Screen Actors Guild–Producers
Pension & Health Plans

Summary Plan Description

Screen Actors Guild–Producers Health Plan

July 1, 2013

Health

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SCREEN ACTORS GUILD – PRODUCERS HEALTH PLAN

To all participants:

The Board of Trustees is pleased to provide you with this Summary Plan Description (SPD) which describes the comprehensive program of Health Plan benefits available to you and your eligible dependents as of July 1, 2013. Whenever the benefits outlined in this SPD materially change, the newsletter for the Health and Pension Plans, Take 2, will be sent to you summarizing the amendment to the Plan. The SPD and Take 2 newsletters constitute the Plan Document. Please keep the Take 2 newsletters with your SPD so that you will always have current information about your Health Plan. The SPD and the Take 2 newsletters are also available on the Plan's website: **www.sagph.org**.

We encourage you to review this book carefully so that you are aware of all the benefits to which you are entitled as well as some important restrictions and responsibilities. Our goal has been to present and explain your benefits in language that is easy to understand. However, sometimes we must use terms that are not used in everyday conversation for legal reasons. Terms and phrases that fall into this category are either explained in the context of their sections or are listed alphabetically in the Glossary of Terms.

This SPD is not a contract and the benefits provided under the Health Plan to participants are not contractual benefits. Therefore, the benefits may be reduced, modified or discontinued by action of the Board of Trustees at any time. The Trustees do not promise to continue the benefits in full or in part in the future, and rights to future benefits are not vested or guaranteed. In particular, retirement or the completion of the requirements to receive a pension benefit under the SAG – Producers Pension Plan does not give any participant or former participant any vested right to continued benefits under the Health Plan.

The Health Plan Trustees are authorized and empowered to construe the meaning of any doubtful or ambiguous provisions of the Health Plan. Any construction adopted by the Health Plan Trustees in good faith is binding upon SAG-AFTRA, the Producers, the participants and all beneficiaries. The Health Plan Trustees are authorized and empowered to decide on a participant's entitlement to or application for benefits under the Health Plan, and any such decision of the Health Plan Trustees is final and binding upon all affected parties. The Health Plan Trustees are authorized and empowered to execute all such agreements, adopt and promulgate all such reasonable rules and regulations, take all such proceedings, exercise all such rights and privileges, and generally to do all things as are necessary in the establishment, maintenance and administration of the Health Plan.

The term SAG-AFTRA refers to the Union which entered into Collective Bargaining Agreements with Producers. These agreements provide for contributions by Producers to the Health Plan for the purpose of providing health benefits to eligible participants. SAG-AFTRA was formed on March 30, 2012 and on that date, among other things, assumed all Collective Bargaining Agreements of Screen Actors Guild (SAG).

The nature and extent of benefits provided by the Health Plan and rules governing eligibility are determined solely and exclusively by the Trustees of the Plan. Employees of the Plan Office have no authority to alter those benefits and eligibility rules. Any interpretations or opinions given by employees of the Plan Office are not binding upon the Trustees and cannot change the benefits and eligibility rules.

Please remember to keep the Plan Office informed of any change to your mailing address. This will ensure you receive all communications. You must also keep the Plan Office informed of any changes to your marital status or your dependents. If you have any questions about the Plan, please call or email the Plan Office:

(818) 954-9400 • (800) 777-4013 • psd@sagph.org

Sincerely,

BOARD OF TRUSTEES

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Screen Actors Guild–Producers
Health Plan

I. ELIGIBILITY

The Screen Actors Guild – Producers Health Plan provides a comprehensive health care package to all eligible participants and their eligible dependents. In order to qualify for these benefits the participant must meet the eligibility requirements of the Health Plan and pay the applicable premium. The following sections describe the basic eligibility requirements for Health Plan coverage, the premium rates and payment rules, and the programs available if eligibility is lost. Additional eligibility rules may apply to certain benefits, such as dental benefits. These rules are described in the sections outlining those benefits.

The Health Plan does not impose a waiting period on coverage for preexisting conditions (conditions which started prior to eligibility); however it does not cover charges for treatment after eligibility terminates, even if the medical condition developed during a period of Health Plan eligibility or the treatment for that condition began during a period of Health Plan eligibility.

Note: The benefits under the Health Plan, including those for Senior Performers and their eligible dependents, are not vested or guaranteed. They may be modified, reduced or canceled at any time by the Board of Trustees.

Earned Eligibility

ELIGIBILITY REQUIREMENTS

The Health Plan has two levels of benefits: Plan I and Plan II. There are three ways to qualify for coverage: Covered Earnings, Days of Employment (Alternative Eligibility Program), or a combination of age, service and Covered Earnings (Age and Service – see page 2). The manner in which you qualify for coverage determines the level of Plan benefits you will receive.

COVERED EARNINGS AND DAYS OF EMPLOYMENT

Covered Earnings are those earnings generated in connection with your work as an actor in theatrical motion pictures, television motion pictures, television commercials, corporate or educational motion pictures, public television, music videos and interactive media projects in accordance with Collective Bargaining Agreements between SAG-AFTRA and Producers in the industry. Earnings are typically credited to the quarter in which payment is made.

If you do not satisfy the Covered Earnings requirement, you may qualify under the Alternative Eligibility Program based on your Days of Employment. Days of Employment are determined by dividing your total sessional earnings by the SAG-AFTRA minimum daily rate, which is based on the type of production.

These services must be performed for Producers who have signed Collective Bargaining Agreements with SAG-AFTRA. Contributions may only be made by signatory Producers in accordance with the Health Plan Trust Agreement.

MINIMUM REQUIREMENTS

The minimum requirements for Earned Eligibility beginning on or after the first day of any calendar quarter in 2013 are outlined below. Calendar quarters start on January 1st, April 1st, July 1st and October 1st. These minimum requirements may increase each year. The Trustees have set a target increase of 3% per year, although they will determine the actual size of the increase based on an annual review of the Health Plan's financial condition.

In addition to satisfying one of these requirements you must pay the Health Plan premium. Premium rates and payment rules are outlined on page 13.

Plan I

You must earn at least $30,750 in Covered Earnings in your Base Earnings Period (see page 3) in order to generate Earned Eligibility for Plan I.

Plan II

There are three ways to generate Earned Eligibility for Plan II:

- Earn at least $15,100 in Covered Earnings in your Base Earnings Period; or
- Alternative Eligibility Program – Have at least 76 Days of Employment in your Base Earnings Period; or
- Age and Service – If you are at least age 40 on the first day of your Benefit Period (see page 4), and have at least 10 years of Earned Eligibility, you must earn at least $10,900 in Covered Earnings in your Base Earnings Period. All years during which you qualified for Earned Eligibility will count toward the 10-year requirement, even those years for which you chose not to pay the premium.

SPECIAL NOTE REGARDING THE ALTERNATIVE ELIGIBILITY PROGRAM

As outlined above, the Alternative Eligibility Program allows you to earn a year of Plan II coverage based on Days of Employment. The Alternative Eligibility Program also applies to the Pension Plan; however a Pension Credit earned under this Program will not be applied toward Senior Performers Health Plan eligibility or eligibility under the Extended Spousal benefit.

NON-COVERED EARNINGS

Non-Covered Earnings are those earnings that do not require contributions to be made to the Health Plan; consequently, they are not counted in determining eligibility for benefits under this Plan. Some examples of Non-Covered Earnings are:

- Payments for various penalties and allowances such as meal penalties, payments for rest period violations, traveling, lodging or living expenses, interest or liquidated damages (late fees), reimbursements for special hair dress, for wardrobe damage or for the use of personal automobile or other equipment.
- Residual payments for the following:
  - Television motion pictures produced prior to June 1, 1960.
  - Television commercials produced prior to November 16, 1960.
  - Theatrical motion pictures produced prior to January 31, 1966, and released to free television. (Theatrical motion pictures produced after that date and released to television after July 31, 1971 may be counted for eligibility.)

- Earnings in excess of the theatrical, television and commercial contribution limits. For a schedule of the applicable "ceilings" amounts, please call the Plan Office or visit the Plan's website, **www.sagph.org**, and click the link for "employers", or contact the Plan Office by email at psd@sagph.org or by phone.

- Payments for work performed for a non-signatory company.

- Payment for services not covered by a SAG-AFTRA Collective Bargaining Agreement, such as producing, directing and writing services.

BASE EARNINGS PERIOD

Your Base Earnings Period is your qualification period. It is the *first* consecutive four-quarter period in which you meet the Covered Earnings, Days of Employment or Age and Service requirement for Earned Eligibility. If you have, you will be entitled to 12 months of Earned Eligibility coverage provided you pay the Health Plan premium described on page 13. This 12-month period of Earned Eligibility coverage is referred to as your Benefit Period.

BECOMING ELIGIBLE FOR COVERAGE

You become eligible for 12 months of health coverage when the Plan reviews your Covered Earnings and Days of Employment. This occurs approximately six weeks after the end of the Base Earnings Period. This six-week period is needed for employers to submit reports of your earnings and for the Plan to process these reports. The 12-month Benefit Period begins on the first day of the calendar quarter after the date that the Plan determines that you are eligible for coverage.

You cannot qualify for Plan I and Plan II simultaneously. You will be eligible for the Plan for which you first meet the requirements. Subsequent Covered Earnings or Days of Employment are not considered until your next Base Earnings Period which will then be used to determine your continuing eligibility status.

In the example below, a participant begins working in covered employment in January. By the end of the second quarter (June 30th), the participant has enough Covered Earnings to satisfy the Plan II requirement. In determining this, the Plan looks back over the four-quarter period that ends June 30th, even though the participant did not actually start working until January. His Base Earnings Period becomes July 1st through June 30th.

Qualifying for Plan II

Quarter	Earnings
Jul 1 through Sep 30	$0
Oct 1 through Dec 31	$0
Jan 1 through Mar 31	$7,000
Apr 1 through Jun 30	$9,000

In the next example, the participant starts working in January and satisfies the Plan I requirement by September 30th. The Plan looks back at the four-quarter period ending September 30th and the Base Earnings Period becomes October 1st through September 30th.

Qualifying for Plan I

Quarter	Earnings
Oct 1 through Dec 31	$0
Jan 1 through Mar 31	$ 4,000
Apr 1 through Jun 30	$10,000
Jul 1 through Sep 30	$19,000

BENEFIT PERIOD

Your Benefit Period is the 12-month period of Health Plan coverage that you *earn* by meeting the Covered Earnings, Days of Employment or Age and Service requirement. The Benefit Period begins on the first day of the calendar quarter after the date that the Plan determines that you are eligible for coverage.

The chart below illustrates the four Base Earnings Periods and the four corresponding Benefit Periods that may apply to you.

MAINTAINING EARNED ELIGIBILITY

In order to maintain your Earned Eligibility without interruption you must continue to meet the minimum Covered Earnings, Days of Employment, or Age and Service requirement during your established Base Earnings Period every year. You must also pay the applicable Health Plan premium. Once you have established Earned Eligibility, your Base Earnings Period and Benefit Period will not change unless you fail to meet the minimum requirement.

If you do not meet the minimum requirement in your established Base Earnings Period, you will no longer be eligible for Earned Eligibility in the Health Plan. To requalify for Earned Eligibility, you will have to meet the requirements outlined on page 2.

EXTENDED COVERAGE FOR MILITARY SERVICE

In accordance with the Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA), the Plan provides certain benefits for participants who have military service which started on or after October 13, 1994. Congress enacted USERRA to provide protection to individuals who are members of the uniformed services. Uniformed services are defined as:

- The Armed Forces, The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty;
- The Commissioned Corps of the Public Health Services; and
- Any other category of persons designated by the President in time of war or national emergency.

You will have the choice of using your Earned Eligibility prior to enrolling in the Plan's Self-Pay Program, or immediately enrolling in the Plan's Self-Pay Program and freezing your Earned Eligibility for up to five years of uniformed service. In either case, the earned or self-pay premium will be waived for up to 24 months.

Upon your return from military service, you may use any frozen Earned Eligibility, provided you notify the Plan Office of your intent to resume coverage and that coverage is resumed within one year of your return from uniformed service. Please contact the Plan Office for additional information if you are going to serve or have served in the military.

Base Earnings Period	Approximate Eligibility Determination Date	Benefit Period
Jan 1 through Dec 31	Feb 15	Apr 1 through Mar 31
Apr 1 through Mar 31	May 15	Jul 1 through Jun 30
Jul 1 through Jun 30	Aug 15	Oct 1 through Sep 30
Oct 1 through Sep 30	Nov 15	Jan 1 through Dec 31

Dependent Eligibility

If you have paid the applicable premium, coverage for your eligible dependents begins on the later of:

- The date your coverage begins; or
- The date they become eligible dependents.

Eligible dependents include:

YOUR LEGAL SPOUSE

Your legal spouse is the person to whom you are legally married.

YOUR SAME-SEX DOMESTIC PARTNER

Effective July 1, 2011, the Plan provides coverage for same-sex couples on par with the benefits provided to legal spouses, subject to the following requirements:

- If you live in a state that recognizes same-sex marriage, you and your same-sex partner must be married.
- If you live in a state that does not recognize same-sex marriage but recognizes same-sex domestic partnerships or civil unions, you and your same-sex domestic partner must have your domestic partnership or civil union recognized by the state.
- If you live in a state that does not provide legal recognition of same-sex marriage, civil unions or domestic partnerships, please contact the Plan Office for information on the documentation that must be provided to qualify for the same-sex domestic partnership program.
- If you are married or have a registered same-sex domestic partnership or civil union in a state other than the state in which you reside, the Plan will also recognize that documentation.

If you are receiving benefits as a same-sex domestic partner and either (i) your state subsequently recognizes same-sex marriage, or (ii) you move to a state where same-sex marriage is recognized, the existing same-sex partnership recorded with the Plans will continue to be honored.

Depending on the tax status of your domestic partner, you may be responsible for federal and state withholding tax on the value of the coverage provided by the Plan to your domestic partner and children. Basically, the tax laws view the value of such health coverage as wages. There is no withholding if your domestic partner and children are your dependents for tax purposes. However, the Plan may request verification of this dependent status from the Internal Revenue Service. If your domestic partner is not your dependent, you must prepay the taxes to the Plan on a quarterly basis. The Plan Office can advise you of the rates and will remit the taxes on your behalf.

If your same-sex domestic partner was covered by the Health Plan prior to July 1, 2011 you are not subject to the new requirements outlined above. However your domestic partner will not be eligible for the Extended Spousal benefit unless you satisfy the new requirements.

YOUR DEPENDENT CHILDREN

This includes your children who are younger than 26 years of age. The children must be your:

- Natural children.
- Stepchildren.
- Foster children.
- Legally adopted children.
- Children for whom you or your spouse or same-sex domestic partner are the legal guardian.
- Children of your same-sex domestic partner although, depending on their tax status, you may be responsible for pre-paying federal and state withholding tax on the value of their coverage.
- Your permanently disabled dependent children. Older children who are physically or mentally disabled may be considered dependents if they were disabled prior to turning age 26 and you were eligible for benefits at the time they became disabled, regardless of whether or not you were enrolled in the Plan at that time. The Plan will require an annual certification of permanent disability status by the child's attending physician.

Dependents do not include parents or any other relatives not listed above.

***Note:** In the event of divorce, or dissolution of a same-sex civil union or domestic partnership, medical expenses incurred by your spouse, domestic partner or stepchild on or after the final divorce or dissolution date are not covered by the Plan. You will be billed for expenses paid by the Health Plan from the date of divorce or domestic partnership dissolution.*

ENROLLING AND VERIFYING QUALIFIED DEPENDENTS

You can make changes to your covered dependents during your Open Enrollment Period (see page 10). The Plan requires documentation for the dependents you want covered as detailed in the chart to the right. In addition, you are responsible for notifying the Plan Office when you move, acquire new dependents, marry or divorce, or establish or terminate a same-sex civil union or domestic partnership. Plan records cannot be changed until the Plan Office receives a Dependent Enrollment Form and the appropriate documentation. There are deadlines in connection with some of these notices. For details contact the Plan Office or visit our website: **www.sagph.org** and click on "Life Events".

Enrollment of a dependent that does not meet the Plan's eligibility requirements will be treated as an intentional misrepresentation of a material fact, or fraud.

Enrolling and disenrolling dependents can affect the amount of your premium. Premium changes will be effective the 1st of the month in which the event occurred if enrolling a new dependent, and the 1st of the month following the month in which the event occurred if you are disenrolling a dependent.

Life Event	Documentation Required by the Plan
Marriage	A copy of the recorded marriage certificate.
Establishment of Same-Sex Domestic Partnership or Civil Union	Download an enrollment packet from **www.sagph.org** or contact the Plan Office.
Divorce	A copy of the recorded final divorce decree.
Dissolution of Same-Sex Domestic Partnership or Civil Union	Certificate of dissolution.
Birth	A copy of the recorded birth certificate. *Exception:* The Plan will accept a copy of the birth certificate from the hospital to add your natural child who is younger than one year of age for a period not to exceed 120 days while you obtain a recorded copy.
Adoption	A copy of the adoption papers issued by the court.
Guardianship	A copy of the guardianship papers issued by the court.
Physically and/or Mentally Disabled Dependents	A completed Total Disability application and a copy of the attending physician's history and physical report. An annual certification of disability status is also required.
Death	A copy of the recorded death certificate.

SPECIAL ENROLLMENT OPPORTUNITIES

Special enrollment opportunities allow you to make changes to your dependent elections outside of the Open Enrollment Period. Please refer to page 11 for these rules.

MEDICAL CHILD SUPPORT ORDERS

In order to pay benefits in accordance with a medical child support order, the Health Plan must determine that the order is a qualified medical child support order (QMCSO). A medical child support order is a court order that provides for medical child support or health benefit coverage with respect to your dependent child. You may obtain a copy of the Plan's procedures for determining whether or not an order is qualified by contacting the Plan Office. There is no charge to obtain the procedures.

Senior Performers Eligibility

The Senior Performers Health Plan provides coverage for pensioners who have at least 15 Pension Credits and are age 65 or older and their eligible dependents. Pensioners with less than 15 Pension Credits may be eligible when they turn 65 if they had at least 10 Pension Credits as of December 31, 2001 and were at least age 55 as of December 31, 2002.

Occupational Disability pensioners are eligible for Senior Performers health coverage at any age, provided they have at least 15 Pension Credits. In order to be eligible for an Occupational Disability pension your injury must have occurred while working under a SAG-AFTRA Collective Bargaining Agreement for which contributions were made to the Screen Actors Guild – Producers Pension Plan. For a complete description of the Occupational Disability pension requirements please refer to the Pension Plan SPD.

Senior Performers Health Plan eligibility will begin on the date you meet the eligibility requirements and pay the Health Plan premium. As outlined on page 14 there is one premium structure for participants with at least 20 Pension Credits and another premium structure for participants with 15 through 19 Pension Credits. Eligibility will continue on a calendar-year basis, which is the Benefit Period for Senior Performers. For Occupational Disability pensioners, coverage begins when Medicare Disability coverage begins.

Benefits under the Senior Performers Plan are the same as those provided to participants under Plan I Earned Eligibility except that the life insurance benefit is $5,000 instead of $10,000 and there are no accidental death and dismemberment benefits.

IMPORTANT: Pension Credits earned under the Alternative Eligibility Program do not count toward eligibility for Senior Performers coverage.

COORDINATION WITH MEDICARE

Senior Performers Health Plan coverage is secondary to Medicare for hospital and medical benefits as long as you do not regain Earned Active Eligibility. You must be enrolled in Medicare Parts A and B to be eligible for full Plan coverage. If your spouse or same-sex domestic partner is age 65 or older, or is eligible for Medicare due to disability, he or she must also be enrolled in Medicare Parts A and B to receive full Plan coverage as a dependent. You and your spouse or partner do not need to enroll in a Medicare Part D Prescription Drug Program. Please refer to pages 80 through 83 for additional information regarding Medicare.

REGAINING EARNED ACTIVE ELIGIBILITY

Your Senior Performers eligibility may be replaced with Earned Active Eligibility if you meet the minimum earnings requirement for Earned Eligibility based on sessional earnings or if you meet the minimum Days of Employment requirement. You will receive Earned Plan I coverage and Medicare will become secondary to the Screen Actors Guild – Producers Health Plan. Please refer to “Coordination of Benefits with Medicare”, pages 81 and 82, for a description of Earned Active Eligibility.

Extended Spousal Eligibility

The Extended Spousal benefit provides Senior Performers Health Plan benefits to your qualified dependents when you die, provided you meet certain requirements at the time of your death. A qualified dependent includes your dependent children and your surviving spouse, provided you and your spouse were married for at least 12 months immediately preceding your death. Your same-sex domestic partner is eligible for the Extended Spousal benefit provided he or she meets the Plan's criteria for domestic partnerships as in effect on or after July 1, 2011 (see page 5) and the partnership had been in effect for at least 12 months immediately preceding your death. Permanently disabled dependent children age 26 or older are only eligible for the Extended Spousal benefit if your surviving spouse or same-sex domestic partner is covered under the Extended Spousal benefit.

The Extended Spousal benefit is provided to your qualified dependents if you meet one of the following conditions:

- You were age 65 or older at the time of your death and you had at least 15 Pension Credits.
- You were age 65 or older at the time of your death and you had at least 10 Pension Credits as of December 31, 2001 and were age 55 or older as of December 31, 2002.
- At the time of your death, you were at least age 50, you had at least 20 Pension Credits and your age plus years of Pension Credit were at least 75. Coverage for your dependents starts when you would have reached age 65 if you had lived.

IMPORTANT: Pension Credits earned under the Alternative Eligibility Program do not count toward eligibility for the Extended Spousal benefit.

