TAKE 2

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

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INSIDE TAKE 2

Dear Participant,

We understand that navigating your benefits and the provisions under the new Affordable Care Act can be daunting (please see page 6 for a review of these benefit enhancements). This issue of Take 2 is devoted to helping you better understand your benefits and provide guidance on how to get the most value from your Health Plan. We hope you find the articles informative and appreciate your feedback **regarding this newsletter** via e-mail to **Take2feedback@sagph.org**.

Here are some key points to help you get the most from your benefits:

- **Schedule regular preventive appointments with a network provider.** Preventive services are designed to keep you and your family healthy. To encourage you to schedule regular preventive appointments, they are provided with no cost to you when you see network providers. For a list of preventive services covered with no cost share, visit **www.healthcare.gov/prevention**.

- **Stay in-network.** The Plan offers preferred provider networks for most of its benefits. Seeing a network provider protects you from unexpected medical costs, saving money for both you and the Plan. Network benefits are generally paid at a higher level and the providers will file your claims for you. To find a network provider, go to **www.sagph.org** and click on Find Network Providers.

  If you do go out of network, FAIR Health (**www.fairhealthconsumer.org**) provides a database of average non-network provider charges for services based on zip code. This site also lists interesting articles on health care and provides a glossary of health terms. FAIR Health also has an app for the smart phone.

- **Use a Delta PPO dentist.** Delta's network includes two types of dentists, Delta Premier and Delta PPO. Both types of dentists have agreed to fixed fees for their services but at Delta PPO dentists you can receive 100% coverage for diagnostic and preventive services with no deductible. You are also encouraged to ask your dentist to request a free pre-treatment estimate from Delta Dental on any services that are expected to cost $300 or more so you know your out-of-pocket responsibility.

- **Use generic drugs whenever possible.** If you use a brand name drug when a generic is available, you pay the difference in cost between the brand and the generic. If no generic is available, use a preferred brand to reduce your expense and save the Plan money.

- **Ask questions.** Email **psd@sagph.org** any time or call the Plan Office during business hours if you have questions about your benefits.

How Are My Claims Paid?

When the Health Plan states it will pay a certain percentage (100%, 90%, 70%) on a claim, how much does the Plan actually pay? That depends on several factors, the most important of which is whether you are using a network or non-network provider. The Plan's payment is always a percentage of the Plan's "Allowance" which may be lower than the amount your provider actually billed.

Network Providers

When you use a network provider, the Allowance has been negotiated. This means that once you have satisfied your deductible and copay, the Plan will pay 90% of the balance of the claim. Even though your network provider may bill a larger amount, you and the Plan are not responsible for anything in excess of the negotiated Contract Allowance. Furthermore, only preventive services performed by network doctors are eligible for the zero cost share benefits under the Affordable Care Act.

How Is A Network Provider Claim Paid?

Provider Billed –	$1,500
Plan's Allowance – (Agreed to by the Provider)	$1,000
Medical Deductible (Plan I) –	$ 250
Balance –	$ 750
Copay –	$ 15
Balance –	$ 735
	X 90%
Plan Pays –	$ 661.50
10% Coinsurance –	$ 73.50
Total Paid by the Plan –	**$ 661.50**
Total Paid by You – (deductible, copay, coinsurance)	**$ 338.50**

Non-Network Providers

When you use a non-network provider, the Allowance is determined by the Trustees based on industry standards. The Plan currently uses the FAIR Health database (**www.fairhealthconsumer.org**) as the standard from which to determine the Allowance. The Plan's Allowance for non-network providers may be significantly less than what the provider charges. This means that you are responsible for your deductible, coinsurance **AND** the difference between what the provider bills and what the Plan pays. The percentage the Plan pays to non-network providers is 70% of the Allowance.

How Is A Non-Network Provider Claim Paid?

Provider Billed –	$1,500
Plan's Allowance – (Based on FAIR Health database)	$1,000
Medical Deductible (Plan I) –	$ 500
Balance –	$ 500
	X 70%
Plan Pays –	$ 350
30% Coinsurance –	$ 150
Total Paid by the Plan –	**$ 350**
Total Paid by You –	**$1,150**

(deductible, coinsurance and the $500 charged in excess of the Plan's Allowance)

Not only will using a non-network provider cost you more, but in many cases it is also much more expensive for the Plan.

