plan pays on your claim after your

deductible and co-payment. Currently, if you use a network provider, the Plan pays the claim at 100% after your deductible and co-pay. Effective January 1, 2011, network co-insurance for all benefits (except Wellness Benefits) will be paid at 90%. To protect participants from too large an out-of-pocket expense, the annual out-of-pocket maximums are capped.

Additional changes were made to non-network benefits, including an increase to the out-of-pocket maximum and a reduction in the Plan I co-insurance. The new benefits are illustrated in the tables provided on pages 6 and 7. *Note:* Dental and Vision are not included in the tables because these benefits are not being changed.

Coverage for Lactation Consultants Added

Effective January 1, 2011, coverage for the services of an International Board Certified Lactation Consultant will be provided under the Plan's Major Medical Benefit. Lactation consultants are considered non-network providers and benefits will be payable at 70% of the Plan's allowance after satisfaction of the non-network deductible. Benefits are available to new mothers and will be limited to a lifetime maximum of three visits.

Plan II Mental Health and Substance Abuse Benefits Eliminated

Effective January 1, 2011, Plan II Mental Health and Substance Abuse Benefits are eliminated. This change also affects Plan II Prescription Drug Benefits. See page 4.

Continued on page 4

Health Plan Modifications Effective January 1, 2011

continued from page 3

New Prescription Drug Co-Pay Structure

For many years the Plan's Prescription Drug Benefits have included a list of prescription drugs that are preferred by the Plan because they are less expensive and help to control rising prescription drug costs. This list is called a formulary, and it contains a wide selection of generic and brand name drugs. Although the formulary was discussed in the Plan's Prescription Drug Benefit brochure, you may not have been aware of it because your co-payment was not affected if you received a non-preferred medication.

Effective January 1, 2011, the Prescription Drug Benefit schedule will change to incorporate different co-payments based on formulary status. 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. The tables on pages 6 and 7 outline the co-payment percentages, minimums and maximums.

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. To find out if a medication is preferred, visit Medco online at **www.medco.com**. After you log in, click "Learn about formularies" in the Planning and Reference section.

Coverage of Drugs Used To Treat Mental Health and Substance Abuse Conditions Eliminated for Plan II

Under 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. Effective January 1, 2011, medications used to treat the symptoms of disorders listed in the Mental Disorders section of the International Classification of Diseases will be excluded from the Plan II Prescription Drug Benefit. This section includes conditions such as schizophrenia, depression, bipolar disorder

(called manic-depressive illness), anxiety disorders, and attention-deficit hyperactivity disorder (ADHD). Prescriptions that are typically used for treating substance abuse will also be excluded from coverage.

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. This may result in a cost savings to you, however the generic forms of these medications will still not be covered under the Plan. Additional information about this change will be coming in a Special Edition of the Take Two.

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

Effective January 1, 2011, the Hospital, Major Medical and Prescription Drug Benefits in the Lower Cost Self-Pay Plan will have the same deductibles, co-pays, co-insurance and out-of-pocket maximums as Plan II, although coverage will continue to be provided for individuals only. Lower Cost Self-Pay participants who previously had Plan I Earned Eligibility will receive Mental Health and Substance Abuse Benefits in parity with their Hospital/Major Medical Benefits. This includes coverage for prescription drugs used to treat these conditions. Lower Cost Self-Pay participants who previously had Plan II Earned Eligibility will not be eligible for Mental Health and Substance Abuse Benefits.

New Health Plan Premium Structure – Effective July 1, 2011

Beginning July 1, 2011, the Health Plan will transition to a new premium structure for participants with Earned Eligibility. The new structure will require different payments depending on whether or not you cover your dependents under the Plan.

- Single – Participants who only want to cover themselves will pay the Single rate.
- Two-Party – Participants who want to cover themselves and one dependent will pay the Two-Party rate.
- Family – Participants who want to cover themselves and two or more dependents will pay the Family rate.

The new quarterly rates are outlined to the right.

Quarterly Premium

	Plan I	Plan II	Plan II Age and Service*
Single	$273	$324	$414
Two-Party	$315	$372	$477
Family	$342	$405	$519

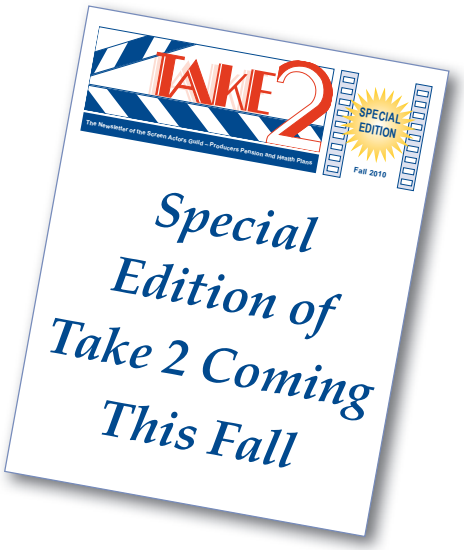
*Plan II Age and Service is for participants who qualify at the lowest earnings requirement and are at least 40 years old with a minimum of 10 years of earned eligibility.