If the Health Plan premium is paid, coverage for your spouse or same-sex domestic partner continues until:

- Your spouse or same-sex domestic partner dies; or
- Your spouse or same-sex domestic partner marries or enters into a same-sex domestic partnership or civil union.

Coverage for dependent children continues until they no longer qualify as dependents unless the child is age 26 or older and permanently disabled. In that case coverage will terminate when the spouse or same-sex domestic partner's coverage terminates. The Plan Office requests verification of the spouse's marital status or the partner's partnership status annually during the Open Enrollment Period. Eligibility will not be extended until a completed questionnaire is received by the Plan Office.

In some cases, additional benefits may be available under the Self-Pay Program. Qualified dependents will be notified by the Plan Office if this additional coverage is available.

Extended Spousal eligibility may be replaced with Earned coverage if the minimum Covered Earnings or Days of Employment requirement is met. Your dependents will receive Earned Plan I coverage.

If you and your spouse or same-sex domestic partner both have Senior Performers coverage and one of you dies, the surviving spouse or partner will not receive Extended Spousal coverage. They will continue to receive their own Senior Performers coverage secondary to Medicare, provided they continue to pay the required premium.

Open Enrollment

When you become qualified for coverage, your Open Enrollment Period begins. You will receive an Open Enrollment packet and an enrollment form with your qualified dependents listed. It will include information about the Plan for which you qualify, your Benefit Period, the premium amount and billing statement, and how to enroll and disenroll eligible dependents. You may make changes to your covered dependents for any reason during the Open Enrollment Period. Make these changes by visiting the Plan's website at **www.sagph.org** or by completing the dependent enrollment form and returning it to the Plan Office. Changes to your covered dependents may affect your premium rate.

After Open Enrollment you may not make changes to your covered dependents except in certain circumstances. Please see pages 11 and 12 under "Special Enrollment Opportunities".

Once your premium is processed, your Notice of Eligibility (NOE) will be sent to you within 7 to 10 business days. The NOE will contain your Health Plan ID cards, information regarding your benefit coverage and a list of your enrolled dependents. You may also print temporary ID cards by visiting the Plan's website at **www.sagph.org**. The ID cards only show your name but they are also valid for your dependents.

Your Open Enrollment Period is based on your type of eligibility and your Benefit Period:

Benefit Period Start Date	Approximate Open Enrollment Period
Jan 1	Dec 1 through Jan 15
Apr 1	Mar 1 through Apr 15
Jul 1	Jun 1 through Jul 15
Oct 1	Sep 1 through Oct 15

Senior Performers and dependents covered under the Extended Spousal benefit are included in the January 1st Benefit Period and corresponding Open Enrollment Period.

If you think you have met the requirements for Earned Eligibility but do not receive an Open Enrollment packet, contact the Plan Office by email at psd@sagph.org or by phone. Earnings are sometimes reported late by production or payroll companies and this delays the Plan Office in notifying you of your Earned Eligibility. The Plan Office will help you determine if your earnings have been appropriately reported. If the Plan Office verifies that your earnings have not been reported, you will need to provide copies of your pay stubs and/or contracts for review. Once the Plan Office reviews your proof of earnings and verifies with the employer that the earnings are reportable, you will receive written notification.

You may also verify that your earnings have been reported to the Plan by checking our interactive website, **www.sagph.org**. Information on registering for a user name and password to access your personal information may be found on page 74. Please keep in mind that the website will not reflect total earnings for any particular quarter until 60 days after the quarter ends.

If you change your address at any time you must notify the Plan Office in addition to the SAG-AFTRA Union Office.

IMPORTANT: If you are also eligible for coverage with another entertainment industry health plan and you select Participant Only coverage, your non-covered dependent(s) may be affected by the Entertainment Industry Coordination of Benefits (EICOB) rules outlined on pages 77 and 78. If you have any questions, please call the Plan Office. You might also want to call the other plan to discuss your individual situation.

SPECIAL ENROLLMENT OPPORTUNITIES

The special enrollment opportunities described below allow you to enroll or make changes to your dependent elections outside of the Open Enrollment Period. Please note that traveling is not considered a special exception.

Loss of Other Health Plan Coverage

If you do not pay the premium because you have other group health coverage, you may be allowed to participate in this Health Plan when your other coverage ends because of a reduction in employment, legal separation, divorce or death. If the other coverage is under a COBRA provision and you exhaust your COBRA coverage, you may also be allowed to participate in this Health Plan. You must submit a written request for coverage under this Plan **within 30 days** after your other coverage ends, along with the certificate of coverage from your other coverage issued in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

If your Health Plan coverage is available under the Extended Spousal benefit, the only special enrollment opportunity available to you is when your other coverage ends because of a reduction in employment.

CHIP/Medicaid

Special enrollment opportunities are available to:

- Participants and their dependents who lose coverage under Medicaid or CHIP; and
- Participants and their dependents who become eligible for a state's Medicaid or CHIP premium assistance program.

The CHIP/Medicaid enrollment events require you to submit a written request to the Plan **within 60 days** of their occurrence.

CHIP is a federal/state program designed to provide health care coverage for uninsured children and some adults although benefits under this program are only provided by certain states. If you think you or any of your dependents might be eligible for Medicaid or CHIP, you can call (877) KIDSNOW or visit www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the Health Plan's premium.

Enrolling New Dependents

If you acquire a new dependent after the start of your Benefit Period you can request coverage under the Plan **within 30 days** of the date of marriage, establishment of a same-sex civil union or domestic partnership, birth, adoption or placement for adoption. This opportunity also allows you to enroll yourself in the Plan if you had previously opted not to pay the premium during Open Enrollment. You will need to complete a New Dependent Form and submit the appropriate documentation outlined in the chart on page 7.

Senior Performers also have the opportunity to make changes to their covered dependents in the event their spouse or same-sex domestic partner turns age 65. In the case of Extended Spousal coverage, the eligible dependents have the opportunity to re-enroll in the Plan when the spouse or partner turns age 65.

***Note**: If you are covered under the Extended Spousal benefit and you remarry or enter into a new same-sex civil union or domestic partnership, your Plan coverage will terminate.*

Disenrolling Dependents

If you are disenrolling a dependent due to divorce, dissolution of a civil union or domestic partnership, or death, you are required to submit a copy of the final judgment of divorce, certificate of dissolution of domestic partnership or civil union, or recorded death certificate. In the event of divorce or same-sex civil union or partnership dissolution, you must notify the Plan in writing **within 60 days** of the date your divorce or dissolution is final in order for the dependent to receive individual self-pay rights. Medical expenses incurred by your spouse, same-sex domestic partner or stepchild on or after the date of divorce or domestic partnership dissolution are not covered by the Plan. You will be billed for expenses paid by the Plan from the date of divorce or dissolution.

Note: *Enrolling and disenrolling dependents can affect the amount of your premium. Premium changes will be effective the 1st of the month in which the event occurred if enrolling a new dependent(s) and the 1st of the following month if you are disenrolling a dependent(s).*

You may also want to update your beneficiaries in the event of death, divorce or dissolution. A Designation of Beneficiary Form can be obtained on the Plan's website, **www.sagph.org**, or by contacting the Plan Office.

For more information on the Health Plan, please visit:

www.sagph.org

Screen Actors Guild – Producers Health Plan

Premium Payment Rules

This section describes the premium payment rules for Earned Eligibility, Senior Performers coverage and the Extended Spousal benefit. The premium payment rules for the Self-Pay Program are outlined in the Self-Pay Program section starting on page 21.

All participants are required to pay a premium for their Health Plan coverage. The amount of your premium depends on the plan for which you qualify and the dependents you will be covering.

PREMIUM RATES

Earned Eligibility

The premium for participants with Earned Eligibility is due quarterly. This premium also applies to individuals covered under the Total Disability Extension described on pages 26 and 27. The current rates outlined below were effective as of July 1, 2011 and are subject to adjustment in the Trustees' sole discretion.

Certain individuals with Earned Eligibility as listed below will pay the applicable Senior Performers premium (see page 14) instead of the Earned Eligibility premium. The premium must be paid quarterly.

- Senior Performers with at least 20 Pension Credits* who regain Earned Active Eligibility through sessional employment. Please refer to "Coordination of Benefits with Medicare", pages 81 and 82, for a description of Earned Active Eligibility.
- Participants with at least 20 Pension Credits* who are at least age 65 but have not actually retired and begun receiving a pension.
- Individuals who regain Earned Eligibility while covered under the Plan's Extended Spousal benefit, provided the participant had at least 20 Pension Credits*.

* Also applies to Senior Performers who had at least 10 Pension Credits as of December 31, 2001 and were at least age 55 as of December 31, 2002.

Earned Eligibility	Plan I	Plan II	Plan II Age and Service
Participant only	$273 quarterly	$324 quarterly	$414 quarterly
Participant plus 1 Dependent	$315 quarterly	$372 quarterly	$477 quarterly
Participant plus 2 or more Dependents	$342 quarterly	$405 quarterly	$519 quarterly

Senior Performers/Extended Spousal

The premium for Senior Performers and Extended Spousal coverage is due monthly unless you Pay by Mail (see page 15). In that case the premium is due quarterly. The current rates below were effective as of January 1, 2013 and are subject to adjustment in the Trustees' sole discretion. In the table below, the term spouse also includes same-sex domestic partners.

Senior Performers and Extended Spousal	With No Spouse or With Spouse Age 65 or Older*	With Spouse Under Age 65*
20 or more Pension Credits**	$50 per month	$100 per month
15 – 19 Pension Credits	$150 per month	$150 per month

* Includes coverage for dependent children.

** Also applies to Senior Performers who had at least 10 Pension Credits as of December 31, 2001 and were at least age 55 as of December 31, 2002.

Senior Performers with 20 or more Pension Credits who have a spouse or same-sex domestic partner that is eligible for Medicare but under age 65 will pay the $50 monthly premium rate. This also applies to Extended Spousal eligibility for surviving dependents of Senior Performers who had 20 or more Pension Credits. Contact the Plan Office to be sure you are billed at the correct rate.

The Senior Performers/Extended Spousal premium rate for a participant with at least 20 Pension Credits will automatically adjust to the lower premium rate effective the first of the month in which the spouse or domestic partner turns age 65.

PAYMENT OPTIONS

You may pay the premium in advance, regardless of your method of payment (except for auto debit). However, you may not pay the premium for any period beyond your current Benefit Period.

Deduction from Monthly Pension (only available to Senior Performers) – You may elect to have the Health Plan automatically deduct the monthly premium from your monthly pension benefit. This ensures your health coverage will continue and eliminates the inconvenience of sending in payments.

Auto Debit – The auto debit plan deducts your quarterly Earned premium or monthly Senior Performers/Extended Spousal premium automatically on a recurring basis from a U.S. checking or savings account. Payments are deducted on the 25th of the month prior to the due date. The Plan will continue to deduct the premium as long as you remain continuously eligible for coverage, even if there is a change in the premium rate because you experience a change in your eligibility type or benefit plan, or if the Trustees make a change in the premium rate. You can sign up online or download an enrollment form on the Plan's website, **www.sagph.org**.

Pay by Web – You may pay your premium online with e-check or a credit card. Simply visit the Plan's website, **www.sagph.org** and enter your checking/savings account or credit card information. You will receive electronic confirmation that your payment has been received.

Pay by Phone – You may pay your premium over the telephone 24/7 with a credit card by calling the Plan Office at (818) 954-9400 or (800) 777-4013 and following the prompts. You will receive a confirmation number indicating that your payment has been received. For your security, this is an automated system and Participant Services Representatives will not be able to take your credit card information.

For your protection, Pay by Web and Pay by Phone payments are non-recurring. This means the Plan will not automatically charge your credit card or debit your account every time a payment is due.

Pay by Mail – A quarterly billing statement and coupon will be sent to you a few weeks before the due date. Make your check, money order or cashier's check from a U.S. bank payable to "Screen Actors Guild – Producers Health Plan" and send it to the Plan's Payment Center with your coupon in the envelope provided. To ensure proper crediting you should include the account number from the billing statement on your check. Your payment must be received at the Payment Center no later than the due date to be considered timely. DO NOT SEND YOUR PAYMENT TO THE PLAN OFFICE OR THE SAG-AFTRA UNION OFFICE.

Any check or debit returned to the Health Plan for any reason will be assessed a handling fee. You may replace the premium payment and pay the fee using any of the payment options outlined above.

TIME LIMITS

Premium Due Dates

Your premium is due on the first day of each calendar quarter for Earned Eligibility or the first day of each month for Senior Performers and Extended Spousal benefits. For example, the quarterly payment for the first quarter of the calendar year (January through March) is due on January 1st. The due date applies even when traveling. There is a 15-day grace period, however it should only be used for unforeseen circumstances. Coverage will not be granted until your premium is processed.

If the Plan does not receive your premium by the due date, you will not be entitled to any coverage under the Health Plan until your next Benefit Period. If your coverage is terminated due to failure to pay your premium, you will not be entitled to self-pay coverage nor will you be entitled to any conversion options.

For example, if you make quarterly payments and your Benefit Period is January 1, 2014 through December 31, 2014 and you fail to pay your first quarterly premium by January 15, 2014, you will not be entitled to any Health Plan coverage until January 1, 2015, provided you re-qualify for coverage by meeting the minimum requirements for Earned or Senior Performers coverage.

Late Payment Waivers

If your payment is not received by the due date you can reinstate your coverage by using a late payment waiver. **The Plan allows one late payment waiver per Benefit Period with a maximum of two late payment waivers per lifetime for Earned Eligibility.** Senior Performers and dependents covered under the Extended Spousal benefit are eligible for one late payment waiver per Benefit Period. Participants may use a late payment waiver up to the last day of the quarter for which the payment is due.

To use a late payment waiver, simply make your payment:

- On the website – **www.sagph.org**;
- By phone – (818) 954-9400 or (800) 777-4013; or
- By submitting your premium payment with your billing coupon to the Payment Center.

When your payment is received after the grace period, the Plan will automatically apply one of your late payment waivers (if available) and your coverage will automatically be reinstated retroactively.

Special Note: *If your coverage in this Plan is terminated because you do not pay your premium, your coverage under other health plans may be reduced or eliminated due to the EICOB rules (pages 77 and 78). You should contact your other plan for further information.*

Loss Of Eligibility

LOSS OF EARNED ELIGIBILITY NOTIFICATION

When you lose eligibility in the Health Plan, you will receive a notice from the Plan Office outlining all the available benefits and options for continued coverage. In the event of your death, your dependents will receive this information.

All notices from the Plan will be mailed to the address on file at the Plan Office. This is one reason why it is so important to keep the Plan Office informed of your current address. If you move, you may update your address on the Plan's secure website. Or, you may complete a Performer Information Form and file it with the Plan Office. This form is available on the Plan's website: **www.sagph.org**.

LOSS OF EARNED ELIGIBILITY

Participants

You will lose Earned Eligibility at the end of the 12-month Benefit Period if you have not satisfied the Covered Earnings or Days of Employment requirement in your established Base Earnings Period. Health Plan coverage may also be terminated by reason of a Plan amendment which revises the eligibility requirements.

If you lose your Earned Eligibility because you do not meet the minimum requirement, you may be able to continue your coverage under one of the following programs:

- *Self-Pay Program:* page 18
- *Total Disability Extension:* page 26
- *Conversion Options:* page 28

Dependents

In general, coverage for your dependents ends when your coverage terminates – or sooner, if they no longer qualify as dependents. However, they may be eligible for coverage under one of the programs listed previously.

If your death occurs during your Earned Eligibility Benefit Period, coverage for your eligible dependents may continue until the end of the Earned Eligibility period accrued as a result of your reported income or employment, provided your dependents pay the Health Plan premium as outlined on page 13.

Thereafter, coverage may be extended to your eligible dependents. Please refer to "Extended Spousal Eligibility" on page 9.

LOSS OF SENIOR PERFORMERS ELIGIBILITY

If you die while you are covered under the Senior Performers Health Plan, coverage for your eligible dependents will continue until:

- The end of the month in which your death occurs if your dependents are eligible for the Extended Spousal benefit; or
- The later of (i) the end of the calendar year in which your death occurs, or (ii) six months following your death if your dependents are not eligible for the Extended Spousal benefit.

LOSS OF EXTENDED SPOUSAL ELIGIBILITY

If you are covered under the Extended Spousal benefit and you remarry or enter into a new same-sex civil union or domestic partnership, your Plan coverage will terminate. Coverage for a permanently disabled dependent child age 26 or older will also terminate if:

- The surviving spouse or same-sex domestic partner remarries or enters into a new same-sex civil union or domestic partnership; or
- The surviving spouse or same-sex domestic partner dies.

Coverage for other dependent children will terminate when they no longer qualify as dependents.

If coverage terminates, you and/or your eligible dependent children may be eligible for coverage under the Self-Pay Program (see page 18).

For more information on the Health Plan, please visit:

www.sagph.org

Screen Actors Guild – Producers Health Plan

Self-Pay Program

When you lose Earned Eligibility because of a Qualifying Event, you and your qualified dependents may continue Health Plan coverage by enrolling in the Self-Pay Program. The length of time you are allowed to self-pay depends on several factors, including which Qualifying Event caused the loss of Earned Eligibility and how many years of previous Earned Eligibility you have in the Health Plan.

A premium is required for Self-Pay Program benefits. The premium is based on the Plan for which you qualify and the number of qualified dependents you choose to enroll for coverage. Self-pay premium rates are determined in accordance with federal COBRA law and may change once a year or more frequently if significant Plan changes occur. The premium is based on a three-tier structure: Individual, Individual plus one dependent or Individual plus two or more dependents.

QUALIFYING EVENTS

Failure to pay the Health Plan premium is not a Qualifying Event. Neither is the termination of Earned Eligibility as the result of a contribution or dependent verification audit.

You and your qualified dependents may have the right to elect self-pay coverage upon the occurrence of the following Qualifying Events:

Participant: Loss of Earned Eligibility due to a reduction in your Covered Earnings or Days of Employment, or the change from Plan I to Plan II due to a reduction in your Covered Earnings.

Early Retirement Pensioner: Commencement of your Early Retirement Pension, or the loss of Earned Eligibility, if later. If you do not enroll in the Self-Pay Program when you start receiving your Early Retirement Pension or lose Earned Eligibility, you cannot enroll at a later date unless you requalify for Earned Eligibility or you meet **all** the postponed enrollment requirements outlined on pages 23 and 24.

Disability Pensioner: Commencement of your Disability Pension, or the loss of Earned Eligibility, if later. If you do not enroll in the Self-Pay Program when you start receiving your Disability Pension or lose Earned Eligibility, you cannot enroll at a later date unless you requalify for Earned Eligibility or you meet **all** the postponed enrollment requirements outlined on pages 23 and 24.

Dependent Spouse or Same-Sex Domestic Partner: Loss of Earned Eligibility due to a reduction in the participant's Covered Earnings or Days of Employment, the change from Plan I to Plan II due to a reduction in the participant's Covered Earnings, divorce from the participant, termination of a domestic partnership or civil union, or the death of the participant.

Dependent Children (as defined by the Plan): Loss of coverage due to a reduction in the participant's Covered Earnings or Days of Employment, the change from Plan I to Plan II due to a reduction in the participant's Covered Earnings, the death of the covered participant, or loss of "child" status as defined by the Plan.

Qualified dependents that are covered under the Plan when Earned Eligibility terminates may be entitled to enroll individually if the participant does not elect self-pay coverage.

YOUR NOTIFICATION REQUIREMENTS

You or your dependents, as the case may be, must notify the Plan Office, in writing, in the event of death, divorce, termination of a domestic partnership or civil union, or a child losing dependent status under the Plan. In order for the dependent to receive individual self-pay rights, notification must be made **within 60 days** of the later of:

- The date the event occurred; or
- The date coverage terminates as a result of the qualifying event.

If the Plan Office is not notified, in writing within this time frame and the appropriate documents establishing proof of dependent status are not submitted, the individual losing eligibility as a dependent will forfeit his or her right to enroll in the Self-Pay Program.

MAXIMUM LENGTH OF SELF-PAY COVERAGE

18 months – For participants (and their qualified dependents) with fewer than 17 years of Earned Eligibility in the Health Plan who lose eligibility or change from Plan I to Plan II due to a reduction in Covered Earnings or Days of Employment. Participants who are entitled to Medicare prior to the date they lose Earned Eligibility should call the Plan Office for information concerning their maximum self-pay period.

36 months

- For participants (and their qualified dependents) with at least 17 years of Earned Eligibility in the Health Plan who lose eligibility or change from Plan I to Plan II due to a reduction in Covered Earnings or Days of Employment.
- For qualified dependents who lose their dependent status due to the death of a participant, divorce from a participant, dissolution of same-sex domestic partnership or civil union, or loss of "child" status as defined by the Plan.

29 months – For participants or dependents who are determined by Social Security to be totally disabled on the date Earned Eligibility terminates or within 60 days thereafter. Non-disabled dependents of the disabled individuals are also entitled to 29 months of self-pay coverage.

Early Retirement and Disability Pensioners – Participants (and their qualified dependents) receiving an Early Retirement or Disability Pension are eligible to self-pay until the last day of the month prior to the month in which they reach age 65 provided they have at least 15 Pension Credits. Pension Credits under the Alternative Eligibility Program do not count toward this self-pay eligibility. Early Retirement and Disability pensioners with less than 15 Pension Credits who lose Earned Eligibility are eligible to self-pay for either 18 or 36 months depending on their years of Health Plan Earned Eligibility.

Dependents who will qualify for the Extended Spousal Benefit – Qualified dependents who will be eligible for the Extended Spousal benefit as a result of a participant's death are eligible to self-pay until the participant would have reached age 65 and the Extended Spousal coverage begins. See page 9 for a description of the Extended Spousal benefit.

