TAKE 2

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

Volume XXII, Number 2
Summer 2014

INSIDE TAKE 2

Prescription Drug Step Therapy Requirements Added

Effective July 1, 2014

As announced in the Winter 2013 edition of *Take 2*, the Trustees have added a step therapy program for the prescription drug benefit in their effort to help reduce cost increases for participants and dependents. The step therapy program will be effective July 1, 2014 and will apply to **medications first prescribed after July 1, 2014** and received at retail pharmacies or through Express Scripts' (formerly Medco) home delivery service. The Plan is implementing step therapy, as have a number of other health plans, in order to counter the ever-increasing cost of prescription drug spending.

What is step therapy?

Step therapy requires that people who have certain conditions, such as high blood pressure, nasal allergies or acid reflux, try effective and more affordable prescription drugs first before "stepping up" to more expensive drugs.

- **Step 1 drugs —** Front-line drugs are generic and sometimes lower-cost brand name drugs that are proven to be safe, effective and affordable. In most cases you should try these drugs first because they usually provide the same health benefit as a more expensive drug, at a lower cost to you and the Plan.
- **Step 2 and Step 3 drugs —** Second-line drugs are brand name alternative drugs that generally are necessary for only a small number of patients for whom front-line drugs have failed. Third-line drugs are the most expensive option and have not shown greater clinical efficacy than lower-cost drugs.

Who decides what drugs are covered in step therapy?

Step therapy is developed under the guidance and direction of independent licensed doctors, pharmacists and other medical experts. Together with Express Scripts, they review the most current research on thousands of drugs tested and approved by the FDA for safety and effectiveness. Then they recommend appropriate prescription drugs for the program.

Not all medications are subject to the step therapy requirement and the prescription drugs that are may change from time to time. Your pharmacist can tell you if your prescription requires step therapy or you can find out by logging in to your account at www.express-scripts.com and clicking "Price a Medication".

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Prescription Drug Step Therapy Requirements Added

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Why couldn't I fill my prescription at the pharmacy?

The first time you submit a prescription that is not for a front-line drug, your pharmacist should tell you that with step therapy you need to first try a front-line drug if you would rather not pay full price for the medication. To receive a front-line drug:

- Ask your pharmacist to call your doctor and request a new prescription; or
- Contact your doctor to get a new prescription.

Only your doctor can change your current prescription to a front-line drug covered by the step therapy program.

What can I do when I need a prescription filled immediately?

If you have just been prescribed a medication subject to step therapy, you may be informed at your pharmacy that your prescription is not covered. If this should happen and you need the medication immediately, you can talk with your pharmacist about filling a small supply right away. You will have to pay full price for this quantity of the drug. Then, you or your pharmacist can contact your doctor for a new prescription for a front-line drug.

What can I do if I have already tried the front-line drugs on the list?

With step therapy, more expensive brand-name drugs are usually covered as second-line alternative drugs if:

1. You have already tried the generic drugs covered in the step therapy program and they were unsuccessful.
2. You cannot take a specific generic drug (for example, because of a documented allergy).
3. Your doctor decides, for medical reasons, that you need a brand-name drug.

If one of these situations applies to you, your doctor can request an override from Express Scripts, allowing you to take a second-line prescription drug. Once the override is approved, you will pay the appropriate copay for the drug.

What happens if my doctor's request for an override is denied?

You can follow the appeals process as outlined in Express Scripts' denial letter or in the Health Summary Plan Description available at www.sagph.org. If you choose not to appeal or your appeal is denied, you can talk to your doctor again about prescribing one of the safe, effective front-line drugs covered by the step therapy program. Or **you can choose to pay the full price for the drug.**

How does step therapy work at the home delivery pharmacy?

When Express Scripts' home delivery pharmacy receives a prescription that requires step therapy, a representative contacts your doctor to request a new prescription for a front-line drug. If after several attempts Express Scripts is unable to reach your doctor, you will be notified by phone that there is a delay with your order. You may want to let your doctor know that the home delivery pharmacy will be requesting this information.