The new premium structure does not apply to participants covered under the Senior Performers Plan or the Extended Spousal Benefit. More details will be contained in a Special Edition of Take Two that will be mailed toward the end of 2010.

E-Check – A New Way To Pay Health Premiums

We are pleased to announce a new way to pay health premiums called E-Check. It is easy to set up; it's free, and it's totally secure. E-Check works like a regular check—only no paper is involved. Information is securely transmitted between the Plan Office and your bank using your bank's routing number and your checking account number.

With E-Check you can help the Plan save money. E-Check transactions are much less costly to the Plan than "regular" checks and credit card transactions. As is currently the case with all premium payment methods, the Plan does not charge any fees for processing. For more information visit the Plans' homepage: **www.sagph.org** and follow the prompts. There is no registration required to set up E-Check.



As we noted on page 2, the Plan Office is still evaluating certain provisions in the Affordable Care Act, such as cost sharing for preventive care and new procedures for claims appeals. We will publish a Special Edition of Take 2 before the end of the year. It will summarize the changes discussed in this edition and update the modifications required for January 1, 2011 compliance with the new healthcare legislation.

Plan I Benefits Summary – Effective January 1, 2011

Hospital (including Mental Health and Substance Abuse Treatment)	**Network Provider**	**Non-Network Provider**
Calendar Year Deductible	The Industry Health Network (TIHN) - $150 per person/$300 per family Blue Cross/BlueCard/ValueOptions - $250 per person/$500 per family	No longer covered except for emergency care*
Co-Pay	$100 per emergency room visit; co-pay is waived if admitted	
Co-Insurance	90% of covered expenses after the deductible and co-pay	
Calendar Year Out-of-Pocket Maximum (after the Deductible and Co-Pay)	$1,250 per person/ $2,500 per family	
Major Medical (including Mental Health and Substance Abuse Treatment)	**Network Provider**	**Non-Network Provider**
Calendar Year Deductible	The Industry Health Network (TIHN) - None Blue Cross/BlueCard/ValueOptions - $250 per person/$500 per family	$500 per person/$1,000 per family
Co-Pay	Office visits or surgery in a doctor's office - $15 per visit Other surgery - $100 per surgery Maternity care - $100 per pregnancy	None
Co-Insurance	90% of covered expenses after the deductible and co-pay	70% of covered expenses after the deductible
Calendar Year Out-of-Pocket Maximum (after the Deductible and Co-Pay)	$1,000 per person/ $2,000 per family	$2,500 per person/ $5,000 per family
Lifetime Maximum	None	None
Mental Health and Substance Abuse	These Benefits will continue to be administered by ValueOptions, however, as a result of the Mental Health Parity law the benefit levels will be the same as the Hospital/Major Medical Benefits outlined above. An updated Value-Options brochure describing these Benefits in greater detail will be available on the website and from the Plan Office before January 1, 2011.	
Prescription Drugs	**Retail Pharmacy**	**Medco by Mail** (includes Accredo Specialty Pharmacy)
Calendar Year Deductible	$150 per person/$300 per family	
Supply	Up to a 30-day supply per prescription or refill	Up to a 90-day supply per prescription or refill
Co-Pay	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

*emergency care is defined on page 31 of the Health Plan SPD

Plan II Benefits Summary – Effective January 1, 2011

Hospital	Network Provider	Non-Network Provider
Calendar Year Deductible	The Industry Health Network (TIHN) - $150 per person/$300 per family Blue Cross/BlueCard - $500 per person/$1,000 per family	Not covered except for emergency care*
Co-Pay	$200 per emergency room visit; co-pay is waived if admitted	
Co-Insurance	90% of covered expenses after the deductible and co-pay	
Calendar Year Out-of-Pocket Maximum (after the Deductible and Co-Pay)	$1,250 per person/ $2,500 per family	
Major Medical	**Network Provider**	**Non-Network Provider**
Calendar Year Deductible	The Industry Health Network (TIHN) - None Blue Cross/BlueCard - $500 per person/$1,000 per family	$750 per person/$1,500 per family
Co-Pay	Office visits or surgery in a doctor's office - $25 per visit Other surgery - $100 per surgery Maternity care - $100 per pregnancy	None
Co-Insurance	90% of covered expenses after the deductible and co-pay	70% of covered expenses after the deductible
Calendar Year Out-of-Pocket Maximum (after the Deductible and Co-Pay)	$1,000 per person/ $2,000 per family	$2,500 per person/ $5,000 per family
Lifetime Maximum	None	None
Mental Health and Substance Abuse	These Benefits are no longer covered.	
Prescription Drugs	**Retail Pharmacy**	**Medco by Mail** (includes Accredo Specialty Pharmacy)
Calendar Year Deductible	$150 per person/$300 per family	
Supply	Up to a 30-day supply per prescription or refill	Up to a 90-day supply per prescription or refill
Co-Pay	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
Psychotherapeutic/Substance Abuse Treatment Medications	Prescription drugs used for mental health and substance abuse treatment will no longer be covered. See page 4 for details.	

*emergency care is defined on page 31 of the Health Plan SPD

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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 (818) 954-9400 or (800) 777-4013.

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
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Information on Dental Claims	
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– Directories	(800) 846-7418
Information on Prescription Drugs	
Medco Health	(800) 903-4728
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