SPECIAL RULES FOR DEPENDENTS

Dependents acquired after the participant's enrollment (due to marriage, birth or adoption, for example), may be added to the participant's coverage. However, except for newborn and adopted children, they will not be entitled to self-pay for coverage on an individual basis.

If your qualified dependents lose their status as eligible dependents while you are covered under the Self-Pay Program or the Senior Performers Plan, they may also qualify for individual self-pay coverage. Additionally, individual self-pay coverage may be available if they lose their dependent status while covered under the Extended Spousal benefit. This would include situations in which a surviving spouse or same-sex domestic partner remarries or enters into a new same-sex domestic partnership or civil union.

Individual self-pay coverage for your dependents is only available if they were covered under the Health

Plan on both the date dependent status was lost **and** the date Earned Eligibility was lost. The maximum length of the individual dependent self-pay coverage is 36 months from the date Earned Eligibility was lost, even if you are an Early Retirement or Disability pensioner.

For example, assume a participant with Earned Eligibility includes his spouse under his coverage. The participant loses Earned Eligibility and enrolls himself and his spouse in the Self-Pay Program. If he and his spouse divorce after being covered under the Self-Pay Program for 28 months, the spouse will be entitled to an additional eight months of coverage.

If you lose Earned Eligibility after you become entitled to Medicare, your qualified dependents will be entitled to self-pay coverage. The maximum period of self-pay coverage available will end on the later of:

- 18 months from the loss of your Earned Eligibility; or
- 36 months from your Medicare entitlement date.

In cases where self-pay coverage is not available, a conversion policy may be available. Please refer to "Conversion Options" on page 28.

ENROLLMENT OPTIONS

Your enrollment options depend on your prior Earned Eligibility as outlined in the chart below. Self-pay coverage is identical to the coverage provided to participants with Earned Eligibility in each respective Plan, **except** that self-pay participants are not entitled to life insurance or accidental death and dismemberment benefits.

If you lose Plan I Earned Eligibility you will be offered a one-time only opportunity to enroll in either Plan I self-pay or Plan II self-pay. You may not change your self-pay plan selection after your enrollment is complete.

Note: *If your Earned Eligibility changes from Plan I to Plan II, you may choose to self-pay for Plan I. However, the Health Plan does not coordinate benefits between your Plan I self-pay and Plan II Earned Eligibility. Instead, you receive Plan I benefits.*

Self-Pay Enrollment Options

Prior Earned Eligibility	Hospital and Medical	Prescription Drugs	Dental	Vision
Plan I	Plan I (Mental Health/ Substance Abuse Included)	Included	Plan I Dental Included	Exam Plus Plan
	Plan II (Mental Health/ Substance Abuse Not Covered)	Mental Health/ Substance Abuse Drugs Not Covered	Plan II Dental Included	Not Included
Plan II	Plan II (Mental Health/ Substance Abuse Not Covered)	Mental Health/ Substance Abuse Drugs Not Covered	Plan II Dental Included if Participant has 3 Years of Earned Eligibility	Not Included

ENROLLMENT PROCESS

When you lose Earned Eligibility, the Plan Office will send you a termination notice describing the Self-Pay Program along with a Self-Pay Enrollment Form. This is the time during which you can choose the dependents you would like to cover and select your premium rate. You can enroll dependents that were not enrolled under your earned coverage although these dependents are not entitled to self-pay on an individual basis. If you do not enroll in the Self-Pay Program following the loss of your Earned Eligibility, the dependents that were covered under the Plan when your Earned Eligibility terminated may enroll individually, provided they enroll within the 60-day time limit.

Your Self-Pay Enrollment Form must be completed online or received by the Plan Office within 60 days of the later of:

- The date your coverage terminated; or
- The date on your self-pay enrollment offer.

You will have additional opportunities to change your dependent enrollment during the annual Open Enrollment Period or if you experience a change in family status. See page 23 for "Coverage Changes".

TIME LIMITS FOR FIRST PAYMENT

Your first payment is due on the first day of the month immediately following the date on which your Earned Eligibility terminates. You are encouraged to submit your first payment with your Enrollment Form. However, you have 45 days from the last day of your enrollment period to make the payment. Coverage will not be granted and claims will not be considered for payment until your premium is received. Also, coverage will not be verified to any hospital or physician prior to the receipt and processing of your premium payment and providers will be advised that you are still in your enrollment or grace period.

Your first payment must include all premiums required to keep your coverage continuous *from the date you lost Earned Eligibility.* For example, if you lost Earned Eligibility on December 31st, and you make your first premium payment in February, your payment must include the premium for both January and February.

Once your premium is processed, your NOE containing your Health Plan ID cards will be sent to you within seven to 10 business days. You may also print temporary ID cards by visiting the Plan's website at **www.sagph.org**.

PREMIUM DUE DATES

After the Plan Office processes your Enrollment Form, an enrollment confirmation letter and payment coupons will be mailed. You will be sent your coupons on an annual basis. After the first premium payment, all subsequent premium payments are due on the first of each month. As mandated by federal law, there is a 30-day grace period. However you are encouraged to submit the payment by the due date. Coverage will not be granted and claims will not be considered for payment until your premium is received in full.

If you elect a change in self-pay coverage, as outlined on page 23, you will receive new payment coupons which reflect your new coverage and premium rate. If you do not receive your billing coupons within 30 days after enrollment or a change in coverage, please contact the Plan Office.

If you fail to pay your premium by the due date and you do not have an available late payment waiver, you will forfeit your rights to continued coverage under the Self-Pay Program.

PREMIUM PAYMENT PROCEDURES

There are several ways to pay your monthly self-pay premium. You may pay the premium for more than one month at a time. However, you may not pay the premium for any period beyond the current calendar year.

Auto Debit – The auto debit plan deducts your monthly premium automatically on a recurring basis each month from a U. S. checking or savings account. Payments are deducted on or about the 25th of the month prior to the due date. The Plan will continue to deduct the monthly premium as long as you remain continuously eligible for self-pay coverage, even if the Trustees make a change in the premium rate. You can sign up online or download an enrollment form on the Plan's website, **www.sagph.org**.

If you were previously enrolled in the auto debit plan during your Earned Eligibility your auto debit will not continue under the Self-Pay Program. You must complete a new auto debit enrollment form for the Self-Pay Program.

Pay by Web – You may pay your premium online with e-check or a credit card. Simply visit the Plan's website at **www.sagph.org** and enter your checking/savings account or credit card information. You will receive electronic confirmation that your payment has been received.

Pay by Phone – You may pay your premium over the telephone 24/7 with a credit card by calling the Plan Office at (818) 954-9400 or (800) 777-4013 and following the prompts. You will receive a confirmation number indicating your payment has been received. For your security, this is an automated system and Participant Services Representatives will not be able to take your credit card information.

For your protection, Pay by Web and Pay by Phone payments are non-recurring. This means the Plan will not automatically charge your credit card or debit your account every time a payment is due.

Pay by Mail – Make your check, money order or cashier's check from a U.S. bank payable to: Screen Actors Guild – Producers Health Plan and send it to the Plan Office with your payment coupon. To ensure proper crediting you should include the account number from the payment coupon on your check. Your payment must be received by the Plan Office no later than the due date to be considered timely.

Any check or debit returned to the Health Plan for any reason will be assessed a handling fee. You may replace the premium payment and pay the fee using any of the payment options outlined above.

LATE PAYMENT WAIVER

If your self-pay coverage is terminated because your payment was not received by the due date, you can reinstate your coverage by using a late payment waiver within 60 days after the premium due date. The Plan allows one late payment waiver per self-pay coverage period.

To use a late payment waiver, simply send your written request with your premium payment to the Plan Office. You must include payment for all the months required to bring your account current. When your payment is received after the grace period, the Plan will apply your late payment waiver (if available) and your coverage will be reinstated retroactively.

COVERAGE CHANGES

Annual Open Enrollment

Under the Self-Pay Program, your Benefit Period is January 1st through December 31st and your Open Enrollment Period will generally occur from December 1st through January 15th. During Open Enrollment you will have an opportunity to change your dependent enrollment. You can make these changes by visiting the Plan's website at **www.sagph.org** or by completing the Dependent Enrollment Form you receive in your Open Enrollment packet and returning it to the Plan Office.

Change in Family Status

You may make dependent enrollment changes outside of the Open Enrollment Period if you have a change in family status. A change in family status is defined as an increase or decrease in the number of your qualified dependents, which results from birth, adoption, marriage, divorce, establishment or termination of a same-sex domestic partnership or civil union, death, or loss of dependent "child" status as defined by the Plan.

If one of these events occurs you will be permitted to change your dependent's enrollment status and change your premium tier, if applicable. Submit a written request to the Plan Office **within 60 days** of the change in family status along with the documents establishing proof of dependent status (see page 7). Once the Plan Office receives your request and required documentation, your change will be processed and you will receive a new set of billing coupons and ID cards to confirm your new coverage and premium rate.

POSTPONED ENROLLMENT FOR INDIVIDUALS WITH OTHER GROUP HEALTH COVERAGE

Self-pay coverage is offered on a continuous basis where enrollment immediately follows the termination of Earned Eligibility. However, if you meet **all** of the following requirements you may enroll following a break in coverage.

- You have at least 17 years of Earned Eligibility in the Health Plan; and
- You have other group health insurance at the time your SAG-Producers Health Plan Earned Eligibility expires, or gain other group health insurance while enrolled in the SAG-Producers Self-Pay Program; and
- Your other group health coverage was either an employer-sponsored plan or a plan available as a result of your status as a student at an accredited school; and
- You have not already exceeded the maximum number of months of self-pay coverage available to you under the SAG-Producers Self-Pay Program; and
- You enroll in the SAG- Producers Self-Pay Program within 60 days following the later of (i) the termination of your other group health coverage if that plan is not required to offer self-pay coverage, or (ii) the last day of your other group health plan's self-pay period (the maximum number of months available for you to self-pay under the other plan); and
- You provide a copy of the other group health plan's certificate of coverage, issued in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

For purposes of determining whether you qualify for postponed enrollment, a termination of your other group health coverage only occurs where you have lost that coverage due to termination of employment, reduction in hours, death, divorce or legal separation, dissolution of same-sex domestic partnership or civil union, loss of student status, or loss of your dependent child status. **Failure to pay premiums under your other group health coverage is not a termination event.**

EXTENDED SELF-PAY COVERAGE FOR MILITARY SERVICE

Your choices under USERRA with regard to immediately using your Earned Eligibility or immediately enrolling in the Self-Pay Program are outlined on page 4. Your maximum self-pay period is 24 months if you had less than 17 years of Earned Eligibility in the Health Plan or 36 months if you had at least 17 years of Earned Eligibility in the Health Plan. The applicable premium must be paid once the waiver period described on page 4 is exhausted.

COORDINATING SELF-PAY BENEFITS WITH OTHER PLANS

You and your eligible dependents may enroll in the Self-Pay Program even if you or your dependents are covered by another group health plan on the date Earned Eligibility is terminated in this Plan. You should contact the Plan Office to determine which plan will be primary and secondary.

However, if your Earned Eligibility changes from Plan I to Plan II, and you choose to self-pay for Plan I, the Plan will not coordinate benefits between your Plan I self-pay and Plan II earned coverage. Instead, you receive Plan I benefits.

If you, your spouse or your same-sex domestic partner are covered by Medicare, you may also enroll in the Self-Pay Program. **Medicare will be your primary plan and this Plan will be your secondary plan.** It is very important that you and your spouse or partner enroll for Medicare Part A and Part B coverage prior to your 65th birthdays. **If you fail to enroll in Medicare Part A and Part B when this Plan is secondary or tertiary, your payments from this Plan will be reduced by 80% because the Plan will coordinate benefits as if you had received reimbursement from Medicare.** You and your spouse or partner are not required to enroll in a Medicare Part D Prescription Drug Program, however it may be to your advantage to do so. Refer to the section on "Medicare Part D – Prescription Drugs", pages 80 and 81 for more information.

TERMINATION OF SELF-PAY COVERAGE

Your self-pay coverage will terminate on the **earlier of:**

- The first of the month for which you do not pay your premium by the due date; or
- The first of the month after the month in which Social Security determines you are no longer totally disabled if your self-pay coverage is based on your being totally disabled; or
- The first of the month following the expiration of the maximum self-pay coverage period for which you qualify; or
- The first of the month for which you qualify for Earned Eligibility, unless you are self-paying for Plan I and your Earned Eligibility is for Plan II; or
- The date on which the Trustees reduce the amount of self-pay coverage available; or
- The date on which the Health Plan no longer provides health coverage.

Screen Actors Guild Foundation Grant Program

The Screen Actors Guild Foundation provides charitable, educational and humanitarian services for SAG-AFTRA members. The Foundation, established in 1985, also offers services to SAG-AFTRA members and opportunities to those interested and able to assist those who need help. The Foundation offers financial grants to individuals who have a catastrophic illness or injury and who, due to financial need, cannot afford the Health Plan's premium.

GRANT QUALIFICATION REQUIREMENTS

To qualify for a SAG Foundation Grant the individual must be a participant or eligible dependent under the Screen Actors Guild – Producers Health Plan. The applicant must qualify for Earned Eligibility, Senior Performer benefits, Extended Spousal benefits or the Self-Pay Program and must meet the following requirements:

1. The applicant must have a catastrophic illness or injury defined as follows:

   Catastrophic Illness or Injury means an illness or injury which prevents you from performing the material and substantial duties of your regular occupation and the effects of which are likely to be of long or indefinite duration. With respect to a minor participant or dependent, Catastrophic Illness or Injury means an illness or injury which prevents you from engaging in most of the normal activities of a person of like age and gender in good health, and the effects of which are likely to be of long or indefinite duration.

2. The applicant must be suffering from a financial hardship that prevents the individual from being able to afford the premium payments.

GRANT BENEFITS

If a grant is approved for Earned Eligibility, Senior Performers benefits or Extended Spousal benefits, the grant funds will automatically be applied to the cost of the premium of the Plan for which you qualified – either Plan I or Plan II.

If a grant is approved for self-pay coverage, the funds will be applied to the cost of the self-pay premium for the medical portion of Plan II. If additional self-pay coverage is desired, such as choosing to self-pay for Plan I, the additional premium amount must be paid for by the applicant. Also, if the applicant qualifies for dental coverage, it is his or her responsibility to pay the additional premium.

Coverage will terminate on the earlier of the date the applicant no longer qualifies for Health Plan coverage or the date on which the grant funds have been expended. Contact the Plan Office for an application or more information about the Screen Actors Guild Foundation and other assistance organizations. Assistance organization information is also available at **www.sagph.org**.

Total Disability Extension

If you or your eligible dependent are Totally Disabled when Earned Eligibility or self-pay coverage terminates, the disabled individual may be entitled to an extension of coverage for a maximum of 12 months beginning with the first month following the month in which the Earned Eligibility or self-pay coverage ends. The disabled individual must pay the Health Plan premium, as outlined on page 13. If the disabled individual qualifies for Medicare, he or she must enroll in Parts A and B or Plan benefits will be reduced as described on page 83.

Coverage is available under this provision only if the disabled individual is Totally Disabled as defined by the Health Plan and is not covered by any other group health plan with the exception of Medicare. If you lose Earned Eligibility in Plan I but satisfy one of the Plan II requirements you are not entitled to the Plan I Total Disability Extension (because you are covered under Plan II).

TOTAL DISABILITY DEFINED

For adult participants and dependents, Total Disability means the disabled individual is prevented, solely because of sickness or accidental bodily injury, from performing the material and substantial duties of their regular occupation. With respect to minor participants and dependents, Total Disability means that the disabled individual is presently suffering from a sickness or accidental bodily injury, the effects of which are likely to be of long or indefinite duration and which will prevent him or her from engaging in most of the normal activities of a person of like age and gender, in good health.

All requests for the Total Disability Extension are reviewed by the Health Plan's medical consultant.

BENEFIT COVERAGE

Only the disabled individual is covered under the Total Disability Extension. Other family members are not covered. However, family members may be entitled to enroll in the Self-Pay Program.

For the most part, the disabled individual will be entitled to the same benefits under the Total Disability Extension that he or she was receiving during their immediately preceding coverage – Plan I or Plan II. However, dental benefits are not included in the Total Disability Extension, nor may they be paid for separately.

LENGTH OF COVERAGE

The Total Disability Extension is available for a maximum of 12 months and will be granted only once for the same disability. If you regain Earned Eligibility during your period of Total Disability Extension, you will be able to use any remaining months of Total Disability Extension when you subsequently lose Earned Eligibility, provided you are still Totally Disabled from the same disability at that time.

If you recover from one disability, regain Earned Eligibility, and subsequently become Totally Disabled from a new and different disability, you will be entitled to another 12 months of Total Disability Extension for the new disability.

If your Total Disability Extension ends during the middle of the month, as commonly occurs in the case of pregnancy, you must pay the full monthly Health Plan premium. The amount will not be prorated.

OPTION TO ELECT SELF-PAY COVERAGE OR TOTAL DISABILITY EXTENSION

If you or your dependent are Totally Disabled at the time Earned Eligibility terminates, you are entitled to a choice of 1 or 2 as follows:

1. **Enrolling in the Self-Pay Program.** If this option is elected, the disabled individual may continue coverage under the Total Disability Extension when the maximum number of self-pay months have elapsed, provided he or she is still Totally Disabled and is not covered under another group health plan.

2. **Electing coverage under the Total Disability Extension.** If this option is elected, the disabled individual may continue coverage under the Self-Pay Program when the maximum number of Total Disability Extension months have elapsed.

If Option 2 is elected and your dependents do not enroll in the Self-Pay Program while you are covered under the Total Disability Extension, they may be added to your self-pay coverage following the Total Disability Extension.

If Option 2 is elected and you first acquire dependents during the 12-month period, you may change from the Total Disability Extension to the Self-Pay Program. However, you will forfeit the remaining months of coverage under the Total Disability Extension and you will not be entitled to return to the Total Disability Extension after the self-pay period ends.

SPECIAL RULES FOR TOTAL DISABILITY EXTENSION

Becoming Totally Disabled While on the Self-Pay Program

If you or your eligible dependent become Totally Disabled while enrolled in the Self-Pay Program, the disabled individual will be eligible for the Total Disability Extension after completion of the applicable maximum number of months of coverage available to the individual under the Self-Pay Program.

Total Disability Extension for Pregnancy

If you, your spouse or your same-sex domestic partner is pregnant at the time of loss of either Earned Eligibility or self-pay coverage, benefits may be provided under the Total Disability Extension but only if the delivery occurs within 31 days of loss of coverage. If this requirement is met coverage will be limited to:

- **Normal Delivery:** 31 days before delivery and six weeks following delivery.

- **Cesarean Delivery:** 31 days before delivery and eight weeks following delivery.

Children born during the Total Disability Extension are not covered under the extension but they may be covered under any self-pay coverage which is elected immediately following the Total Disability Extension.

Conversion Options

HOSPITAL AND MEDICAL

A conversion policy for hospital and medical coverage is available to you and your qualified dependents upon termination of eligibility. No test of insurability is required, although the carrier may request information about your medical history in order to provide you with more favorable premium rates.

You may purchase a hospital and medical conversion policy upon termination of Earned Eligibility or you can enroll in the Self-Pay Program first. If you enroll in the Self-Pay Program you will have another opportunity to purchase conversion coverage at the end of your maximum term of self-pay coverage.

For conversion information call Anthem Blue Cross at (888) 756-7542. They will refer you to the appropriate local Blue Cross Blue Shield office. You must submit an application and payment to the carrier within 31 days of the date you lose coverage.

Dependent children who lose dependent status when they turn age 26 may also convert their hospital and medical coverage, as may your spouse or same-sex domestic partner in the event of divorce, dissolution of your civil union or partnership, or your death. Applications and payment must be submitted within 31 days of the loss of coverage.

LIFE INSURANCE

A life insurance conversion policy is available to the participant only at the time Plan I Earned Eligibility terminates. You may convert $5,000 if you are losing Plan I Earned Eligibility and gaining Senior Performers coverage. You may convert $2,000 if you have received an accelerated life insurance payment. Otherwise you may convert $10,000.

You must submit an application and payment to Metropolitan Life Insurance Company (MetLife) within 31 days of the date you lose coverage. For applications call MetLife at (877) 275-6387 or email solutions@metlife.com.

For more information on the Health Plan, please visit:

www.sagph.org

Screen Actors Guild – Producers Health Plan

II. HEALTH PLAN BENEFITS

Health Plan benefits are designed to help you pay for everyday medical costs as well as expenses resulting from a serious or lengthy illness or injury. The Plan has limitations and may not cover all treatment even if it is medically necessary and approved by your doctor. It pays toward covered physician charges in and out of the hospital, surgical expenses, and laboratory and radiology charges among many other medical expenses. The Plan reserves the right to request that you or your dependent undergo an independent medical evaluation should the Plan deem it necessary to do so.

Several important terms, such as Plan's Allowance, Deductible, Coinsurance and Network Level of Benefits are used in this section. Please refer to the Glossary of Terms on pages 107 through 109 to better understand these terms.

Using The Plan's Network Providers

The Health Plan uses networks of preferred providers for its hospital, medical, mental health, substance abuse, prescription drug, dental and vision care benefits. All of the providers in these networks are carefully monitored to ensure that they continue to meet high professional standards and deliver services in the most effective way. However, just because you obtain care from a network provider, it does not mean that all services and supplies are automatically covered. If you have questions regarding coverage of a particular treatment, diagnostic test or supply, it is strongly recommended that you contact the Plan Office for coverage information rather than rely on a physician or his or her staff who deal with many different plans on a daily basis.