Your doctor will write you a new prescription for a front-line drug covered by the step therapy program. Or, if your doctor decides your current drug is medically necessary, he or she can ask for an override. The appeals process is also available if your doctor's request is denied.

What if I am already taking a second-line drug on July 1, 2014?

This medication will not be subject to the step therapy requirement for as long as your doctor continues to prescribe it, provided you remain continuously eligible for prescription drug coverage under the Health Plan.

Who should I call if I have additional step therapy questions?

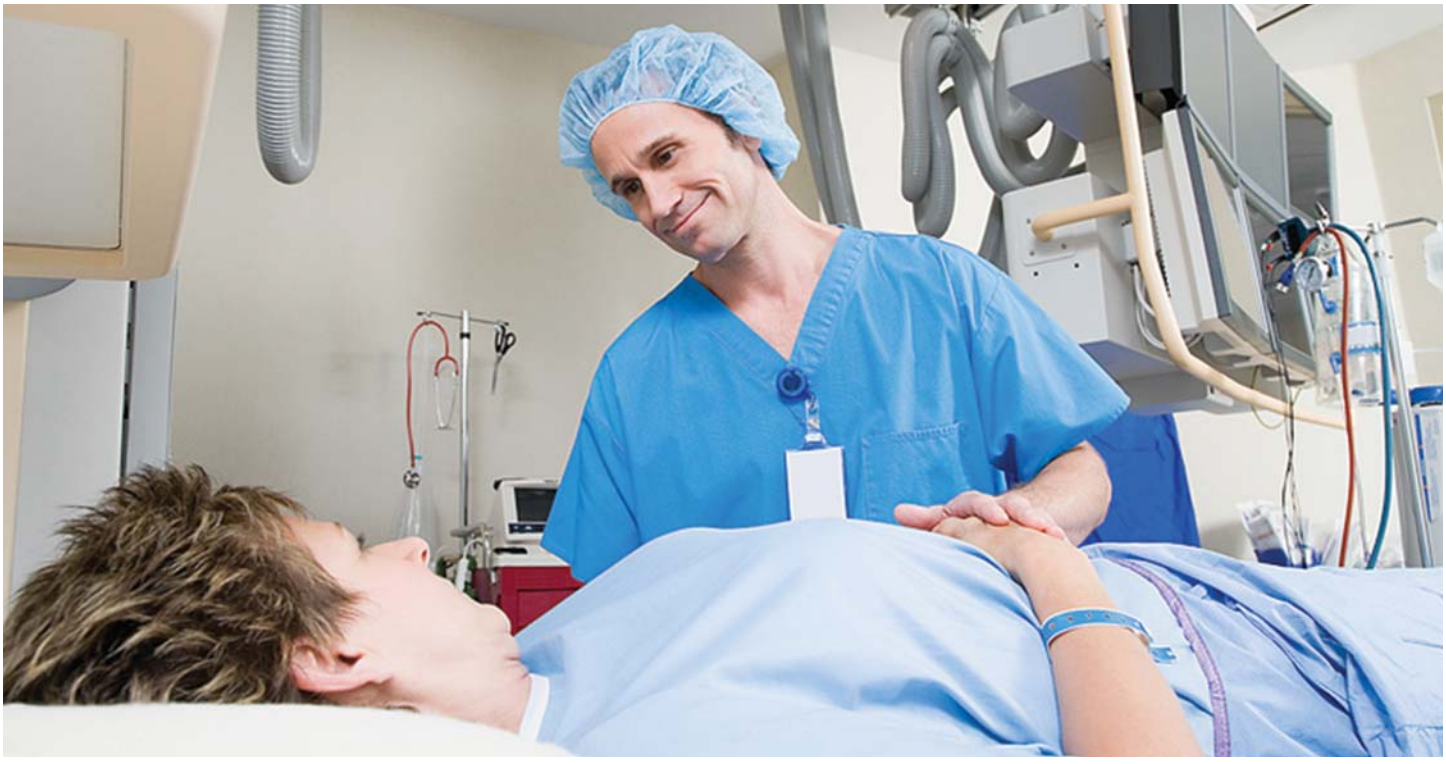
Express Scripts (800) 903-4728

Anesthesia During Colonoscopy and Upper GI Endoscopy Understanding Your Coverage

The Health Plan encourages participants to take advantage of the wellness benefits offered by the Plan. One of these important benefits is a routine colonoscopy offered to participants beginning at age 50. The Plan also covers diagnostic colonoscopies and upper gastrointestinal endoscopies regardless of age, although these procedures are not considered under the wellness benefit. Best medical practices indicate that these procedures, whether diagnostic or preventive, should be performed under moderate sedation provided by a gastroenterologist or a member of his or her team. This level of sedation is highly effective and is included in the doctor's surgical package fee at no additional expense to the patient when performed in this manner. If a separate anesthesiologist is used, the Plan will not cover his or her charges.

However, patients with certain health conditions or physical abnormalities may need a deeper level of sedation using different medications than those used in moderate sedation. Deep sedation may affect your ability to breathe on your own and your cardiovascular function. Due to the need for more intensive monitoring, deep sedation usually requires that an anesthesiologist be present to administer the specific medications that induce the deep sedation. The Plan's coverage of an anesthesiologist is based on whether you have a health condition or abnormality which necessitates the use of these different medications. The Plan does provide coverage for a separate anesthesiologist for patients over the age of 70 or under the age of 18. The Plan will not provide coverage for an anesthesiologist simply because they are used to achieve deeper sedation in patients for whom they are not considered medically necessary.