Here is an example of a surgeon's claim where both the participant and the Plan have a much higher cost:

Non-Network Provider

Provider Billed –	$10,500
Plan's Allowance – (based on FAIR Health database)	$10,000
Medical Deductible (Plan I) –	$ 500
Balance –	$ 9,500
	X 70%
Plan Pays –	$ 6,650
Coinsurance –	$ 2,850
Total Paid by the the Plan –	**$ 6,650**
Total Paid by You –	**$ 3,850**

(deductible, coinsurance and the $500 charged in excess of the Plan's Allowance)

***Network Provider** (same services as above)*

Provider Billed –	$ 3,000
Plan's Allowance – (Agreed to by the Provider)	$ 2,500
Medical Deductible (Plan I) –	$ 250
Balance –	$ 2,250
Copay –	$ 100
Balance –	$ 2,150
	X 90%
Plan Pays –	$ 1,935
Coinsurance –	$ 215
Total Paid by the Plan –	**$ 1,935**
Total Paid by You –	**$ 565**

(deductible, copay, coinsurance)

Network Providers Give You The Best Value For Mental Health and Substance Abuse Benefits Too

If you are covered under Plan I, you are eligible for mental health and substance abuse benefits administered by ValueOptions. ValueOptions negotiates the best possible rates with its network providers and passes along that cost savings to you. For treatment in a hospital or alternative levels of care, such as residential and intensive outpatient programs, you must use a network provider. For outpatient therapy, the best way you can save out-of-pocket expenses is to use the Plan's network providers. These network providers have undergone a stringent credentialing process to ensure their licensure, education and qualifications meet ValueOptions' standards.

In addition to lower costs, there are significant benefits to using ValueOptions' network providers:

	Network Provider	Non-Network
Outpatient Services	• ValueOptions helps match you with the right provider. • Deductibles and out-of-pocket maximums are lower • After the deductible, you are only responsible for your copays and coinsurance • You have protection from ValueOptions' provider contracts so that you cannot be billed additional fees after ValueOptions has paid your claim.	• Deductibles and out-of-pocket maximums are higher • You might have to pay all out-of-pocket costs up front • You may be potentially liable for days/costs not approved • A provider can bill you directly for additional charges even after ValueOptions has made payment
Convenience	• There is no need for you to file claims	• You may need to file your own claims
Quality of Care	• All facilities/providers are screened on admission to the network and on a regular basis thereafter regarding accreditation, staffing levels, licensure, qualifications and programming, to ensure high quality, appropriate care • Network providers are subject to review by ValueOptions' Quality of Care and Credentialing Committees • ValueOptions can assist with any concerns or complaints you have about quality of care, accessibility, billing, etc.	• You conduct your own research to evaluate potential providers to determine the best choice for your needs • Advertising claims and marketing may not truly reflect the patient experience • There is a potential risk if the provider does not have the correct license or accreditation for coverage under your plan

Note: Benefits for mental health and substance abuse treatment are subject to medical necessity.

The Affordable Care Act and the Health Insurance Marketplace

In the next several months, you may receive a lot of information regarding the Health Insurance Marketplace and the fact that everyone must have insurance by January 1, 2014. The Health Insurance Marketplace refers to the state and federal websites that will become operational on October 1, 2013 and will provide a "one stop shop" to select and purchase coverage from one of the insurance companies who will offer policies in the Marketplace. **If you have Earned Eligibility or Senior Performers coverage under the SAG-Producers Health Plan, you do not need to do anything.** If you do not have coverage or you are covered under the Self-Pay Program you might want to shop the Marketplace in your state to find affordable coverage for you and your family. The Marketplace may offer less expensive options than taking Self-Pay coverage under the Health Plan. For more information on this and other Affordable Care Act topics, please visit **www.sagph.org/AffordableCareAct**.

New Summary Plan Descriptions To Be Mailed

You Can Help the Plans Save on Printing and Mailing Costs

The updated Pension and Health Plan Summary Plan Descriptions (SPDs) will be mailed this summer. The cost to the Plans to print and mail these materials is quite high. Therefore we are asking as many participants as possible to **sign up for e-communications to receive the SPD electronically. To sign up, go to www.sagph.org and click on Register.** You will be able to elect to receive the SPD and other documents electronically and securely view your medical claims, pension and earnings information online.

To further encourage you to sign up for e-communications, we are also enhancing the SPDs available on the website. Beginning this summer, the electronic versions of the SPDs will be updated whenever eligibility requirements, premiums and benefits are changed – no more linking to or searching for Take 2 articles. All the information you need will be in one place.

Even if you sign up for e-communications, you can always request that a printed version of the SPDs be mailed to you.

Supreme Court Decisions Regarding Same-Sex Marriage

On June 26, 2013 the Supreme Court struck down Section 3 of the federal Defense of Marriage Act (DOMA). The Court also affirmed a federal court finding that California's Proposition 8 banning same-sex marriage was unconstitutional. The immediate impact of the Court's decisions is that the term "spouse," when used in federal law, must include same-sex spouses lawfully married under state law.

The Plans immediately began to implement changes that comply with this ruling. The Health Plan no longer withholds imputed federal income taxes from same-sex couples lawfully married under state law, and residing in states recognizing same-sex marriage. The Pension Plan requires same-sex couples to follow the joint and survivor waiver rules, as well as the rules in connection with Qualified Domestic Relations Orders (QDROs) in case of divorce. Lawfully married same-sex couples should review their beneficiary designations to ensure that their spouses have consented to changes in beneficiaries or to the form of the payout. The Plans will continue to monitor federal guidance on implementation of these decisions.