SAVINGS

When you use network providers, both you and the Plan save money because the network providers have agreed to accept a designated fee schedule for their services. In some cases, you are required to use the network in order to receive any benefits. In other cases, you may choose whether or not to use the network. If you choose to use a non-network provider you will receive a lower level of benefits.

CONVENIENCE

Using network providers is convenient. The provider will complete and submit the claim forms for you. You must verify that they are in the network prior to each visit and then simply show your Health Plan ID card when you arrive for your appointment. The provider will usually collect your copay at that time. After the claim is processed, the Plan's payment will be made directly to the provider. You will receive notification from the Plan Office that the payment has been made. This notification is called an Explanation of Benefits (EOB).

LOCATING A NETWORK PROVIDER

Provider directories are not printed for distribution because new providers are continually being added to the networks which means the directories become outdated very quickly. You can always find out if a particular provider is in the network or obtain a list of providers in your area at no charge by visiting the Plan's website, **www.sagph.org**, or contacting the networks at the numbers or websites shown in the chart to the right.

IMPORTANT: The providers in these networks change on an ongoing basis. New providers are added and old providers drop out. Some providers offer services at more than one location and not all locations may be in the network. It is your responsibility to make sure that the provider is in the network at the location where you receive services at the time you receive care.

THE INDUSTRY HEALTH NETWORK OF MPTF (MOTION PICTURE & TELEVISION FUND

The Health Plan has also contracted with The Industry Health Network (TIHN), a wholly owned subsidiary of MPTF. It is available to all Health Plan participants although its health centers are located only in Southern California. Its network of physicians and outpatient health centers offers the least expensive option for quality care because when you use a TIHN primary care physician (PCP), the annual deductible does not apply. Also, if you use TIHN facilities for non-emergency care you will have a lower annual hospital deductible. Please note that the Motion Picture & Television Hospital does not provide emergency care.

To take advantage of this program, make an appointment with a PCP at one of the MPTF Health Centers. The PCP will coordinate your care and, if necessary, will refer you to a specialist in TIHN. Without the PCP's referral, the Industry Health Network level of benefits will not apply. This means you will have higher deductibles. You must see the PCP in person to receive a referral to a specialist; you cannot just call the PCP.

In order to receive services through the MPTF you must be at least 13 years of age. A TIHN referral to a pediatrician for children under the age of 13 may be obtained over the phone by calling TIHN customer service at (800) 876-8320.

To establish a relationship with a PCP, please contact one of the conveniently located health centers and make an appointment.

Bob Hope Health Center
335 North La Brea Avenue
Los Angeles, CA 90036
(323) 634-3850

Glendale Health Center
800 South Central Avenue, #305
Glendale, CA 91204
(818) 876-4790

Jack H. Skirball Health Center
23388 Mulholland Drive
Woodland Hills, CA 91364
(818) 876-1050

Santa Clarita Health Center
25751 McBean Parkway, #210
Santa Clarita, CA 91355
(661) 284-3100

Toluca Lake Health Center
4323 Riverside Drive
Burbank, CA 91505
(818) 556-2700

Westside Health Center
1950 Sawtelle Boulevard, #130
Los Angeles, CA 90025
(310) 996-9355

Preferred Provider Networks

Hospital and Medical	BlueCard PPO*	(800) 810-BLUE (2583) **www.sagph.org** link to "Find Network Providers" then link to "BlueCard PPO"
	The Industry Health Network (TIHN)	(800) 876-8320 www.mptf.com/sagph
Prescription Drug	Express Scripts	(800) 903-4728 www.express-scripts.com
Mental Health and Substance Abuse	ValueOptions*	(866) 277-5383 www.valueoptions.com/sagph
Dental	Delta Dental	(800) 846-7418 www.deltadentalins.com/sagph
Vision	Vision Service Plan	(800) 877-7195 www.vsp.com
All Networks	Plan Office	(818) 954-9400 (800) 777-4013 **www.sagph.org**

* If you need hospital or medical services and you live more than 25 miles from two providers of any type who participate in the BlueCard PPO network you are considered to be outside a network area but will receive the Network Level of Benefits for these services. However, if you travel to a network area, you must use network providers to obtain the higher level of benefits. These same rules apply to Plan I participants who need mental health or substance abuse treatment and live more than 25 miles from two facilities or providers of any type who participate in the ValueOptions network.

If a participant who lives in a network area is being treated for a serious condition that requires a specialist's care, and there are no network specialists in his or her area, the participant will receive the Network Level of Benefits for services rendered by that specialist. A serious condition includes conditions such as cancer and cardiac surgery. It does not include situations of a non-serious nature, such as claims for chiropractic or acupuncture.

You are responsible for the lower network deductibles, copays and coinsurance plus the difference between the Plan's Allowance and the billed amount. The Plan's Allowance will be used to determine the amount the Plan will consider instead of the lower network contracted amount.

Understanding Your Non-Network Costs

Non-network charges are generally much more expensive and can take a bite out of your pocketbook. The FAIR Health website can help you plan ahead by providing an estimate of your potential expense based on actual provider charges in your local area.

www.fairhealthconsumer.org

FAIR Health is a national independent, not-for-profit corporation whose database of billions of billed medical and dental services powers a free website for consumers. Its consumer cost estimators give you an informed, comprehensive picture of what medical and dental procedures cost near your zip code. You can use this tool to get a real-world cost estimate that you can use to gain an informed understanding of how much you might need to pay in non-network costs for specific treatments and procedures.

Hospital Benefits (including Mental Health and Substance Abuse Treatment)

The Plan uses the BlueCard PPO network and The Industry Health Network (TIHN) for all hospital benefits except mental health and substance abuse. The Plan uses the ValueOptions network for mental health and substance abuse benefits. Non-network services are only covered in the event of an emergency. See page 34 for a description of emergency treatment.

ELIGIBILITY

Plan I

Plan I Earned, Self-Pay and Senior Performer participants and their enrolled dependents are eligible for the hospital benefits, including treatment for mental health and substance abuse conditions. In accordance with the Mental Health Parity and Addiction Equity Act of 2008, Plan I hospital coverage includes coverage for mental health and substance abuse benefits. This means that deductibles, copays, coinsurance and out-of-pocket maximums for Plan I hospital benefits now include mental health and substance abuse benefits.

Plan II

Plan II Earned and Self-Pay participants and their enrolled dependents are eligible for the hospital benefits. **Coverage for the treatment of mental health and substance abuse conditions is not included.**

DEDUCTIBLE

Hospital charges are subject to a calendar year deductible. The hospital deductible is separate from the deductibles for the other benefits provided by the Plan, including the medical, prescription drug and dental deductibles. The sole exception is the Plan I mental health and substance abuse hospital deductible, which is combined with the Plan I hospital deductible. The amount of the hospital deductible varies depending on which network you use and the Plan for which you are eligible.

The family deductible is satisfied when at least two or more family members have paid the amount of the family deductible in covered expenses. However, the Plan will not apply more than the individual deductible amount to any one family member. For example, if a participant in Plan I who has a spouse and two children uses BlueCard PPO hospitals, the $500 family deductible will be satisfied once he and his family have paid a total of $500 in covered expenses. However, the Plan will not apply more than $250 toward the deductible for any one family member.

The Plan applies expenses toward your deductible as it processes claims, rather than according to the date of service. Providers submit their claims in ac-

Hospital Deductibles

	Network	Non-Network
Plan I	TIHN (non-emergency care only) – $150 per person / $300 per family BlueCard PPO/ValueOptions – $250 per person / $500 per family	No coverage*
Plan II	TIHN (non-emergency care only) – $150 per person / $300 per family BlueCard PPO – $500 per person / $1,000 per family	No coverage*

* Coverage will be provided in the event of an emergency. See page 34 for a description of emergency treatment.

cordance with their own billing schedules and claims are frequently not received in the order of their date of service, particularly when multiple providers are used.

If you go to a hospital for emergency treatment your deductible is based on the BlueCard PPO deductibles outlined to the left. These deductibles apply even if you called or visited TIHN first and they told you to go to the emergency room. TIHN hospital deductibles apply only to non-emergency hospital care received through TIHN.

If your eligibility changes from Plan I to Plan II during a calendar year, any charges that applied toward your deductible under Plan I will apply toward your Plan II deductible. If your eligibility changes from Plan II to Plan I during a calendar year, the reverse is also true.

COINSURANCE AND OUT-OF-POCKET MAXIMUMS

Once the deductible has been satisfied, the Plan will provide reimbursement of covered hospital expenses at 90% of the Contract Allowance.

The out-of-pocket maximum is the maximum amount you and your family must pay for covered expenses during the calendar year after your deductible is satisfied. For example, a participant who is single and who has satisfied his deductible is responsible for 10% of the first $17,500 of covered network hospital expenses, or $1,750. This is called the coinsurance. When you have paid your deductible and the maximum out-of-pocket amount, the Plan will reimburse 100% of covered hospital expenses, with the exception of emergency room copays.

Plan I mental health and substance abuse out-of-pocket hospital expenses are combined with Plan I out-of-pocket hospital expenses.

If your eligibility changes from Plan I to Plan II during a calendar year, any charges that applied toward your out-of-pocket maximum under Plan I will apply toward your Plan II out-of-pocket maximum. If your eligibility changes from Plan II to Plan I during a calendar year, the reverse is also true.

Hospital Coinsurance and Out-of-Pocket Maximums

Plan I and Plan II	Network	Non-Network
Plan Pays	90% of Contract Allowance	No coverage*
Coinsurance	10% of Contract Allowance	No coverage*
Out-of-Pocket Maximum	$1,750 per person/$3,500 per family	No coverage*

* Coverage will be provided in the event of an emergency. See page 34 for a description of emergency treatment.

EMERGENCIES

Emergency treatment at network and non-network hospitals is covered within 72 hours after an accident or within 24 hours of a sudden and serious illness. There is a copay for the emergency room. This copay is waived if there is immediate confinement for the same accident or illness.

Emergency Room Copay

Plan I	$100 per visit
Plan II	$200 per visit

If you are admitted to a non-network hospital, you or the hospital should call one of the following within 48 hours to report the emergency admission:

- For participants and dependents covered under Plan I with a mental health or substance abuse emergency – ValueOptions (866) 277-5383.

  Mental health and substance abuse treatment are not covered under Plan II.

- For all other emergency admissions – Anthem Blue Cross (800) 274-7767.

Your care will be reviewed and the coverage will be authorized if it is medically necessary.

HOSPITAL BENEFITS (OTHER THAN MENTAL HEALTH AND SUBSTANCE ABUSE)

Hospital benefits include the following:

- Emergency treatment including services billed by the hospital on their statement of charges. Any services that are not included on the hospital bill and are billed separately, such as physicians' or surgeons' charges, may be covered under the medical benefits. Urgent care centers are also covered under the medical benefits.

- Inpatient hospice care provided by a Medicare-certified program, when an individual is terminally ill with a life expectancy of less than 12 months. Hospice benefits are not subject to the deductible. Outpatient hospice care may be covered under the medical benefits.

- Network birthing centers. Charges for non-network birthing centers may be covered under the medical benefits.

- Outpatient hospital treatment for diagnostic services and therapy such as x-rays, machine tests, physical therapy and chemotherapy.

- Outpatient surgery in a hospital, surgical suite or ambulatory surgical center, including charges for services connected with surgery that are billed by the facility. Services not billed by the facility and charges at a non-network surgical suite or surgical center may be covered under the medical benefits.

- Semi-private room, board, hospital services and supplies for acute care for a covered diagnosis. For stays in a private room, the Plan pays the hospital's most common semi-private room rate. You are responsible for the difference between the semi-private and private room rates.

Hospital services and supplies include:

- Administration of blood or blood plasma. (The actual charge for blood is covered under the medical benefits.)
- Anesthesia.
- Basal metabolism studies.
- Cardiac testing.
- Drugs and medicines.
- Intensive care.
- Operating, delivery and treatment rooms.
- Oxygen.
- Physiotherapy and hydrotherapy.
- Special diets.
- Splints, casts and dressings.
- Staff nursing care.
- X-ray and laboratory exams.

HOSPITAL STAYS FOR MATERNITY

A stay related to childbirth, miscarriage, ectopic pregnancy, or premature termination of pregnancy is only covered if the patient is a participant or the spouse or same-sex domestic partner of a participant. A newborn's ordinary nursing care in the hospital is also covered. For dependent children, only complications of pregnancy are covered. Complications of pregnancy do not include elective termination of pregnancy.

Under federal law, the Plan generally may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HOSPITAL BENEFITS FOR MENTAL HEALTH AND SUBSTANCE ABUSE (PLAN I ONLY)

Mental health and substance abuse benefits cover a vast number of conditions. Among them are anxiety, stress, eating disorders, depression, bi-polar disorders such as manic depression, psychosis, schizophrenia and substance abuse (alcohol and drugs). If you have a question about a particular mental health or substance abuse condition and whether it is covered please contact ValueOptions at (866) 277-5383 or visit www.valueoptions.com/sagph.

All mental health and substance abuse hospital claims are administered by ValueOptions. See page 85 for how to file a claim. Benefits include the following:

- Inpatient care – Treatment that is provided in a 24-hour medical facility.
- Alternative levels of care –
  - Residential Treatment Center – Treatment that is provided in a 24-hour non-medical facility.
  - Partial Hospital Program – Treatment that is provided for 6 – 8 hours per day.
  - Intensive Outpatient Program – Treatment that is provided for 2 – 3 hours per day.
- Emergency treatment, including services billed by the hospital on their statement of charges. Services that are not included on the hospital bill and are billed separately, such as non-psychiatric professional charges, may be covered under the medical benefits.

NON-COVERED HOSPITAL EXPENSES

- All expenses at a non-network hospital, except for emergency treatment as described on page 34.
- A stay in a facility or hospital that is not registered as a general hospital by the American Hospital Association and does not meet accreditation standards of the Joint Commission on Accreditation of Hospitals, except facilities that provide alternative levels of care for the treatment of mental health and substance abuse to Plan I participants and dependents.
- A stay primarily for diagnostic tests, pulmonary tuberculosis, convalescent care, rest cure or custodial care.
- A stay primarily for physical or rehabilitative therapy. If a patient is transferred to a hospital's rehabilitation wing (either from the same acute care hospital or from another acute care hospital), **and** the care is still considered acute care, the Plan may consider benefits.
- Care that is covered under other portions of the Plan, such as ambulance, blood and blood plasma, x-ray or radiation therapy, special braces, appliances or equipment, or outpatient care.
- Convalescent facilities.
- Charges in connection with cosmetic surgery, except under the limited circumstances described on pages 40 and 44.
- Non-network birthing centers. (Limited coverage for these services is provided under the medical benefits.)
- Outpatient hospice care. (This is covered under the medical benefits.)
- Personal comfort items such as TV or telephone.
- Physician's surgical suite or a non-network surgery center. (Limited coverage for these services is provided under the medical benefits.)
- Services of doctors, surgeons and anesthesiologists **not employed** by the hospital. (These are covered under the medical benefits.)
- Services of technicians and other vendors **not employed** by the hospital.
- Skilled nursing facilities. If a patient is transferred to a skilled nursing facility from an acute care hospital **and** the care is still considered acute, the Plan may consider benefits.
- Urgent care centers. (These are covered under the medical benefits.)

See also General Exclusions on page 72.

Medical Benefits (including Mental Health and Substance Abuse Treatment)

The Plan uses the BlueCard PPO network and The Industry Health Network (TIHN) for all network medical benefits except mental health and substance abuse. The Plan uses ValueOptions for network mental health and substance abuse benefits. Non-network services are also covered under these benefits.

ELIGIBILITY

Plan I

Plan I Earned, Self-Pay and Senior Performer participants and their enrolled dependents are eligible for the medical benefits, including treatment for mental health and substance abuse conditions. In accordance with the Mental Health Parity and Addiction Equity Act of 2008, Plan I medical coverage includes mental health and substance abuse benefits. This means that deductibles, coinsurance and out-of-pocket maximums for medical benefits now include mental health and substance abuse benefits.

Plan II

Plan II Earned and Self-Pay participants and their enrolled dependents are eligible for the medical benefits. **Coverage for the treatment of mental health and substance abuse conditions is not included.**

DEDUCTIBLE

Medical charges are subject to a calendar year deductible. The medical deductible is separate from the deductibles for any other benefits provided by the Plan, including the hospital, prescription drug and dental deductibles. The sole exception is the Plan I mental health and substance abuse medical deductible which is combined with the Plan I medical deductible. The amount of the medical deductible varies depending on whether or not you use network providers and the Plan for which you are eligible. Refer to the chart below.

The family deductible is satisfied when at least two or more family members have paid the amount of the family deductible in covered expenses, except that the Plan will not apply more than the individual deductible amount to any one family member. See the example under hospital "Deductible" on page 32.

The Plan applies expenses toward your deductible 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, particularly when multiple providers are used.

Medical Deductibles

	Network	Non-Network
Plan I	TIHN – No deductible BlueCard PPO / ValueOptions – $250 per person / $500 per family	$500 per person / $1,000 per family
Plan II	TIHN – No deductible BlueCard PPO – $500 per person / $1,000 per family	$750 per person / $1,500 per family

If your eligibility changes from Plan I to Plan II during a calendar year, any charges that applied toward your deductible under Plan I will apply toward your Plan II deductible. If your eligibility changes from Plan II to Plan I during a calendar year, the reverse is also true.

COPAYS, COINSURANCE AND OUT-OF-POCKET MAXIMUMS

Once you have satisfied the annual deductible, the Plan will provide reimbursement of covered expenses as shown in the table below. You are responsible for the applicable copays and coinsurance. Copays are flat dollar amounts while the coinsurance is a percentage of the Plan's Allowance.

The out-of-pocket maximum is the maximum amount you will have to pay for covered expenses during the calendar year after your deductible is satisfied. For example, a participant who is single and who has satisfied her deductible is responsible for 10% of the first $10,000 of covered network medical expenses, or $1,000. This is called the coinsurance. When you have paid your deductible and the maximum out-of-pocket amount, the Plan will pay 100% of covered expenses with the exception of network copays.

See TAKE 2 Update Winter 2013

See TAKE 2 Update Summer 2014

Medical Copays, Coinsurance and Out-of-Pocket Maximums

	Network	Non-Network
Plan I – Copays	$15 per office visit; $15 for surgery performed in a doctor's office*; $100 per inpatient surgery; $100 per outpatient surgery**; $100 maternity care – delivery	None
Plan Pays	90% of Contract Allowance	70% of Plan's Allowance
Coinsurance	10% of Contract Allowance	30% of Plan's Allowance
Out-of-Pocket Maximum	$1,000 per person / $2,000 per family	$2,500 per person / $5,000 per family
Plan II – Copays	$25 per office visit; $25 for surgery performed in a doctor's office*; $100 per inpatient surgery; $100 per outpatient surgery**; $100 maternity care – delivery	None
Plan Pays	90% of Contract Allowance	70% of Plan's Allowance
Coinsurance	10% of Contract Allowance	30% of Plan's Allowance
Out-of-Pocket Maximum	$1,000 per person / $2,000 per family	$2,500 per person / $5,000 per family

* If surgery is performed during a scheduled office visit, you are only responsible for one copay for that visit.
** This applies to surgery performed in i) the outpatient department of a hospital, ii) a freestanding surgical center, or iii) a physician's surgical suite.

Plan I mental health and substance abuse out-of-pocket medical expenses are combined with Plan I out-of-pocket medical expenses.

If your eligibility changes from Plan I to Plan II during a calendar year, any charges that applied toward your out-of-pocket maximum under Plan I will apply toward your Plan II out-of-pocket maximum. If your eligibility changes from Plan II to Plan I during a calendar year, the reverse is also true.

MEDICAL BENEFITS (OTHER THAN MENTAL HEALTH AND SUBSTANCE ABUSE)

The Health Plan covers a wide range of medical services including the following:

- Ambulance – Professional ambulance service and regularly scheduled airlines or railroads for **emergency transportation** to or from the **nearest** legally constituted hospital which has the facilities to treat your medical problem. Services provided to relocate a patient for family or personal convenience are not covered.

- Anesthetics and their administration. See page 46 for anesthesia limits for colonoscopy and upper gastrointestinal endoscopy.

- Artificial limbs and eyes, crutches, splints, casts and braces, surgical dressings, and medical supplies when prescribed by a doctor, including:
  - Initial charge for appliances to replace or aid the function of physical organs or parts (does not include dental appliances).
  - Initial pair of orthopedic or corrective shoes following surgery.
  - Orthopedic or corrective shoes for children under 12, two pairs in a calendar year.

- Birth control for women– Norplant, IUDs and Depo-Provera. Birth control received from a network provider is not subject to the deductible or coinsurance. (Birth control pills, diaphragms, vaginal rings and patches are covered under the Express Scripts prescription drug program.)

- Blood and plasma, except Protein Rich Plasma.

- Breast implant removal when medically necessary due to pain from contracture or rupture of an implant – The Plan will cover the cost to remove the implant but not the cost of a replacement implant or reconstruction. Benefits are payable for a maximum of one surgery per breast per lifetime. This limit does not apply to breast surgeries resulting from cancer treatment. Please see page 46 for surgery pre-authorization requirements.

- Breast pumps – Rental or purchase from a network provider only. Total rental payments are limited to the Plan's Allowance for purchase. Breast pumps are not subject to the deductible or coinsurance and are limited to one pump per birth.

- Cardiac and cerebrovascular rehabilitative therapy – Benefits are payable for a maximum of three months, if such therapy commences within six months of a clinical cardiac or CVA (cerebrovascular accident) episode.