Talk with your doctor regarding your particular needs ahead of the procedure if you have concerns about your comfort during a colonoscopy or upper gastrointestinal endoscopy. Some providers offer deep sedation for an additional fee that the patient must pay. If you have any questions about coverage of an anesthesiologist under these circumstances, please call the Plan Office.



Therapy Benefit Limits and Allowances

The Health Plan's therapy benefits include coverage for different types of therapies such as physical therapy, occupational therapy, chiropractic care and acupuncture. The Plan has a maximum allowance it will consider that depends on the type of therapy and whether you are using a network or non-network provider. In addition, the Plan has a maximum number of visits for certain types of therapy. The chart below outlines these allowances and maximums.

Therapy	Network Allowance	Non-Network Allowance	Maximum Visits Per Quarter
Acupuncture	Contract Allowance	$55 per visit	8 visits*
Biofeedback	Contract Allowance	$55 per visit	9 visits
Chiropractic	$45 per visit	$45 per visit	12 visits*
Physical,Occupational and Osteopathic	Contract Allowance	$65 per visit	None
Speech and Vision	Contract Allowance	$55 per visit	None

*** The Plan will not consider more than 12 visits per calendar quarter for chiropractic treatment or eight visits per calendar quarter for acupuncture. Chiropractic visits count toward the acupuncture maximum and vice versa. While the number of visits for physical, occupational, osteopathic, speech and vision therapies do not have a visit limit, they will count toward the chiropractic and acupuncture limits.**

As an example of how these visit limits apply, suppose you have six physical therapy visits during a calendar quarter followed by four chiropractic visits. This is allowable because you are still within your 12 visit limit (6 + 4 = 10 visits). If you then wanted to go to an acupuncturist, no acupuncture visits would be payable for the rest of the quarter. You are over the eight visit acupuncture maximum because your earlier physical therapy and chiropractic care visits count toward that limit.

If you are receiving multiple types of therapy from different providers, you should be aware that the Plan applies visits toward the limits as it processes claims rather than according to the date of service. Providers submit their claims in accordance with their own billing schedules and claims are frequently not received in the order of their date of service.

The therapy benefits are subject to additional requirements and limitations regarding provider type and covered services. For a more complete description of the benefits, please refer to your Health Plan Summary Plan Description.