A Reminder Of Your Benefits Under The Affordable Care Act

Effective January 1, 2011 the Health Plan implemented the following benefit enhancements:

- Added coverage for dependent children to age 26.
- Eliminated the $2 million medical and hospital lifetime maximum.
- Eliminated the visit limits for certain therapies:
  - ⇨ Occupational;
  - ⇨ Osteopathic manipulation;
  - ⇨ Physical or physical medicine;
  - ⇨ Speech; and
  - ⇨ Vision.

  Although the visit limits have been removed, the Plan continues to apply its medical necessity requirement and the per visit dollar maximum for non-network providers.

  These visits will also count toward the visit maximums for acupuncture and chiropractic. Please see page 5 of the Winter 2011 Take 2 for more details.
- Eliminated deductibles, copays and coinsurance for preventive services received from **network providers.**
  - ⇨ To avoid cost share you must use a network provider, **the primary purpose of your office visit must be for preventive care**, and the services provided must be on the U.S. Preventive Services Task Force list at: **www.healthcare.gov/prevention**.
- Added coverage for certain over-the-counter medications with no cost share when prescribed by your doctor:
  - ⇨ Aspirin to prevent cardiovascular disease (men: age 45-79; women: age 55-79);
  - ⇨ Folic acid supplements for women who may become pregnant;
  - ⇨ Iron supplements for children 6 to 12 months who are at risk for anemia.

  You may obtain reimbursement directly from the Plan for these items upon submission of a claim form, a copy of the prescription and original receipts.
- Eliminated the annual maximum for pediatric dental services
  - ⇨ The Plan removed the annual dollar limit for individuals under age 19. As a reminder, orthodontia benefits are still excluded. Please see page 4 of the Winter 2011 Take 2 for more details.

Using Anthem Blue Cross or Industry Health Network providers allows you to take advantage of the preventive services benefits with no cost share. Both you and the Plan save money with network providers because they have agreed to accept a designated fee schedule for their services. Non-network providers may charge whatever rate they deem reasonable. This can leave you with significant out-of-pocket costs, particularly if the charges are higher than the Plan's Allowance.

Life Insurance and Accidental Death and Dismemberment (AD&D) Benefits Enhanced Effective June 1, 2013

Life Insurance Benefit

The Plan provides a $10,000 life insurance benefit to participants with Plan I earned eligibility and a $5,000 life insurance benefit to participants with Senior Performers coverage. In order to provide some financial assistance to terminally ill participants, the benefit includes an accelerated life insurance provision which allows terminally ill participants to receive a percentage of their life insurance benefit while still living. Effective June 1, 2013, this percentage has been increased from 50% to 80%. For the purpose of this benefit, terminally ill means that due to injury or sickness, you are expected to die within 24 months. The Plan will require a signed physician's statement that you are terminally ill.

AD&D Benefits

The $10,000 AD&D benefit is for participants with Plan I earned eligibility. Senior performers are not eligible for this coverage. Prior to June 1, 2013, if you suffered the accidental loss of one hand, one foot or the sight of one eye, you would have received 50% of the benefit, or $5,000. The entire benefit would have been paid for the accidental loss of two or more of the previous body parts, or for an accidental death.

Effective June 1, 2013, the benefit has been expanded to provide coverage for a wider range of losses as shown in the table to the right.

Additional benefits may be available if you die in a car accident and you were wearing a seat belt and sitting in a seat protected by an air bag. These benefits are available if you were driving or riding as a passenger in a passenger car.

If you were wearing a seat belt which was properly fastened at the time of the accident an additional $1,000 benefit will be paid. If you were wearing a seat belt and sitting in a seat protected by an airbag an additional $500 benefit will be paid. The air bag benefit is in addition to the seat belt benefit.

Accident Resulting in:	The Benefit Paid is:
Loss of life	$10,000
Loss of one arm at or above elbow	$7,500
Loss of one leg at or above knee	$7,500
Loss of one hand	$5,000
Loss of one foot	$5,000
Loss of thumb and index finger on same hand	$2,500
Loss of sight of one eye	$5,000
Loss of hearing in both ears – must continue for six consecutive months	$5,000
Loss of speech – must continue for six consecutive months	$5,000
Paralysis of one arm	$2,500
Paralysis of one leg	$2,500
Coma – benefit becomes payable on the 7th day of a coma	$100 per month for up to a maximum of 60 months
Brain damage – requires a five day hospitalization and brain damage that has persisted for 12 consecutive months	$10,000
More than one of the above resulting from one accident	$10,000 or the sum of the benefits payable for each loss (whichever is less)

A more complete description of these benefit improvements, including definitions for terms such as brain damage and passenger car will be contained in the new Health Plan SPD. If you would like additional information in the meantime please email **psd@sagph.org** or call the Plan Office.

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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	