- Certified nurse practitioner acting within the scope of his or her license.

- Cervical traction units, except those prescribed by a chiropractor or naturopath.

- Chemotherapy.

- Christian Science practitioner – The Plan does not pay for any medical treatment when you are receiving services from a Christian Science practitioner. The Plan does not pay for Christian Science homes or sanitariums.

- Cosmetic surgery, only if necessary:
  - For the prompt repair of accidental injury; or
  - To repair birth defects (congenital anomalies) as certified by a doctor, on individuals under 19 years of age; or
  - For certain reconstructive surgery following a mastectomy, including reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas (as required by the Women's Health and Cancer Rights Act of 1998).

- Dentist's charges as a result of accidental injury to natural sound teeth when repair work is completed within six months of the accident. A natural sound tooth is one which has not been restored or has been restored with amalgam or composite filling. A natural sound tooth does not include a missing tooth. The Plan may consider the repair of a tooth which was previously crowned provided the accidental injury is due to external causes and resulted in either hospitalization or surgery to the injured tooth. If approved under the medical benefits, no coverage is available under the dental benefits.

- Dentist's charges for the removal of cysts and tumors.

- Dialysis treatment.

- Drugs and medications that are injectable or infusible and administered by the doctor's office, including allergy shots. (Specialty medications are covered under the Express Scripts prescription drug program and must be obtained through the Accredo specialty pharmacy.)

- Drugs and medications requiring a doctor's or a dentist's prescription and dispensed by a registered pharmacist for eligible participants who are not covered by the Express Scripts prescription drug program (see page 55). Benefits are payable at the non-network level subject to the medical deductible.

- Drugs that do not require a prescription if you are under the care of a physician for a current illness. The doctor must state, in writing, to the Plan Office the necessity for the use of such medication for the treatment of your illness. The non-prescription drugs must be generally accepted treatment for a given condition or illness. Not included are non-drug items dispensed in the doctor's office, food and/or nutritional supplements and homeopathic remedies or vitamins taken orally, by injection or by infusion.

- Durable medical equipment (DME) – Rental or purchase of items when prescribed by a medical doctor, provided by a qualified DME supplier, and determined to be medically necessary by the Plan. Total rental payments are limited to the Plan's Allowance for the purchase of the equipment. If equipment is to be used for an extended period of time purchase may be preferred. NOT ALL EQUIPMENT IS COVERED. CHECK WITH THE PLAN OFFICE. DME that does not require a medical doctor's prescription is not covered. Neither is DME that is prescribed by an acupuncturist or chiropractor, or DME purchased from a non-qualified supplier such as Amazon or eBay.

  Note: *In order for the Plan to consider charges for DME, the equipment must meet the criteria outlined in the Glossary under "Durable Medical Equipment" on pages 107 and 108.*

- Eyeglasses (initial pair only), or contact or scleral lenses when required following a covered eye surgery.

- Food allergy testing, when performed as part of the normal work-up of an allergy patient. The tests must be medically necessary. The Plan does not cover allergy treatments such as food antigens.

- Foot orthotics when prescribed by a doctor, subject to the following replacement guidelines:
  - Age 16 or younger – One pair every 12 months.
  - Age 17 or older – One pair every 24 months.

  The Plan does not cover additional pairs of orthotics purchased for different styles of shoes.

- Hearing aids for:
  - Participants and dependents covered under Plan I; and
  - Individuals under age 19 who have congenital hearing defects and are covered under Plan II.

  This benefit is payable at either 90% or 70%, as applicable, up to a maximum payment of $1,500 per device. Devices are limited to one per ear per three-year period. Repairs and battery replacement are not covered. Cochlear implants are not subject to these limits.

- Home health care (may include nursing, durable medical equipment, and other medical supplies such as IV medications) – Please see page 52 for limitations on nursing and page 40 for limitations on durable medical equipment.

- Hospice – Outpatient hospice care provided by a Medicare-certified program, when an individual is terminally ill with a life expectancy of less than 12 months. Hospice benefits are not subject to the deductible. Inpatient hospice care may be covered under the hospital benefits.

- Lab and diagnostic tests to diagnose an illness or injury. Only tests which are appropriate for the clinical diagnosis as determined by medical consultants for the Plan will be considered. All tests are subject to medical review. Lab tests that are part of a panel will not be paid as separate tests.

- Lactation support and counseling – Services are not subject to the deductible, copay or coinsurance. Benefits for non-network lactation consultants require that the consultant be an International Board Certified Lactation Consultant and are subject to a lifetime maximum of three visits.

- Mammogram.

- Nutritional counseling by a Registered Dietitian (R.D.) for participants or dependents with chronic illnesses such as diabetes (including gestational diabetes), coronary artery disease, ulcerative colitis, Crohn's Disease, malabsorption syndrome, cystic fibrosis, HIV/AIDS and cancer. Nutritional counseling is not subject to the deductible or the network copay and is limited to one initial and two follow-up visits per person per lifetime.

- Obstetrical care and delivery for participants or their spouses or same-sex domestic partners, when provided by a M.D., Certified Nurse Midwife or State-Licensed Midwife, including pre and post-natal care and delivery. Additional charges for diagnostic tests such as ultrasound or amniocentesis may be considered separately, if medically necessary. Prenatal care from a network provider is not subject to the deductible, copay or coinsurance. If you change obstetricians and/or midwives during your pregnancy, the Plan will only consider charges up to the global maternity allowance.

- Obstetrical prenatal care for dependent children when provided by a network provider (M.D., Certified Nurse Midwife or State-Licensed Midwife). This care is not subject to the deductible, copay or coinsurance. Complications of pregnancy are covered for both network and non-network providers, subject to the medical deductible, copay and coinsurance. Delivery and post-natal services are not covered, nor are prenatal charges from a non-network provider.

- Oxygen and its administration.
- Pap test.
- Pediatrician's charges for attendance at birth by cesarean section.
- Physician's services – Fees of a legally qualified licensed physician or surgeon for professional medical or surgical services in or out of the hospital or at an urgent care center.
- Private duty *outpatient* nursing (R.N., L.V.N., L.P.N. or equivalent state license) other than a relative or resident in your home **when approved in advance**, see page 52.
- Psychological testing **when approved in advance**. Psychological testing in connection with learning disabilities, academic accommodations, or mental health or substance abuse treatment is not covered.
- Pulmonary rehabilitation.
- Radiation therapy.
- Radium and radioactive isotope therapy.
- Rast testing – The Plan will consider the minimum number of tests that are medically required in order to make a diagnosis.
- Sleep studies (Polysomnography) **when approved in advance**. The Plan Office will review the referring physician's clinical exam notes and a completed sleep study questionnaire, which includes the Epworth Sleepiness Scale. Home studies and separate sleep studies to determine C-PAP titration are not covered unless medically necessary. The Plan covers treatment of sleep apnea when documented by medical records. Sleep studies performed for primary snoring are not covered.
- Temporomandibular joint syndrome (TMJ) treatment, only when osseous changes (bony abnormalities) exist and can be determined by x-ray or other appropriate imaging techniques or in situations in which soft tissue degeneration in the temporomandibular joint can be documented. Dental expenses in connection with orthodontia are not included.
- Therapy benefits, subject to specific limitations. Refer to pages 47 and 48.
- Therapy exam – One initial medical exam per type of therapy for the doctor or covered therapist who is providing covered therapy treatment. For physical therapy and physical medicine, the Plan will also consider an additional exam.
- Urgent care centers.
- Visiting nurse **when approved in advance** (limited to reasonable and customary both by amount and frequency of visits). Each visit counts as one hour toward the 672 hour maximum as described on page 52.
- Wellness or preventive services, such as physical exams and certain diagnostic tests, subject to specific limitations. Refer to pages 48 through 51.
- Wigs – Limited to one per lifetime following cancer treatment.
- X-rays, CT scans or MRIs to diagnose an illness or injury. Only tests which are appropriate for the clinical diagnosis as determined by medical consultants for the Plan will be considered.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS (PLAN I ONLY)

Mental health and substance abuse benefits cover a vast number of conditions. Among them are anxiety, stress, eating disorders, depression, bi-polar disorders such as manic depression, psychosis, schizophrenia and substance abuse (alcohol and drugs). If you have a question about a particular mental health or substance abuse condition and whether it is covered please contact ValueOptions at (866) 277-5383 or visit www.valueoptions.com/sagph.

All mental health and substance abuse medical claims, whether network or non-network, are administered by ValueOptions. See page 85 for how to file a claim. Benefits include the following:

- Professional fees for disorders listed in the Mental Disorders section of the current edition of the International Classification of Diseases publication. Not all diagnoses are covered. Please contact ValueOptions for additional information.
- Psychiatrist or Psychopharmacologist for drug management.
- Psychotherapy (for psychological testing see page 42).

SPECIAL RULES FOR RADIOLOGY, ANESTHESIOLOGY AND PATHOLOGY (RAP) PROVIDERS

If a network physician refers you to a non-network radiology, anesthesiology or pathology (RAP) provider, the Plan will pay the Network Level of Benefits for the RAP claims. Payment will be based on the Plan's Allowance and you will be responsible for charges over this amount. When the Plan Office receives a RAP claim it is not always clear that you were referred by a network doctor. You must let the Plan Office know about the referral so that RAP benefits can be paid at the network level.

You will also receive the Network Level of Benefits (based on the Plan's Allowance) if you receive RAP services as an inpatient or outpatient at a network hospital or facility, regardless of whether or not you were referred by a network physician.

Note: *For a* ***colonoscopy or upper gastrointestinal endoscopy****, the Plan will cover moderate sedation when performed by the surgeon or a member of his or her team. A separate anesthesiologist's charges will not be covered unless the Plan's medical consultants determine that it is medically necessary. You should check with your surgeon before the procedure to determine if he or she intends to use a separate anesthesiologist as this may increase your out-of-pocket expenses.*

SURGICAL BENEFITS

Contact the Plan Office *before undergoing any surgical procedure to determine if the procedure is covered under the Plan, if a pre-authorization is required and if there are any limitations.*

Obtaining a Second Opinion

The Plan encourages you to obtain a second opinion when surgery is recommended. A second opinion assists you in determining whether surgery is required or whether some alternative treatment may also be appropriate. The Plan will pay 100% of the Allowed Amount for a second (or third) opinion for you or your dependent for a covered surgery. The deductible and copay/coinsurance amount will not apply to the second (or third) opinion.

Transplants

With the exception of corneal transplants, expenses incurred in connection with organ transplants will not be considered as a covered expense under the Plan unless a written pre-authorization approval is obtained. The Plan reserves the right to deny coverage for a transplant if it is not performed in a Blue Distinction Center or Center of Excellence. Anthem Blue Cross maintains the list of these authorized network facilities. To obtain pre-authorization for a transplant, please follow the instructions under "Pre-Authorization for Surgery" on page 46.

If your transplant surgery is approved by the Plan, donor expenses are considered for payment provided the donor does not have such coverage under his or her own medical insurance plan. Written documentation from the donor's insurance plan is required. **However, if you are donating an organ to another person, the Plan does not consider your donor expense for coverage because it is not considered a medically necessary expense for you.**

If you or your dependents are covered under more than one health plan, including AFTRA, Directors or Writers, we recommend that you obtain pre-authorization from all plans.

Bariatric Surgery

Bariatric surgery will be considered as a covered expense if you receive a written pre-authorization approval from the Plan and you have:

- A Body Mass Index (BMI) of at least 40; or
- A BMI of at least 35 with other weight-related health conditions such as diabetes or hypertension.

To obtain pre-authorization for a bariatric surgery, please follow the instructions under "Pre-Authorization for Surgery" on page 46.

Cosmetic Surgery and Other Cosmetic Procedures

The Plan does not cover cosmetic surgeries or procedures except under specific limited conditions. Eyelid, nasal, and breast surgeries have a **mandatory** pre-authorization requirement. The Plan will cover cosmetic surgery necessary for the prompt repair of accidental injury, or to repair birth defects of an individual under age 19, or for certain reconstructive surgery following a mastectomy.

If your doctor advises you that surgery is required for functional reasons, it is strongly recommended that you obtain pre-authorization before the surgery is performed. That way you will know whether it is covered. The final amount payable will not be determined until the actual operative report is reviewed. In all cases, your doctor will be asked to furnish certain information to the Plan. If you are required to be examined by an independent medical examiner selected by the Plan, the cost of the examination will be paid by the Plan.

The following is a list of some of the cosmetic surgeries and procedures **NOT** covered by the Plan.

- Abdominoplasty.
- Alopecia senilis or male pattern baldness treatment.
- Blepharoplasty (eyelid) – Elective surgery to the upper eyelids is generally not covered, however, under certain circumstances it may be reviewed by the Plan's medical consultants to determine if it meets the criteria for a covered expense. Please have your physician **follow the Surgery Pre-Authorization procedures on page 46** and provide an ophthalmologist's report which includes an automated visual field test and preoperative frontal and lateral gaze photos.
- Botox injections, except for the treatment of certain medical conditions as approved by the FDA.
- Breast reduction – Elective breast reduction is generally not covered, however under certain circumstances it may be reviewed by the Plan's medical consultants to determine if it meets the criteria for a covered expense. Please have your physician **follow the Surgery Pre-Authorization procedures on page 46** and include the patient's height, weight and the number of grams of tissue to be removed from each breast.
- Chemical peel, except for severe acne when accepted treatment has failed.
- Collagen injections, except when used for the restoration, repair and correction of abnormalities or defects caused by an accident or covered surgery.
- Dermabrasion.
- Dermatology procedures for skin conditions which do not require treatment, such as the removal of freckles, age spots, wrinkles, etc.
- Genioplasty (chin implants).
- Gynecomastia surgery for enlarged male mammary glands, except for documented hormone imbalance or presence of tumor in the breast or an endocrine producing tumor.
- Hair transplants.
- Laser hair removal.
- Laser resurfacing.
- Lipectomy.
- Liposuction.
- Otoplasty (ear).
- Panniculectomy.
- Repair of diastasis recti when done at the same time as abdominoplasty, panniculectomy or lipectomy.
- Revision of scar tissue from previous cosmetic surgery. See page 39 for information on breast implant removal.
- Rhinoplasty (nose).
- Rhytidectomy (face lift).
- Telangiectasia (spider veins) treatment.

Pre-Authorization for Surgery

Transplants, bariatric surgery and eyelid, nasal and certain breast surgeries have a mandatory pre-authorization requirement. Breast surgeries that are required by the Women's Health and Cancer Rights Act of 1998 do not require pre-authorization. See page 40 for information on these surgeries.

To obtain pre-authorization for surgery, the following steps must be taken.

1. You must advise your physician of the Plan's pre-authorization requirement. Your doctor is required to contact the Plan and provide all of the necessary information directly to the Plan Office.
2. Your surgeon must submit a letter stating the surgical procedures to be performed, the medical necessity for the surgery and the anticipated fee for the surgery. The doctor's request for pre-authorization must be sent to the Plan Office and must include the patient's history and physical report, together with diagnostic quality preoperative photographs for eyelid, nasal and breast surgeries. The Plan's medical consultants will review the information and the Plan will advise you in writing if the surgery is covered. The final amount payable will not be determined until the actual operative and pathology reports are reviewed. If your doctor performs different or additional procedures than those that were pre-authorized, and these procedures are not covered under the Plan, these charges will not be considered for payment.

Surgeon

The Plan provides coverage for the surgeon's fee for covered surgeries. A copy of the operative and pathology reports are required for most surgeries. Please have your surgeon include the reports when the surgeon's charges are submitted. Surgical benefits are payable whether surgery takes place in or out of the hospital.

Assistant Surgeon

The Plan will consider 20% of the amount that is considered for the surgeon if a M.D. assistant is necessary for the procedure. The Plan will consider 10% of the amount that is considered for the surgeon if a non-M.D. assistant such as a Registered Nurse First Assistant or Physician Assistant is necessary for the procedure.

Anesthesiologist

The Plan will consider an allowance that takes into account the type of surgery, time in attendance and area of the country in which the surgery is performed. Please see page 43 for special rules on when network benefits are paid for anesthesiology and other RAP services.

Note: *For a* ***colonoscopy or upper gastrointestinal endoscopy****, the Plan will cover moderate sedation when provided by the surgeon or a member of his or her team. A separate anesthesiologist's charges will not be covered unless the Plan's medical consultants determine that it is medically necessary. You should check with your surgeon before the procedure to determine if he or she intends to use a separate anesthesiologist as this may increase your out-of-pocket costs.*

Benefits for More Than One Surgery

If multiple surgical procedures are performed at the same time, whether through the same or separate incisions, the Plan's Allowance is limited as follows:

- 100% of covered expenses will be allowed for the major procedure;
- 50% of covered expenses for the second procedure; and
- 25% of covered expenses for each remaining procedure.

Procedures that are considered global to or incidental to another covered procedure are not allowable.

Use of a Non-Network Surgical Suite, Ambulatory Surgical Center or Birthing Center

A surgical suite or an ambulatory surgical center is a site, either in a doctor's office or an independent facility, where outpatient surgery is performed. If the surgery takes place in a non-network surgical suite or ambulatory surgical center, the Plan will allow up to $1,000 for use of the facility's operating and recovery rooms and all central supplies when medically necessary for the procedure performed. The Plan will also allow up to $1,000 for the use of a non-network birthing center. Coverage for network surgical suites and surgical centers and for network birthing centers is provided under the hospital benefits.

THERAPY BENEFITS (EXCLUDING MENTAL HEALTH AND SUBSTANCE ABUSE)

Contact the Plan Office before undergoing any type of therapy to determine if the therapy and provider are covered and if there are any limitations. All therapy visits must be medically necessary for the diagnosis or treatment of an accidental injury, sickness, pregnancy or other medical condition. For a complete definition of medical necessity, please see pages 108 and 109.

Medically necessary therapy for mental health and substance abuse treatment is covered under Plan I but it is not subject to the non-network allowances or visit limits outlined in this section.

Covered Therapies and Providers

The Plan will consider charges for the following therapies subject to the limitations noted:

- Acupuncture when performed by a licensed Certified Acupuncturist. No benefits will be paid for any diagnostic tests performed or ordered by a Certified Acupuncturist or for equipment or supplies prescribed by a Certified Acupuncturist even if the provider is duly licensed by a state agency and authorized to provide such services within the scope of his or her license.
- Biofeedback only if biofeedback is recommended and/or prescribed by a physician for migraine headaches, hypertension, chronic pain, organic muscle abnormalities, chronic anorectal dysfunction associated with incontinence and constipation, or chronic pelvic muscular dysfunction associated with urinary incontinence.
- Chiropractic care, when performed by a Doctor of Chiropractic (D.C.) and limited to traditional chiropractic services which include the initial physical examination, subsequent chiropractic manipulations and x-rays of the spine when medically necessary. No benefits will be paid for any other diagnostic tests performed or ordered by a chiropractor or for cervical traction units and other supplies or equipment prescribed by a chiropractor even if he or she is duly licensed by a state agency and authorized to provide such services within the scope of his or her license.
- Occupational therapy when performed by an Occupational Therapist, Registered (O.T.R.).
- Osteopathic manipulative therapy when performed by a Doctor of Osteopathy (D.O.).
- Physical therapy and physical medicine when performed by a Registered Physical Therapist (R.P.T.), Medical Doctor (M.D.), or Doctor of Osteopathy (D.O.).
- Speech/voice therapy when performed by a Speech/Language Pathologist provided the services are not part of an educational program.
- Vision therapy when performed by a Doctor of Optometry (O.D.), including developmental vision therapy.

The Plan does not consider the fees of health clubs, masseurs, masseuses, fitness instructors, dance ther-

apists, colon hydrotherapists or similar practitioners, even when recommended or prescribed by a doctor. Nor does it recognize the fees of medical assistant therapists, aides or other providers not specifically licensed by the state to render physical therapy, physical medicine or rehabilitative therapy, even though they are operating under the supervision of a covered provider. The Plan does not consider the fees for rolfing, alexander technique, feldenkrais, bioenergetics, posture realignment, pilates therapy or yoga.

Plan's Allowance and Maximums for Therapy Benefits

The Plan has a maximum allowance it will consider for therapy benefits. The allowance 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.

PREVENTIVE AND WELLNESS BENEFITS

The Plan provides two levels of benefits for routine care: preventive benefits and wellness benefits. Preventive benefits are for services identified by the Affordable Care Act that are to be covered without cost sharing (deductible, copay or coinsurance) when rendered by a network provider. Wellness benefits apply to routine care services not identified as preventive by the Act and may be subject to the deductible, copay and coinsurance.

Preventive Benefits – Network Providers Only

The Affordable Care Act requires the Plan to cover certain preventive services received from network providers with no deductible, copay or coinsurance. The Plan will cover these preventive services whether they are performed separately or in the course of an annual physical. However, to avoid cost sharing

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 outpatient sessions every calendar quarter for any combination of acupuncture and chiropractic treatment. In addition, visits for occupational, osteopathic, physical, speech and vision therapy will count toward the 12-visit quarterly maximum. For example, if you use five physical therapy visits during a calendar quarter and then want to visit a chiropractor, you would have seven visits available for the remainder of that quarter.

The Plan will also consider one initial medical exam per type of therapy for the doctor or therapist who is providing treatment. For physical therapy and physical medicine, the Plan will consider a second medical exam. Additional exams for all types of therapies except chiropractic will only be considered if there is a significant change to the patient's condition that warrants a re-examination. This determination will be based on a review of medical records by the Plan's medical consultants.

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, copay and coinsurance and the cholesterol test is paid at 100%. Conversely, if you are diagnosed with a condition such as 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.