Mental health therapy visits are not counted towards any of the above therapies. Like physical, occupational, osteopathic, speech and vision therapies, there is no maximum number of visits per quarter, however **all therapy visits are subject to medical necessity.**

Reminder of Changes to Non-Network Medical Benefits

Effective July 1, 2014

The Trustees periodically review the provisions of the Health Plan in order to make sure they are in line with industry practice and make sense for the Plan. In an effort to encourage network utilization, effective July 1, 2014, the Plan will add copays to non-network medical benefits for Plan I and Plan II. The non-network copays will be the same as the copays under network medical benefits. Please refer to the chart below:

Medical Copays — Network or Non-Network	Plan I	Plan II
Office Visit	$15 per visit	$25 per visit
Surgeon —		
Doctor's Office	$15 per surgery	$25 per surgery
Inpatient	$100 per surgery	$100 per surgery
Outpatient Hospital, Surgical Center, Surgical Suite	$100 per surgery	$100 per surgery
Maternity —		
Prenatal Visits	No copay	No copay
Delivery	$100 per delivery	$100 per delivery

Although the non-network copays will be the same as the network amounts, you still have lower out-of-pocket expenses from a network provider. The network deductible is significantly lower than the non-network deductible. So is the coinsurance, which is the percentage of covered charges that you pay after the deductible and copay are satisfied – 10% as compared to 30%. Plus, as announced in the Fall 2013 *Take 2*, the Plan added a new overall out-of-pocket maximum of $6,350 per person and $12,700 per family for network hospital and medical services effective January 1, 2014.

Non-network services do not have an overall out-of-pocket maximum. Instead you continue to be charged a copay for each visit and surgery even if your coinsurance maximum has been satisfied.

You can withdraw money, put some in savings or pay bills - all the things you do with your money now. The only difference is your check is not printed or mailed.

At this time, direct deposit is only mandatory for those planning to retire on or after July 1, 2014. However, as of January 1, 2015 the Plan will require that **all retirees** receive their benefit electronically. If you are currently receiving retirement benefits and you did not sign up for electronic payments, we encourage you to do so now. Sign up for direct deposit by contacting the Pension Department at (818) 954-9400 extension 2020.

If your Senior Performers premium is currently deducted from your pension benefit, it will continue to be deducted.

Pension Benefit Payments to Transition to Electronic Funds Transfer

Effective July 1, 2014 the Screen Actors Guild-Producers Pension Plan will require that all new retirees receive pension benefit payments electronically. You may choose to have your payments directly deposited to a bank or credit union account. Or, like Social Security, if you do not have a checking or savings account, the Plan will set up a debit card account for you.

The benefits of using electronic payments are numerous for the Plan as well as for Plan participants.

- Electronic payments eliminate the cost and waste associated with the use of paper, ink, printers and postage;
- The possibility of lost or stolen checks will be eliminated;
- Your benefits will be available in your account on time, even if you are out of town, sick or unable to get to the bank; and
- Your money is safe.

Combined Earnings Eligibility Reminder

For Coverage Beginning July 1, 2014 or After

Participants who do **not** qualify for health coverage under **either** the AFTRA Health Plan or the SAG-Producers Health Plan may combine their earnings reportable to each Plan in order to meet the dollar earnings requirement for **Plan II** eligibility (currently $15,100) for coverage beginning July 1, 2014. To find out if you qualify, go to www.sagph.org , click on the Apply for Combined Earnings Eligibility button and follow the instructions on the web.

Self-Pay (COBRA) vs. Marketplace Coverage... Which One is Right for You?

In today's changing marketplace, every participant needs to understand their health insurance options.

At the time earned eligibility terminates, you have 60 days to enroll in the Self-Pay (COBRA) Program. This Program offers you the option of continuing the same coverage you had under the Plan (except life insurance and AD&D benefits). Unfortunately, this option may not be affordable for more than a few months.

The Affordable Care Act (ACA) has created an alternative for many members to consider! Some people might even be eligible for assistance in paying their monthly premiums. The Actors Fund's Covered California Helpline **(855) 491-3357** is there to help you understand your options, determine if an ACA plan is right for you, and figure out how to move forward.

But act quickly. You only have that same 60-day period from when your earned eligibility terminates to make your decision and sign up for an ACA plan. **Keep in mind, while The Actors Fund Helpline is focused on providing information on Covered California, they can direct you to resources all across the country.**

SCREEN ACTORS GUILD – PRODUCERS PENSION AND HEALTH PLANS

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. 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	