The list of covered preventive services appears below. It may be updated by the federal government from time to time. Many of these services are provided during a routine physical, well-child, well-woman or well-man exam. Routine physicals, well-woman exams and well-man exams are limited to one per calendar year. Well-child exams are also limited to one per calendar year after age 4, although more frequent exams may be covered before that age.

Covered Preventive Care Services as Required by the Affordable Care Act

Newborns	• Gonorrhea preventive medication for eyes of all newborns	• Screening all newborns for: – Hearing loss – Sickle cell disease – Hypothyroidism – Phenylketonuria (PKU)
Childhood/Adolescent Immunizations	• Diphtheria, Tetanus, Pertussis • Haemophilus influenzae type B • Hepatitis A and B • Human Papillomavirus (HPV) • Inactive Poliovirus • Influenza (Flu)	• Measles, Mumps, Rubella • Meningococcal • Pneumococcal (pneumonia) • Rotavirus • Varicella (chickenpox)
Childhood	• Autism screening for children at 18 and 24 months • Behavioral assessment for children of all ages • Blood pressure screening • Developmental screening for children throughout childhood • Dyslipidemia screening for children at higher risk of lipid disorder • Fluoride supplements for children without fluoride in their water – Fluoride supplements require a doctor's prescription and are covered under the Express Scripts prescription drug benefits. • Height, weight and BMI measurements • Hematocrit or Hemoglobin screening	• Iron supplements for children 6 to 12 months at risk for anemia – Iron supplements are covered under the medical benefits and require a doctor's prescription in order to be considered for coverage. • Lead screening for children at risk of exposure • Medical history for all children throughout development • Obesity screening and counseling • Oral health risk assessment for young children • Tuberculin testing for children at higher risk of tuberculosis • Vision screening when performed during the course of a routine pediatric visit
Additional Screenings for Adolescents	• Alcohol and drug use assessment • Cervical dysplasia screening for sexually active young women • Depression screening	• HIV screening for adolescents at higher risk • Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk

Covered Preventive Care Services as Required by the Affordable Care Act (continued)

Adults	• Alcohol misuse screening and counseling • Aspirin use to prevent cardiovascular disease – Aspirin is covered under the medical benefits provided you have a doctor's prescription and you meet the age and risk criteria. • Blood pressure screening • Cholesterol screening for men age 35 or older, women age 45 or older, and younger adults at higher risk • Colorectal cancer screenings including fecal occult blood testing, sigmoidoscopy or colonoscopy for adults age 50 or older	• Depression screening • Diabetes screening for type 2 diabetes for adults with high blood pressure • Diet counseling for adults at higher risk for chronic disease • HIV screening for sexually active women and adults at higher risk • Obesity screening and counseling • Sexually transmitted infection (STI) prevention counseling for adults at higher risk • Syphilis screening for adults at higher risk • Tobacco use screening
Adult Immunizations	• Diphtheria, Tetanus, Pertussis • Hepatitis A and B • Herpes Zoster (Shingles) • Human Papillomavirus (HPV) • Influenza (Flu)	• Measles, Mumps, Rubella • Meningococcal • Pneumococcal (pneumonia) • Varicella (chickenpox)
Additional Screenings for Men	• Abdominal aortic aneurysm one-time screening for men age 65 to 75 who have smoked	
Additional Services and Screenings for Women	• BRCA counseling about genetic testing for women at higher risk • Breast cancer chemoprevention counseling for women at high risk for breast cancer • Breast cancer mammography every 1 to 2 years for women age 40 or older • Cervical cancer pap test for women • Chlamydia infection screening for younger women and women at higher risk • Contraception – FDA-approved contraception methods, sterilization and contraceptive counseling. Contraceptives that require a doctor's prescription are covered under the Express Scripts prescription drug benefits. Contraceptives that are administered in the doctor's office or that are available over-the-counter are covered under the medical benefits. Over-the-counter items require a doctor's prescription in order to be considered for coverage. Condoms are not covered. • Domestic violence screening and counseling • Gonorrhea screening for women at higher risk • Human Papillomavirus (HPV) DNA testing every three years for women age 30 or older • Osteoporosis screening for women age 60 or older, depending on risk factors • Well-woman visits	
Specifically for Pregnant Women	• Anemia screening for iron deficiency • Bacteriuria urinary tract infection screening • Breastfeeding support, supplies and counseling • Folic acid supplements for women who may become pregnant – Folic acid supplements are covered under the medical benefits and require a doctor's prescription in order to be considered for coverage.	• Gestational diabetes screening • Hepatitis B screening during the first prenatal visit • Prenatal visits • Rh incompatibility blood type screening

Wellness Benefits

Not all routine services are included in the Affordable Care Act's preventive services list. The Plan considers these procedures under the wellness benefits.

Plan I

Wellness benefits for Plan I participants and their dependents are not subject to the medical deductible. You may see the doctor of your choice, in or out-of-network, subject to the appropriate copay and coinsurance. The Plan will consider generally accepted standards of medical practice for routine procedures such as the following:

- Bone density tests for women under age 60 and for men – One per calendar year. Bone density tests for women age 60 or older are covered under preventive benefits.
- Chest x-ray.
- Complete blood count.
- EKG.
- Mammograms for women under age 40 – One per calendar year. Mammograms for women age 40 or older are covered under preventive benefits.
- Travel immunizations – If no office visit is billed, no copay applies for network providers. The coinsurance does apply for network and non-network providers.
- Urinalysis.

Plan II

- **Network Providers** – Network wellness benefits for Plan II participants and their dependents are not subject to the medical deductible, although the copay and coinsurance do apply. The Plan will consider the following wellness services:
  - Bone density tests for women under age 60 and for men – One per calendar year. Bone density tests for women age 60 or older are covered under preventive benefits.
  - For individuals age 40 or older, generally accepted lab work and diagnostic tests for a routine physical such as a chest x-ray, complete blood count, EKG or urinalysis.
  - For children under the age of six, generally accepted lab work and diagnostic tests for a well-child care visit, such as a urinalysis and a complete blood count. ***Exception:*** In areas where no network providers are available, the Plan will consider well-child care provided by non-network providers.
  - Mammograms for women under age 40 – One per calendar year. Mammograms for women age 40 or older are covered under preventive benefits.
  - Travel immunizations – If no office visit is billed, no copay applies. The coinsurance does apply.
- **Non-Network Providers** – Non-network wellness benefits for Plan II participants and their dependents are subject to the medical deductible and coinsurance. The Plan will only consider the following non-network wellness services:
  - Bone density tests.
  - Mammogram (limited to one per calendar year unless diagnosis exists).
  - Pap test (limited to one per calendar year unless diagnosis exists).
  - Routine colonoscopy once every 10 years starting at age 50.

OUTPATIENT NURSING BENEFITS

For private duty outpatient nursing services, the Plan's benefit is limited to 672 hours per person per calendar year. For example, this is equivalent to 28 days of nursing at 24 hours per day, or 56 days at 12 hours per day. The number of days of nursing allowable depends on the number of hours of nursing required per day. The allowance does not need to be used all at one time.

For example: If you use 150 hours of nursing at the beginning of the year, the balance of 522 hours is available for the remainder of the calendar year. Private duty nursing in excess of the 672 hours may be considered by case management. Because the nursing benefit contains several restrictions, as described below, you should obtain approval before services are rendered. The amount allowed per visit will be determined by the Plan's Reasonable Charge guidelines.

The Plan does not cover inpatient private duty nursing services under any circumstances.

Obtaining Approval for Private Duty Outpatient Nursing Care

Private duty nursing at home may be covered if you obtain advance approval as follows:

- The nursing services must be prescribed by your doctor as medically necessary for treatment of an illness or injury that is covered by the Plan.
- The level of nursing care must require a registered nurse (R.N.), licensed vocational nurse (L.V.N.), licensed practical nurse (L.P.N.) or equivalent state license who is not a relative or resident of your home.
- The nursing must not be for custodial or long-term care. (See Glossary on page 107.)
- The doctor must submit a written diagnosis and treatment report within 14 days of the start of nursing services.
- Nursing notes must be submitted for review as claims are filed.

Medical consultants for the Plan will review the doctor's report and nursing notes. If the nursing care is approved, the Plan will specify the number of days that it will cover, and the amount per visit that it will allow.

If your doctor prescribes private duty nursing care, please contact the Plan Office as soon as possible.

Services by Christian Science practitioners are not recognized as nursing services.

CASE MANAGEMENT

One of the Health Plan's most important tools in providing benefits for individuals with catastrophic illness or injury is the case management program. Case management offers a personal approach by which a coordinator works with the patient, the family and the attending physician to develop an appropriate treatment plan and to identify and suggest alternatives to traditional inpatient hospital care.

Some services that are not normally covered under the medical benefits may be considered under the case management program. These include, but are not limited to, home nursing services, home physical and/or occupational therapy and durable medical equipment. Long term custodial care is not covered under the hospital benefits, the medical benefits or case management. All services and equipment must be pre-authorized by the case management team.

The case management team at the Plan Office utilizes case management nurses to assist in approving and arranging necessary services and equipment, locat-

ing appropriate providers and negotiating rates with non-network providers where there are no network providers available.

Case management can help with a wide variety of catastrophic illnesses and injuries including burns, spinal cord injuries, multiple trauma injuries, cancer, cardiovascular disease, stroke, joint replacement post-surgical care, acquired immune deficiency syndrome, cerebral palsy and multiple sclerosis. The case management team can also assist in arranging hospice care. If you feel the case management program is appropriate for your care you should contact the Plan Office as soon as possible.

The case management program is totally voluntary. Its purpose is to benefit the patient. Accordingly, if the patient, the physician and the family do not agree that the alternative plan is to the patient's benefit, the patient does not have to participate. The program is provided as part of the benefit plan so there is no additional cost to participants or their eligible dependents.

NON-COVERED MEDICAL EXPENSES

(Includes all Practitioners)

- Acupuncture – Diagnostic services ordered or performed by a Certified Acupuncturist or supplies and equipment prescribed by a Certified Acupuncturist even if the provider is duly licensed by a state agency and authorized to provide such services within the scope of his or her license.
- Applied behavioral analysis.
- Charitable hospitals – Treatment received in charitable hospitals.
- Chiropractic care – Diagnostic services ordered or performed by a chiropractor, (except spinal x-rays) or supplies and equipment prescribed by a chiropractor even if he or she is duly licensed by a state agency and authorized to provide such services within the scope of his or her license.
- Condoms.
- Cord blood harvesting and storage charges.
- Cosmetic surgery and procedures, except where otherwise noted (see page 40 under "Medical Benefits" and page 44 under "Cosmetic Surgery and Other Cosmetic Procedures").
- Custodial care – Treatment received in custodial, convalescent, educational, rehabilitative care or rest facilities.
- Custodial nursing services.
- Cytotoxic testing.
- Dental services or appliances.
- Durable medical equipment – A second or duplicate piece of approved durable medical equipment for travel or convenience purposes.
- Electrolysis.
- Environmental equipment such as air filters, humidifiers and nonallergic bedding.
- Equipment and procedures not approved by the Food and Drug Administration.
- Exercise equipment, whirlpools, sunlamps, heating pads and other similar general use items, whether or not prescribed by your doctor.
- Food allergy antigens.
- Food supplements, herbs, minerals, vitamins and other nutritional supplements.
- Foot care – Routine foot care (removal of corns and calluses or cutting of nails) is not covered except when prescribed by a doctor who is treating you for a metabolic, neurologic or peripheral vascular disease such as diabetes or arteriosclerosis.
- Gestational surrogate – Charges for services rendered to a gestational surrogate or to a fetus implanted into a gestational surrogate.

- Glasses, contact lenses or eye refractions (except following covered eye surgery as described on page 40 or as provided through VSP as described on pages 67 and 68).
- Growth hormones (except when pre-approved by the Plan under the prescription drug benefit as outlined on page 59).
- Health clubs, rolfing, alexander technique, feldenkrais, bioenergetics, posture realignment, pilates therapy or yoga.
- Homeopathic remedies.
- Hypnosis or hypnotherapy.
- Infertility treatment – Charges in connection with achieving and maintaining pregnancy.
- Inpatient private duty nursing.
- Intraoperative neurophysiologic monitoring, except in limited cases where the Plan's consultant determines that it is medically necessary.
- Learning disabilities – Charges in connection with learning disabilities and academic accommodations.
- Masseurs, masseuses, Massage Therapists (M.T.), Oriental Medical Doctors (O.M.D. or D.O.M., one who practices oriental medicine), fitness instructors, dance therapists or colon hydrotherapists.
- Medical assistant therapists, aides or other providers not specifically licensed by the state to render physical or rehabilitative therapy, even though they are operating under the supervision of a covered provider.
- Medical necessity – Services or supplies not recognized as generally accepted medical practice or necessary for diagnosis or treatment.
- Modifications to a home or automobile to accommodate illness or injury.
- Multifocal intraocular lens (IOL) implanted during cataract surgery that corrects presbyopia and astigmatism. The Health Plan covers cataract surgery and a standard (monofocal) IOL.
- Naturopathic services, even if the provider is duly licensed in any state and authorized to provide medical services, including diagnostic tests performed or ordered by a naturopath. Naturopathic services include conventional diagnosis, therapeutic nutrition, botanical medicine, homeopathy, naturopathic childbirth attendance, classical Chinese medicine, hydrotherapy, manipulation, pharmacology and minor surgery.
- Oral and topical medications dispensed in a physician's office.
- Over-the-counter pregnancy tests.
- Personal comfort items while hospitalized, such as TV or telephone.
- Pregnancy for dependent children including elective termination of pregnancy (prenatal care from a network provider and complications of pregnancy are covered).
- Reversal of vasectomy or tubal ligation.
- Sleep Number beds.
- Smoking cessation programs.
- Surgical correction of a bite defect.
- Surgical procedures to correct a refractive error such as LASIK, photorefractive keratectomy (PRK), radial keratotomy or radial thermocoagulation (RTK).
- Weight control or weight loss programs, regardless of any underlying medical condition for which they may be prescribed.

See also "General Exclusions" on page 72.

Prescription Drug Benefits

The Health Plan's nationwide prescription drug benefits are administered by Express Scripts. All participants eligible for the program will be issued an Express Scripts ID card. For participants who are not entitled to the Express Scripts program, prescription drug coverage is provided at the non-network level under the medical benefits.

ELIGIBILITY

You and your enrolled dependents are covered under the Express Scripts prescription drug program if this Plan is your primary plan or if your primary plan does not include prescription drug coverage. If Medicare is your primary plan and this Plan is your secondary plan, you and your eligible dependents are covered under the Express Scripts prescription drug program, provided you and your spouse or same-sex domestic partner do not enroll in a Medicare Part D Prescription Drug Program. If you enroll in Medicare Part D, you will not be eligible for any prescription drug coverage under the Plan.

If this Plan is not your primary plan or if you owe the Plan money due to audit findings by the Contribution Compliance or Participant Eligibility Departments, your prescription drug benefits will be covered at the non-network level under the medical benefits.

Some key provisions of the prescription drug benefits are outlined below.

	Retail Pharmacy Program	Home Delivery Pharmacy (includes Specialty)
Plan I		
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
Copay	You will pay the greater of the two copays shown: • 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.	You will pay the greater of the two copays shown: • Generic: $20 or 10%; maximum $50 per prescription • Preferred Brand: $50 or 25%; maximum $125 per prescription • Non-Preferred Brand: $100 or 40%; maximum $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 subject to the maximum copays listed above.
Preventive Services Prescriptions	Generic prescription medications that appear on the list of Affordable Care Act preventive services are not subject to the deductible or copay. See pages 49 and 50.	
Plan II	Same as Plan I except that prescriptions used for mental health and substance abuse treatment are not covered. See page 60.	

DEDUCTIBLE

The calendar year deductible for the Express Scripts prescription drug benefit is outlined on the prior page. The deductible applies to both the retail pharmacy program and the home delivery program. The family deductible is satisfied when at least two or more family members have paid $300 in covered expenses, except that the Plan will not apply more than the individual deductible to any one family member. The pharmacist will collect deductible amounts.

Any price differences you are requested to pay between brand and generic drugs do not apply toward the deductible amount.

COPAY

Your pharmacy copays are outlined on the prior page and vary depending on whether the prescription is a generic, preferred brand or non-preferred brand drug. If your prescription is for a preferred or non-preferred brand name drug that has a generic alternative, you will be responsible for the regular copay plus the difference in price between the generic and brand name prescription. You will be responsible for the brand/generic difference even if your doctor indicates "DAW" (dispense as written) or "no substitution" on the prescription. The price differential does not apply toward the deductible amount.

PREFERRED PRESCRIPTIONS FORMULARY

The Plan uses a formulary or a list of commonly prescribed brand name and generic medications. These medications are selected because they can safely and effectively treat most medical conditions while helping to contain costs. The list of preferred medications is available online at www.express-scripts.com.

YOUR RETAIL PHARMACY PROGRAM

You should use a participating retail pharmacy for short-term prescriptions such as antibiotics to treat infections. Show your prescription drug ID card to the pharmacist and pay your retail copay each time you order a new prescription. Because your card does not contain your ID number, please remember to share it as appropriate with your pharmacist when you obtain prescriptions.

To find a participating retail pharmacy near you:

- Ask at your retail pharmacy whether it participates in the Express Scripts network.
- Visit www.express-scripts.com, log in to the secure website and click "Locate a pharmacy". If you do not have an online Express Scripts account follow the prompts to create one.
- Call Express Scripts at (800) 903-4728.

If you use a non-participating pharmacy, you must pay the entire cost of the prescription and then submit a claim form to Express Scripts as described on page 85. You will be reimbursed the amount that would have been charged by a participating retail pharmacy less the required copay. The discounted cost will be used to satisfy your prescription drug deductible.

If you are eligible for an Express Scripts drug card, your prescriptions will not be considered under the medical benefits of the Plan except for certain over-the-counter prescriptions under the list of Affordable Care Act preventive services. Please refer to page 60.

HOME DELIVERY PHARMACY

Ordering Prescriptions

The first time you are prescribed a medication, ask your doctor for two prescriptions: the first for up to a 30-day supply to be filled at a retail pharmacy; the second for the balance, up to a 90-day supply, to be filled through the home delivery pharmacy.

- By Fax from Your Doctor – Give your ID number to your doctor and have your doctor call (888) EASYRX1 ((888) 327-9791) to obtain fax instructions.

- On the Internet – Visit www.express-scripts.com and follow the instructions to register for the home delivery pharmacy. Once you have registered, click "Order center" and follow the instructions. Express Scripts will contact your doctor to transfer your current prescriptions to the home delivery pharmacy.

- By Mail – Request an order form and reply envelope from the Plan Office. Mail your prescription and required copay along with the order form in the envelope.

  Express Scripts
  P.O. Box 30493
  Tampa, FL 33630-3493

Delivery of Your Medication

Prescription orders are processed promptly and are usually delivered to you within eight days. If you are currently taking a medication, be sure to have at least a 14-day supply on hand when ordering. If you do not have enough, ask your doctor to give you a second prescription for a 14-day supply and fill it at a participating retail pharmacy while your home delivery prescription is being processed.

Paying for Your Medication

You may pay by check, money order, VISA, MasterCard, Discover/NOVUS, American Express or Diners Club.

Please note: *The pharmacist's judgment and dispensing restrictions, such as quantities allowable, govern certain controlled substances and other prescribed drugs. Federal law prohibits the return of dispensed controlled substances.*

OTHER PLAN FEATURES

Specialty Pharmacy

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. After the initial prescription, these medications must be obtained through Accredo, Express Scripts' dedicated specialty pharmacy, rather than at your local retail pharmacy or through your doctor's office. If you choose to use a pharmacy other than Accredo after the first fill, you will have to pay the entire cost of the prescription.

Accredo includes access to nurses who are trained in specialty medications, pharmacist availability 24/7 and coordination of home care and other health care services. They can also arrange for prescriptions to be delivered to a doctor's office for administration. For more information please call Member Services at (800) 903-4728.

Personalized Medicine Program

Personalized medicine takes advantage of advances in science to help your doctor make more precise and effective prescribing decisions through genetic tests.

These tests, called pharmacogenomics tests, have several advantages, including better outcomes, more precise therapy, dosing decisions and less waste.

If you are using a medication covered by the Personalized Medicine Program, such as warfarin for a heart condition, a pharmacist will contact your doctor to see if it is appropriate for you to participate in the program. If your doctor agrees, you will be contacted by a pharmacist to let you know that the testing is available. If you agree to participate, you will receive a cheek swab test that you can administer on your own. The results will be sent to your doctor and to a specially trained Express Scripts pharmacist who can help your doctor interpret the results. Of course, your doctor decides which drug and dose is right for you.

The Personalized Medicine Program is available to you at no additional cost and requires no action on your part. It is completely voluntary and any decisions to change treatments or dosages remain up to you and your physician. All information gathered during testing is treated confidentially and no tests are conducted other than the tests which you specifically authorize. All aspects of the program comply with privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA) and the Genetic Information Non-Discrimination Act of 2008 (GINA) as well as applicable state laws.

Prior Authorization

Most of your prescriptions can be filled without prior authorization at a retail pharmacy. However, some drugs are only covered for certain uses or in certain quantities. Lamisil and Wellbutrin SR are examples of medications that require prior authorization by Express Scripts before they can be covered. If you present a prescription requiring prior authorization, your doctor may need to provide additional information *before* the prescription is covered.

When you take a prescription that needs prior authorization to the retail pharmacy, the system will automatically review your file (age, sex and prior drug therapy history) to determine if the medication can be dispensed on the criteria available. The pharmacy will advise you if additional information is required. Either you or the pharmacy can ask your doctor to call Express Scripts at (800) 753-2851 to initiate the prior authorization process. This call will start a review that typically takes two to five business days unless additional information is required, in which case, the review may take longer. Both you and your doctor will be notified in writing of the decision. If the prescription is approved, the letter will tell you the length of your coverage approval. If the prescription is denied, the letter will include the reason for coverage denial and instructions on how to submit an appeal if you choose.

If you want the prescription immediately without waiting for the prior authorization, you will have to pay the full retail price at the pharmacy. If the prescription is approved, your claim should be sent to Express Scripts for reimbursement at 100% minus the prescription drug copay and deductible.

Compound Medications

A compound medication is custom-made by a pharmacy based on a doctor's prescription, often including more than one ingredient. At a participating retail pharmacy, you will pay your retail copay for compound medications if the pharmacist submits a claim electronically. In other cases, you must submit a claim for reimbursement to Express Scripts, which must be accompanied by an itemized list of the ingredients with their full 11-digit National Drug Code (NDC) number(s) for the claim to be processed.

Please note: *Coverage limits apply to compound medications. The Health Plan will only reimburse the cost of the active main ingredient, minus the copay. In addition, if one ingredient is a non-covered item, the compound claim will be denied.*

Male Erectile Dysfunction Drugs

Prescriptions for male erectile dysfunction drugs, including but not limited to, Cialis, Levitra and Viagra, are covered only when there is an underlying medical condition, such as diabetes or prior prostate surgery, that warrants treatment with these medications. Prescriptions are limited to six pills of any combination of these drugs in a 30-day period. These medications require pre-authorization from the Plan and you may contact the Plan Office for a list of the information needed to complete this process.

Alternatively, you may fill your first prescription at a participating pharmacy with your Express Scripts prescription drug card and pay 100% of the discounted price for the prescription. Send your original pharmacy receipt to the Plan Office, along with 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, the Plan will forward the claim to Express Scripts for reimbursement at 100% minus the prescription drug copay, subject to the prescription drug deductible.

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 the amount that would have been paid if you had used a participating pharmacy. You are responsible for the remainder of the bill.

After medical necessity is determined, subsequent prescriptions may be filled in the usual way by paying the prescription drug copay at participating pharmacies. For non-participating pharmacies, claims should be submitted to Express Scripts as described on page 85.

Infertility Drugs Prescribed for Non-Infertility Conditions

Certain medications commonly used to treat infertility, may also be prescribed for conditions that are not related to infertility. In these cases, you should follow the procedures for pre-authorization and filing a claim as outlined under "Male Erectile Dysfunction Drugs".

Sleep Aids

Prescriptions for sleep-aid therapy, such as Ambien or Lunesta, are limited to quantities sufficient to treat 21 days per month. If you require medication in excess of this amount you must obtain a pre-authorization from the Plan. Contact the Plan Office for a list of the information needed to complete the pre-authorization.

Growth Hormones

Growth hormones are considered specialty medications and are covered only when purchased through Accredo. They also require pre-authorization from the Plan before filling your first prescription. Contact the Plan Office for a list of the information needed to complete the pre-authorization. Growth hormones are not covered for familial short stature, constitutional growth delay or for non-FDA-approved uses such as anti-aging programs or athletic enhancement.

Generic Drugs

Ask your doctor to prescribe generic drugs whenever possible. This will help us provide the highest quality medications and program benefits while keeping costs down. We will remind your doctor when a generic equivalent is available for brand name drugs.

SPECIAL NOTE FOR PARTICIPANTS COVERED UNDER PLAN II

Plan II excludes prescription drug coverage for mental health and substance abuse treatment. Based on guidelines established by the National Institute of Mental Health, there are five psychotherapeutic medication categories for which the Plan excludes coverage:

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

Although Plan II does not pay for these drugs, you are still eligible to receive the Plan's discounted rates from participating retail pharmacies. Simply fill your prescription using your Express Scripts prescription drug card.

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 pimozide 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 pre-authorization from the Health Plan.

If you need an excluded medication for a non-mental health or substance abuse reason, you should follow the procedures for pre-authorization and filing a claim as outlined on page 59 under "Male Erectile Dysfunction Drugs".

PRESCRIPTION DRUG COVERAGE THROUGH YOUR MEDICAL BENEFITS

Prescription drug coverage is provided through the medical benefits under the following circumstances:

- This Plan is not your primary plan and your primary plan includes prescription drug coverage.
- You have a prescription for an over-the-counter medication that appears on the list of Affordable Care Act preventive services:
  - Aspirin to prevent cardiovascular disease (men: age 45 – 79; women: age 55 – 79);
  - FDA-approved contraceptives for women;
  - Folic acid supplements for women who may become pregnant;
  - Iron supplements for children 6 to 12 months at risk for anemia.

Prescriptions for over-the-counter medications on the list of preventive services are not subject to the medical deductible or coinsurance and will be paid at 100% of the Plan's Allowance. Other prescriptions and supplies that are processed under the medical benefits will be paid at the non-network level of benefits, subject to the non-network medical deductible and coinsurance.

To receive reimbursement, submit a copy of the drug bill to the Plan Office. If you have primary prescription drug coverage under another plan, you must also submit that plan's Explanation of Benefits (EOB) form. The drug bill must include the prescription number, name of the patient, name of the doctor, quantity filled and strength of medication. Credit card vouchers, cash receipts or canceled checks will not be accepted as bills for processing drug claims. The Plan reserves the right to request original drug receipts should it become necessary to do so.

OFFSET OF FUTURE BENEFIT REIMBURSEMENTS DUE TO AUDITS

If you owe the Plan money due to any audit findings by the Contribution Compliance or Participant Eligibility Departments, you or your dependents are not eligible to use the Express Scripts retail or home delivery programs until the balance due is paid in full. You will need to submit prescription charges as outlined previously under "Prescription Drug Coverage through Your Medical Benefits". As soon as the Plan has recovered the entire amount that you owe, irrespective of the source of recovery, you will be notified and may resume using the Express Scripts retail and home delivery programs.

QUESTIONS

If you need help or have any questions about your prescription drug program, you can call the Plan Office or contact Express Scripts:

www.express-scripts.com or (800) 903-4728

EXCLUSIONS AND LIMITATIONS

The prescription drug program is designed to cover those prescriptions and medicines that, under state or federal law, require a doctor's prescription. However, the Plan reserves the right to restrict prescription drug coverage to one retail network pharmacy or to deny coverage for individual drugs. If a restriction is imposed, the home delivery pharmacy service option is not available. Listed below are certain items which are not covered:

- Anti-obesity preparations.
- Any prescription refilled in excess of the number of refills specified by the physician or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.
- Condoms.
- Contraceptive jellies, creams, foams, implants or injections. (These are covered under the medical benefits if FDA-approved and prescribed by your doctor.)
- Dehydroepiandrosterone (DHEA).
- Drugs whose sole purpose is to promote or stimulate hair growth (i.e., Rogaine, Propecia) or drugs for cosmetic purposes (i.e., Renova).
- Drugs not approved by the Food and Drug Administration for the treatment rendered.
- Fluoride products (except for children whose water source does not contain fluoride).
- Glucowatch products. (These are covered under the medical benefits.)
- Homeopathic medications, both over-the-counter and Federal Legend.
- Infertility drugs, except when approved by the Health Plan for the treatment of non-infertility conditions.
- Insulin pumps. (These are covered under the medical benefits.)
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Mifeprex.

- Non-Federal Legend drugs.
- Non-sedating antihistamines (NSAs) such as Allegra, Clarinex, Xyzal and Zyrtec, except for coverage for generic Zyrtec 5 mg chewable tablets and generic Zyrtec syrup to patients age 6 or younger.
- Prescription drugs used for mental health and substance abuse treatment for Plan II participants as outlined on page 60.
- Relenza for children age 6 or younger.
- Sleep aids such as Ambien and Lunesta in excess of a quantity sufficient to treat 21 days per month. Medication in excess of this amount requires prior authorization for possible approval of extended benefits.
- Smoking deterrents.
- Therapeutic devices or appliances.
- Yohimbine.
- Federal Legend vitamins.

For more information on the Health Plan, please visit:

www.sagph.org

Screen Actors Guild – Producers Health Plan

Dental Benefits

The dental benefits are designed to help pay a portion of your dental expenses. Delta Dental PPO is a preferred provider organization program offered by Delta Dental, the nation's largest and most experienced dental benefits carrier.

ELIGIBILITY

Plan I

Plan I Earned, Self-Pay and Senior Performer participants and their enrolled dependents are eligible for the dental benefits.

Plan II

Plan II Earned and Self-Pay participants who have a minimum of three years of Earned Eligibility and their enrolled dependents are eligible for the dental benefits.

SELECTING A DENTIST

There are two types of dentists in the Delta network:

- Delta Dental PPO dentists
- Delta Premier dentists

When you use a Delta Dental PPO dentist, your diagnostic and preventive services are covered at 100% and are not subject to the deductible. Payment is based on a pre-approved fee and the dentist will file your claims for you.

When you use a Delta Premier dentist, payment is based on a preapproved fee. These dentists will file your claim forms for you, but diagnostic and preventive services are subject to the deductible and paid at less than 100%.

To find a Delta Dental PPO or Delta Premier dentist:

- Visit Delta's website: www.deltadentalins.com/sagph.
- Call your dentist and ask if he or she is a Delta Dental PPO dentist or Delta Premier dentist.

USING A NON-NETWORK DENTIST

When you use a dentist outside of the available networks, or you reside outside the United States, payment is based on the Plan's Allowance or the fee the dentist actually charges, if less. If your dentist's fees exceed the Plan's Allowance, you are responsible for the difference between the Plan's payment and the dentist's actual charges. In addition, you will be responsible for your regular coinsurance and any deductible that may apply. Finally, your non-network dentist may collect payment up front and may not be willing to file a claim form for you.

DEDUCTIBLE

Dental benefits are payable once you satisfy a calendar year deductible. This is a separate deductible from the hospital, medical and prescription drug deductibles. The amount of the dental deductible differs for Plan I and Plan II as noted below:

- **Plan I** - $75 per person/$200 per family*
- **Plan II** - $100 per person/no family maximum

* If two or more members of your family are injured in the same accident, only one deductible will be applied against all the covered dental charges incurred during any one year as a result of such accident.

Note: *There is no deductible for diagnostic and preventive services when you use a Delta Dental PPO network dentist.*

MAXIMUM BENEFIT

The maximum amount the Plan will pay for all covered dental charges in a calendar year is:

- **Plan I** - $2,500 per person
- **Plan II** - $1,000 per person

There is no calendar year maximum for individuals under age 19.

PRE-TREATMENT ESTIMATES

The dental program contains this optional feature which allows you to determine in advance how much the Plan will pay on extensive dental procedures before they are performed. The Plan strongly suggests that you ask your dentist to request a free pre-treatment estimate from Delta Dental on all basic and major services (see chart to the right). This will ensure that you know up front what the Plan will pay and the amount for which you will be responsible. Please refer to the section on filing a claim on page 86.

COVERED DENTAL CHARGES AND LIMITATIONS

Covered dental charges are the charges of a dentist or physician for the services and supplies required for dental care and treatment of any disease, defect or accidental injury, or for preventive dental care. Covered dental charges do not include any charge in excess of the charge customarily made for similar services and supplies by dentists or physicians in the locality concerned. Where alternative services or supplies are customarily available for such treatment, covered dental charges will only include the least expensive service or supply resulting in professionally adequate treatment.

Charges must be incurred and the services and supplies furnished while you or your dependent are covered. A charge is incurred as of the date the service is rendered or the supply is furnished, with the following three exceptions:

1. With respect to fixed bridgework, crowns, inlays, onlays, or gold restorations, the charge is incurred on the first date of preparation of the tooth or teeth involved.

2. With respect to full or partial dentures, the charge is incurred on the date the impression is taken.

3. With respect to endodontics, the charge is incurred on the date the tooth is opened for root canal therapy.

Covered charges for both a temporary and permanent prosthesis will be limited to the charge for a permanent one.

Covered charges for a crown or gold filling will be limited to the charge for an amalgam filling unless the tooth cannot be restored with amalgam.

Covered charges for porcelain or plastic veneer crowns (tooth colored crowns) may be limited to the charge for a metal crown on certain teeth in the back of the mouth. You may want to obtain a pre-treatment estimate so you will know how much the Plan will pay.

Charges for amalgam fillings, gold fillings, inlays and crowns are payable when they are necessary to restore the structure of the tooth broken down by decay or non-accidental injury.

Implants (an artificial tooth root that a periodontist places into your jaw to hold a replacement tooth or bridge) are covered under the major services portion of the Plan's dental benefits. Additional surgical procedures, such as bone grafting or tissue regeneration, or special imaging techniques such as CT scans, that are performed in connection with the placement of the implant are not covered under the dental or medical benefits. You may want to obtain a pre-treatment estimate so you will know how much the Plan will pay.

DENTAL BENEFITS

Calendar Year Deductible:
Plan I – $75 per person / $200 per family;
Plan II – $100 per person / no family maximum.

Calendar Year Maximum:
Plan I – $2,500 per person;
Plan II – $1,000 per person.

There is no maximum for individuals under age 19.

If your eligibility changes from Plan I to Plan II during a calendar year, any charges that were applied toward your Plan I deductible or annual maximum will apply toward the Plan II deductible and annual maximum. If your eligibility changes from Plan II to Plan I during a calendar year, the reverse is also true.

Covered Services	Delta Dental PPO Network Dentists	Delta Premier or Non-Network Dentists
Diagnostic and Preventive Services • Oral examination – once every six months • Cleanings – two per calendar year* • X-rays: Bitewing – once every six months Full mouth – once every three years Panoramic – once every three years • Fluoride treatment – individuals under age 19, once per calendar year • Biopsy/tissue examination • Emergency palliative treatment • Consultation by a covered specialist • Space maintainers • Study models • Sealants – individuals under age 14, once every three years	**Plan I** No deductible; 100% of dentist's fees **Plan II** No deductible; 100% of dentist's fees	**Plan I** 75% of Plan's Allowance after deductible **Plan II** 60% of Plan's Allowance after deductible
Basic Services • Restorative – amalgam, silicate or composite fillings • Oral surgery – extractions including surgical removal of teeth • Endodontics – root canal therapy • Periodontics – treatment of gums and bones supporting teeth • General anesthetics or IV sedation for oral surgery and certain endodontic and periodontal procedures • Injectable antibiotics • Addition of teeth to existing denture • Repair and rebasing of existing dentures	**Plan I** 75% of dentist's fees after deductible **Plan II** 60% of dentist's fees after deductible	**Plan I** 75% of Plan's Allowance after deductible **Plan II** 60% of Plan's Allowance after deductible
Major Services • Restorative – gold fillings, inlays and crowns • Crown replacement – if crown is over three years old • Gold filling replacement – if filling is over five years old • Fixed bridges/partial or full dentures/implants – if required to replace lost natural teeth or an existing prosthesis or implant which is over five years old and cannot be made serviceable	**Plan I** 50% of dentist's fees after deductible **Plan II** 50% of dentist's fees after deductible	**Plan I** 50% of Plan's Allowance after deductible **Plan II** 50% of Plan's Allowance after deductible

* Individuals receiving post-periodontal surgery maintenance from a network or non-network dentist are entitled to cleanings and scalings up to four times per year.

An additional oral exam and teeth cleaning/scaling is available for women while they are pregnant.

QUESTIONS

If you need help or have any questions, you can call the Plan Office or contact Delta Dental:

www.deltadentalins.com/sagph or (800) 846-7418

NON-COVERED DENTAL EXPENSES

- Accidental injury to natural sound teeth. (This benefit is provided under the medical benefits. See page 40.)
- Adjustments to prosthesis within six months from installation.
- Anesthesia, other than anesthesia or IV sedation administered by a licensed dentist in connection with covered oral surgery and select endodontic and periodontal procedures.
- Extra-oral grafts (grafting tissues from outside the mouth to oral tissue).
- Hospital costs and any additional fee charged by the dentist for hospital treatment.
- Occlusal guards and complete occlusal adjustment.
- Orthodontic treatment other than for related extractions or space maintainers.
- Procedures, restorations and appliances to increase vertical dimension or to restore occlusion.
- Replacement of existing restorations for any purposes other than active tooth decay.
- Services with respect to congenital or developmental malformations, or services and supplies cosmetic in nature, including but not limited to cleft palate, upper or lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (discoloration of the teeth) and anodontia (congenitally missing teeth).
- Services and supplies not recognized as generally accepted dental practice.
- Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth, including but not limited to equilibration and periodontal splinting.
- Specialized techniques involving precision attachments, personalization or characterization.
- Surgery or special imaging performed in connection with the placement of a dental implant.
- Training in or supplies used for dietary counseling, oral hygiene or plaque control.
- Temporomandibular joint syndrome (TMJ) treatment. (In certain circumstances, this benefit may be provided under the medical benefits. See page 42.)
- Treatment by someone other than a dentist or physician, except when performed by a duly qualified technician under the direction of a dentist or physician.

Please also refer to "General Exclusions" on page 72.

LOSS OF COVERAGE

When you lose your eligibility for dental benefits, coverage will still be provided for services or supplies furnished within 90 days after coverage terminates if the charges were incurred while the individual was covered. See page 64 for an explanation of how to determine when a dental charge is incurred.

Vision Benefits

The Health Plan provides vision benefits through Vision Service Plan (VSP). This benefit is intended for routine vision care. The diagnosis and treatment of eye disease or injury is covered under the medical benefits.

ELIGIBILITY

Plan I Earned, Self-Pay and Senior Performer participants and their enrolled dependents are eligible for the Exam Plus Plan. Vision benefits are not provided to Plan II Earned and Self-Pay participants and their enrolled dependents.

HOW TO LOCATE A VSP PROVIDER

- You may call (800) 877-7195 and request that a list of VSP participating doctors be mailed to you. Or, you may enter a specific doctor's telephone number to verify the office's participation in the VSP network.
- You may visit the VSP website at www.vsp.com to locate a participating provider near you.
- You may contact VSP through the mail at: Vision Service Plan, P.O. Box 997100, Sacramento, CA 95899-7100.

HOW TO USE THE BENEFIT

1. Locate a VSP Exam Plus doctor.
2. Call the doctor to make an appointment.
3. Identify yourself as a VSP Exam Plus participant through the SAG-Producers Health Plan.
4. Provide the doctor with your ID number. If the patient is a dependent child, you will also need to state the patient's date of birth.

After you make an appointment, your doctor and VSP will handle the rest.

The Exam Plus Plan includes an eye exam every calendar year for Plan I participants and their eligible dependents. Vision exams include an analysis of the patient's visual functions, including prescription of corrective lenses when indicated. The exam includes additional services and follow-up eye care for participants and dependents with type 1 diabetes. The Plan also offers discounts on complete pairs of glasses as well as professional services associated with prescription contact lenses. These discounts are off the doctor's usual and customary charge.

Vision Benefits

Exam Plus Plan	Eye Exams	Glasses	Professional Services for Contact Lenses
Network	$10 copay; one exam per calendar year	20% discount	15% discount
Non-Network	80% of doctor's customary charge up to a maximum payment of $50*; one exam per calendar year	No benefit	No benefit

* If the eye exam is received through a non-VSP provider, pay the full amount of the bill and submit a claim for reimbursement as described on page 86.

Discounts on frames, lenses and professional fees for contact lenses are only guaranteed when you purchase them within 12 months of the last covered eye exam from any VSP network provider. For glasses, you must purchase both lenses and frames. Contact lenses are available at the VSP doctor's normal retail price.

LASER VISION CORRECTION SURGERY

The Exam Plus Plan provides a discount on three commonly performed laser vision correction procedures – laser-assisted in-situ keratomileusis (LASIK), Custom LASIK and photorefractive keratectomy (PRK). Although the Health Plan does not pay the cost of the surgery, you have access to the procedures at reduced fees through VSP's network of doctors and laser centers. You will pay the provider's discounted rate which will not exceed the following:

- $1,500 per eye for PRK;
- $1,800 per eye for LASIK; or
- $2,300 per eye for Custom LASIK.

The fee includes both pre and post-operative care through your VSP doctor.

To schedule a complimentary screening and consultation on the benefits and risks of laser vision correction, call your VSP doctor. Participating doctors can also be located on VSP's website at www.vsp.com or by calling toll-free, (800) 877-7195.

For more information on the Health Plan, please visit:

www.sagph.org

Screen Actors Guild – Producers Health Plan

Life Insurance Benefits

ELIGIBILITY

To qualify for the life insurance benefit, you must be covered under Plan I Earned Eligibility or Senior Performer eligibility at the time of your death. The life insurance benefit is not available if you are covered under Plan II Earned Eligibility or the Self-Pay Program, nor is it available to dependents.

Life insurance coverage starts when your Earned Plan I or Senior Performers eligibility begins provided you pay the Health Plan premium. However, if a participant with Earned Eligibility dies during the period between the Base Earnings Period and the Benefit Period, the life insurance benefit will be payable (but not the accidental death and dismemberment benefit).

LIFE INSURANCE BENEFIT

- **Plan I Earned Eligibility** **$10,000**
- **Senior Performer** **$ 5,000**

Your life insurance benefit is payable to the beneficiary(ies) you named on the most recent Beneficiary Designation Form on file with the Plan Office.

Please call the Plan Office to request a new Performer Information Form and Beneficiary Designation Form for any changes that may affect your personal profile, or to make a change in beneficiary designation.

FUNERAL EXPENSES

Up to $500 can be reimbursed to an individual who has incurred the cost for funeral expenses on behalf of an eligible participant. However, a claim needs to be submitted prior to the payment of the life insurance. The amount of life insurance benefit payable will be reduced by the amount paid for funeral expenses. In order to receive reimbursement of funeral expenses, you must submit a copy of the itemized charges, a certified copy of the death certificate and proof of payment.

ACCELERATED LIFE INSURANCE BENEFIT

In order to provide some financial assistance to terminally ill participants, the Plan provides an accelerated life insurance provision which allows terminally ill participants to receive 80% of their life insurance benefit while still living. 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.

LOSS OF ELIGIBILITY

When you lose Earned Eligibility under Plan I, your life insurance (but not the accidental death and dismemberment benefit) will remain in effect for 31 days following the date you lose Earned Eligibility. You can convert your life insurance (but not the accidental death and dismemberment benefit) to an individual policy during that 31-day period without undergoing a medical examination. You may convert $5,000 if you are losing Plan I Earned Eligibility and gaining Senior Performers eligibility. You may convert $2,000 if you have received an accelerated life insurance payment. Otherwise you may convert $10,000.

If you are totally disabled, at the time of loss of Earned Eligibility, and you are under age 65, your life insurance can remain in effect on a nonpayment of premium basis. For the purpose of this section, totally disabled means that due to an accidental bodily injury or sickness:

- You are unable to perform the material and substantial duties of your regular occupation; and
- You are unable to perform any occupation for which you are fit by education, training or experience.

Benefits will be payable upon your death if you were totally disabled for at least nine months. You must apply for a waiver of premium with Metropolitan Life Insurance Company within 12 months from the date your Earned Eligibility ends. You will be required to provide proof of continued disability each year. Contact the Plan Office for information and forms.

Accidental Death And Dismemberment (AD&D) Benefits

ELIGIBILITY

AD&D benefits are provided in addition to life insurance. To qualify for AD&D benefits, you must be covered under Plan I Earned Eligibility at the time of your loss. Your AD&D insurance coverage ends when you lose Plan I Earned Eligibility. AD&D benefits are not available if you have Plan II Earned Eligibility or are covered under the Senior Performers Health Plan or the Self-Pay Program, nor are they available to dependents.

AD&D BENEFITS

Benefits are payable if you are involved in an accident and if you suffer any of the losses indicated below as a result of the accident. Generally the loss must occur within 90 days of the accidental injury. Exceptions are for coma and brain damage, which must occur or manifest within 30 days of the accidental injury. The maximum benefit that will be paid for all losses resulting from one accident is $10,000.

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)

Paralysis means loss of use of a limb, without severance. A physician must determine the paralysis to be permanent, complete and irreversible.

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused.

Brain damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life.

If you die in the accident, the benefit will be paid to your beneficiary. Otherwise, the benefit will be paid to you.

Seat Belt and Air Bag Benefits

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. Passenger car means any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes or any vehicle used for recreational or professional racing.

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. Seat belt also includes any child restraint device that meets the requirements of state law.

If you were wearing a seat belt and sitting in a seat protected by an airbag an additional $500 benefit will be paid. This benefit is in addition to the seat belt benefit.

A police officer investigating the accident must certify that the seat belt was properly fastened. If applicable, the police officer must also certify that the passenger car in which you were traveling was equipped with airbags. A copy of such certification must be submitted with the claim for benefits.

EXCLUSIONS

AD&D benefits are not payable for losses due to:

- Diagnosis of or treatment for physical or mental illness or infirmity.
- Committing or trying to commit a felony.
- Infection, unless it occurs in an external accidental wound.
- Intentional or reckless self-inflicted injury.
- Intoxication, if you were the operator of a vehicle or other device involved in the accident.
- Service in the armed forces of any country or international authority, except the United States National Guard.
- Suicide or attempted suicide.
- Voluntary use of:
  - Any drug, medication or sedative unless it is:
    - Taken or used as prescribed by a physician; or
    - An over- the-counter drug, medication or sedative taken as directed.
  - Alcohol in combination with any drug, medication or sedative.
  - Poison, gas or fumes.
- War, whether declared or undeclared; or act of war, insurrection, rebellion or riot.

General Exclusions

The following exclusions apply to all of the Health Plan benefits:

- Charges for any injury or sickness resulting from or occurring during the commission of, or attempt to commit, a felony.
- Charges for completing claim forms, reports or copying of medical records.
- Charges for Experimental or Investigative procedures (see Glossary on page 108).
- Charges for military related injury or illness. However, any governmental agency has the right to be reimbursed for any charges for services rendered which are not military related.
- Charges for on-the-job injuries or illnesses. These charges are excluded whether or not your employer obtained a Workers' Compensation policy. Occupational injuries or illnesses are normally covered by Workers' Compensation Insurance. **If you work through a loan-out company, you should make sure that your employer covers you under its Workers' Compensation policy.** The Plan will consider charges for injuries or illnesses that are specifically excluded from Workers' Compensation laws.
- Charges for services of practitioners not recognized by the Plan for the type of treatment rendered.
- Charges for services or supplies not recommended by a doctor.
- Charges for services or supplies which are provided by any Government or governmental political subdivision in conjunction with the operation of their correctional or mental health programs.
- Charges for services rendered by providers who are not licensed by the appropriate state or federal authority.
- Charges for services rendered to you by a provider who is an "immediate relative". An "immediate relative" includes husband and wife, natural or adoptive parent, child and sibling, stepparent, stepchild, stepbrother, and stepsister, father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, grandparent and grandchild, spouse of grandparent and grandchild. This exclusion does not apply to benefits provided under the Express Scripts prescription drug program.
- Charges for state mandated benefits. The Health Plan is self-funded and, therefore, is not subject to state mandated insurance laws because of its exemption provided under ERISA.
- Charges for telephone, email or internet consultations.
- Charges in excess of the Contract Allowance (see Glossary on page 107). In addition, network providers cannot bill you for covered charges in excess of the Contract Allowance.
- Charges in excess of the Plan's Allowance (see Glossary on page 107).
- Charges in excess of the Reasonable Charge (see Glossary on page 109).
- Charges incurred for a service or supply that is not Medically Necessary (see Glossary on page 108).
- Charges incurred on account of declared or undeclared war, and illness or injuries resulting from war, whether declared or undeclared, or any act of war.
- Charges submitted for which you are not financially responsible.
- Charges submitted more than 15 months after the date services are incurred (18 months for hospital charges).
- Charges that are not considered appropriate for the treatment of an illness or accident.
- Charges for services or supplies that are ordered from internet retailers such as Amazon, Overstock and eBay.

III. GENERAL PROVISIONS FOR ALL BENEFITS

The Performer Information Form

The Health Plan requires you to complete a Performer Information Form. This form is a confidential legal document containing the participant's signature. It provides basic demographic information which allows us to process your claims once you enroll in the Plan.

Once the Plan has your basic information you can log in to our secure website at **www.sagph.org** to make changes to your information, such as changes to your address, enrolling qualified dependents and paying your premium. You also gain access to your personal information, including claims status, earnings, eligibility and pension information.

You may also need to complete other forms for the Plan to ensure your benefits are not interrupted. For instance, the Plan Office cannot release any information about a participant or dependent unless an Authorization for Release of Health Information is signed by the participant or dependent, or the Plan receives a proper legal subpoena. The New Dependent Form is used to add new dependents to the Plan with the appropriate supporting documents as outlined on page 7. In addition, the Designation of Beneficiary Form tells the Plan who you want to receive any benefits that may be payable from the Health Plan upon your death.

It is the participant's responsibility to promptly notify the Plan Office of any changes in personal information, including change of address, addition of dependent children, marriage, divorce, name change, death of a dependent or change of beneficiary. The Plan requires documentation if you add or drop a dependent from coverage for any reason.

The Health Plan Office is separate from the SAG-AFTRA Union office. Notification of a change of address provided to SAG-AFTRA does not constitute notification to the Health Plan.

Interactive Website

The Plan's interactive website, **www.sagph.org**, gives you the ability to securely and conveniently manage your Screen Actors Guild – Producers Health Plan benefits online.

Using a secure password, you can view your personal account information as it appears in the Plan's records. This information includes:

- **Earnings History**: Your detailed personal account pages will show your reportable earnings – sessions and residuals as reported to the Plan over the last 10 years, including earnings for future Health Plan eligibility.
- **Enroll and Pay Your Health Premium**: Make enrollment changes and pay your premium online. Receive electronic enrollment and payment confirmation.
- **Family Information**: Review dependent coverage and eligibility.
- **Health ID Cards**: Print temporary ID cards.
- **Health Plan Information**: See how much has been applied toward your deductibles and out-of-pocket maximums.
- **Medical Claims**: Check the status of your medical claims and view your Explanations of Benefits (EOBs).
- **Personal Information**: Check your address on file and update as needed. Change your password.

E-COMMUNICATIONS

You can enjoy the convenience of securely accessing information from home by signing up for e-communications. You must have a valid email address on file with the Plan Office to register. The following items are available:

- Annual Summary of Earnings
- EOBs
- Health Plan SPD
- Pension Plan SPD
- Premium Payment Reminder
- Take 2 Newsletter

ONLINE REGISTRATION – FAST AND EASY

To access your personal information online you need a user name and a password. To obtain these, you need to register on the Plan's secure website: **www.sagph.org**. Click on "REGISTER" for interactive features, and follow the simple prompts. When registration is complete, you will be assigned a user name online. Your password will be emailed to you provided the email address you enter when registering matches the email address on file at the Plan. If the email addresses do not match, your password will be mailed to you at the address on record with the Plan Office. You should receive your password in a few days.

Receiving your Health Plan information online is completely voluntary. If you do not choose to register, you do not need to do anything. The rest of the website content, which includes the complete Health Plan SPD, network provider locations, forms, past issues of the Take 2 newsletter, and more, remains accessible without registration. If you change your mind, you may register for access to your personal information at any time in the future.

Right Of Reimbursement

Benefits are not payable from the Health Plan for any illness, injury, disease or other condition for which a third party may be liable ("Loss"). Such third parties include, but are not limited to, organizations or individuals who caused the Loss by any act or omission, and insurance carriers, including insurance carriers liable under no-fault and/or uninsured motorist policies.

In the event you experience a Loss, the Plan will advance funds to you in order to assist you with medical bills relating to the Loss. The Plan will not advance more than the amount of benefits to which you would otherwise have been entitled if no third party was liable. If you receive any funds from the Plan as a result of any Loss, you are required to reimburse the Plan for the full amount of such funds from any and all recoveries that you obtain, including any payment, judgment, settlement or other recovery from a third party (the "Full Recovery"). The Plan's share of such Full Recovery will not be reduced because you have not received the full damages or recovery that you claim from the third party (regardless of whether or not you assert a claim under the "make whole doctrine," the "double-recovery rule" and/or under any other such equitable right to relief) unless the Plan agrees to such reduction in writing.

The Plan's right to recover any advanced funds extends to any amount paid with respect to, associated with, or stemming from the injuries incurred, whether paid directly or indirectly to you, your spouse, dependents, beneficiaries or estate, or whether held in trust or constructive trust for your benefit, the benefit of your spouse, or the benefit of any dependents, beneficiaries or estate. All funds the Plan advances shall be recoverable regardless of whether the funds have been commingled with other assets and the Plan may recover from any available funds without the need to trace the source of the funds. In the event that you, your spouse, dependents, attorney, beneficiary, estate or other third party distribute funds without regard to the Plan's right of reimbursement, you will be personally liable to the Plan for the amounts so distributed.

The Plan's right of reimbursement is net of reasonable attorney's fees and costs, such fees and costs not to exceed one-third (1/3) of the Full Recovery by the Plan.

You also agree to do all of the following:

1. Notify the Plan within 90 days of the date that you (i) become aware that any third party is or may be liable for your Loss, and/or (ii) file a claim or institute an action against any third party.

2. Keep the Plan informed of the progress of any claim you assert against a third party.

3. Provide the Plan with information reasonably requested by the Plan regarding your claims against any third party, including filling out the Plan's questionnaire.

4. Enter into a written agreement with the Plan and instruct any attorney you may have to enter into a written agreement with the Plan (the "Lien Agreement") on a form to be provided by the Plan, whereby you grant the Plan a lien on any recoveries from a third party for the full amount of all funds advanced by the Plan related to the Loss.

5. Reimburse the Plan for funds advanced to you with respect to the Loss immediately upon the receipt of any recovery from a third party.

Your failure to comply with the above requirements may result in the Plan taking legal action to obtain reimbursement for amounts advanced to you for the Loss and/or offsetting any amounts you must pay the Plan against benefits otherwise payable to you under the Plan.

Coordination Of Benefits

Coordination of Benefits (COB) is the method of dividing responsibility for payment among the health plans that cover an individual so that the total of all reasonable expenses for covered services will be paid. You must inform the Health Plan about the existence of other health coverage so that the benefits payable may be properly coordinated.

The Health Plan coordinates benefits with all other group and private health plans. It also coordinates benefits for married couples who are both eligible participants in the Plan and for dependent children of two eligible married participants. If a parent and a child are both participants, the Plan will coordinate with respect to the child's coverage. However, since under the Plan rules the parent cannot be a qualified dependent of the child, the parent will only be treated as a participant with one coverage.

If you qualify for coverage with the SAG – Producers Health Plan and another health plan, it is very important for you to understand the impact of choosing whether or not to pay the premium for that plan or for the SAG – Producers Health Plan. COB rules can be very challenging to understand. Therefore, we strongly recommend you contact the Plan Office to discuss your individual situation when deciding whether or not to pay a premium for coverage. You should also contact the office of your other plan as they may have their own special rules regarding COB.

DETERMINATION OF PRIMARY PLAN

The primary plan is the plan that pays first on the claim. If a balance is still due after the primary plan's payment, the claim should be sent to the secondary plan for consideration.

General Rules

In determining which of the plans is primary or secondary, this Health Plan will apply the rules outlined below. The first rule that applies to the situation will be used.

1. The plan without a COB provision is always primary.

2. The plan covering the person as a participant is primary to the plan covering the person as a dependent.

3. The plan covering the person with Earned Eligibility is primary to the plan covering the person with Senior Performers (retiree) eligibility or Self-Pay coverage.

4. The plan covering the person for the longest continuous period is primary to the plan covering the person for a shorter period if the person has the same type of eligibility (for example, Earned Eligibility) in both plans. If you have the same coverage effective date under more than one plan, please contact the Plan Office for your COB rules.

Note: *When coordinating benefits with Medicare, the Plan also uses active and inactive coverage rules. Please see pages 81 through 83 for a description of Medicare COB.*

Determination of Dependent Child's Primary Plan

In the case of a dependent child where the parents are not divorced, this Plan uses the "birthday rule". This means the plan of the parent whose birthday occurs earlier in the calendar year is primary. If both parents have the same birthday, the plan that has covered the child for the longer period is primary. If the other plan does not have the birthday rule, the other plan's rules will determine who is primary.

In the case of a dependent child where the parents are divorced, the rules are:

- If the parent with custody has not remarried, the plan of the custodial parent is primary to the plan of the non-custodial parent.
- If the parent with custody has remarried, the plan of the custodial parent is primary, the plan of the custodial stepparent is secondary and the plan of the non-custodial parent is third.
- If a court order provides a different order of benefit determination, the court order will be followed. A copy of the court order will be required.

Coordination of Benefits with Other Entertainment Industry Health Plans (EICOB)

Note: *The Plan's EICOB rules can be very challenging to understand. We strongly suggest you contact the Plan Office to discuss your individual situation.*

If you are entitled to primary coverage with another entertainment industry plan, but fail to pay the premium in that plan, the SAG – Producers Plan will maintain its secondary position. The Plan refers to this as EICOB and the rule serves to maintain the correct primary/secondary positions of the health plans based on your longest continuous coverage. The other entertainment industry plans include the AFTRA Health Plan, the Directors Guild of America – Producer Health Plan, the Equity – League Health Plan, the Motion Picture Industry Health Plan and the Writers' Guild – Industry Health Fund. These rules apply to participants and dependents in both Plan I and Plan II, regardless of whether your eligibility is Earned or Senior Performers.

In order to maintain its secondary position, the Plan will pay up to 20% of the Allowed Amount for your hospital and medical claims, subject to the deductibles. The Plan will also pay 20% of the Allowed Amount for Plan I mental health and substance abuse claims, subject to the deductibles. For prescription drug benefits, you will not receive an Express Scripts ID card. You must pay for your prescriptions at the pharmacy and submit a claim to the Plan Office for reimbursement of up to 20% of the Allowed Amount, subject to the non-network medical deductible. Dental and vision benefits will continue to be administered through Delta Dental and Vision Service Plan as if the SAG – Producers Plan is primary.

Exceptions:

Same Longest Continuous Coverage Date – When the longest continuous coverage date, as described on page 76, is the same under the SAG – Producers Health Plan and your other plan, you are referred to as a "pro rata" participant. This means that you will be able to choose the plan you wish to be primary. Only participants in this situation are given a choice between plans. If you think you may be a pro rata participant please contact the Plan Office.

Primary Plan is Individual Only – If your primary plan provides only individual coverage and excludes coverage for your dependents, the SAG – Producers Health Plan will continue to pay primary for your dependents. For example, the Individual Plan at AFTRA provides no dependent coverage, so dependents of participants in that plan would continue to be covered as primary in the SAG – Producers Health Plan, *regardless of whether you continued your AFTRA coverage*. However, the AFTRA Family Plan does provide for dependent coverage by paying a premium.

Accordingly, you will be required to keep your AFTRA Family Plan dependent coverage in force to *avoid a reduction in coverage* with the SAG – Producers Health Plan.

Deferral of Equity – League Health Plan Eligibility – The Equity – League Health Plan has a rule that gives its participants the choice to defer their health coverage in order to gain a longer period of coverage. If your other primary plan is the Equity – League Health Plan and you elect to defer your Equity eligibility in accordance with their plan rules, the SAG – Producers Health Plan will not apply its special EICOB rule. This means the SAG – Producers Health Plan will pay as primary for those participants. However, if you drop your Equity coverage for any reason other than the special deferral rule, such as for non-payment of premiums, this Health Plan will reduce its benefits accordingly.

SAG – Producers Health Plan Original Position is Third or Lower – If the SAG – Producers Health Plan's original position is third or lower the reduction does not apply. So, if you have DGA as primary, AFTRA as secondary and SAG as third, but you fail to pay your AFTRA premium, SAG will pay as if it were in second position. Your benefits will not be reduced because of your failure to pay the AFTRA premium.

If Medicare is your primary plan, however, this exception changes so that the reduction does not apply if the SAG – Producers Health Plan's original position is fourth or lower. For example, suppose Medicare is primary, AFTRA is second and SAG is third. If you fail to pay the AFTRA premium, SAG will only pay what it would have paid in the third position.

Married Participants Both Eligible for SAG – Producers Health Coverage – A special rule applies to married participants who are both eligible for the SAG – Producers Health Plan and who also have coverage in another entertainment industry plan. If the SAG – Producers Health Plan is primary for one or both of the participants, the SAG – Producers Health Plan will not penalize the family for failure to pay all three premiums. You may choose to pay for only one SAG coverage, in which you and your family will receive primary coverage. If you pay the premiums for both SAG coverages, you and your family will receive full coverage (100%), subject to the Plan's Allowances.

Parent and Dependent Child Both Eligible for SAG – Producers Health Coverage – The special rule just described also applies to families where a parent and dependent child are both eligible for the SAG – Producers Health Plan.

Coordination of Benefits with HMOs

If you or your dependent have primary coverage with an HMO, including a Medicare HMO, you must use your HMO provider network. When you do, the SAG – Producers Health Plan will pay secondary for any copays or deductibles you may incur. If you do not use the HMO network providers, the Health Plan will reduce benefits by 80%. In other words, the maximum the Plan will pay is 20% of the Allowed Amount on the claim.

This rule applies to HMO coverage you or your dependents may have through Medicare, another employer or privately. It is extremely important that you use your HMO when it is your primary plan. If you do not, your benefits under this Health Plan are reduced and you will have much larger out-of-pocket expenses.

In cases where your HMO excludes specific services for which this Plan has a benefit, such as chiropractic care, regular Health Plan benefits will be paid.

HOW BENEFITS ARE COMPUTED

Once a determination has been made about which plan is primary, the benefits are processed as follows:

When This Health Plan is Primary

If this Health Plan is primary, the bills should be submitted to the Plan first (see page 84, "Filing a Claim for Benefits"). This Plan will pay benefits based on its rules as if there were no other coverage.

When This Health Plan is Secondary

If this Plan is secondary, copies of the original bills and a copy of the other plan's EOB should be submitted to the Plan Office. This Plan will determine how much it would have paid had there been no other coverage. It will then subtract what was paid by the primary plan from the total Allowed Amount.

The Allowed Amount is based on whether or not the provider is a network provider.

The difference between the Allowed Amount and what the primary plan paid will be paid by this Health Plan, provided it does not exceed the amount this Plan would have paid as primary. When a BlueCard PPO provider is involved, if the primary plan has already reimbursed more than the network contracted rate, this Plan will not make any payment and the remaining charges become a network write-off. You are not responsible for the balance.

Here are examples. Both examples assume that the participant is in Plan I, is not using a network provider and that the deductibles have been met.

PROVIDER STATUS		
This Plan	**The Primary Plan**	**Allowed Amount**
Network	Network	The lower of this Plan's network contracted rate or the primary plan's network contracted rate.
Network	Non-Network	This Plan's network contracted rate.
Non-Network	Network	The primary plan's network contracted rate.
Non-Network	Non-Network	The higher of this Plan's allowance or the primary plan's allowance.

If This Plan Is Primary	If This Plan Is Secondary
$ 600 Allowed Amount x 70% Plan's benefit $ 420 This Plan's payment	$ 600 Allowed Amount – 420 Primary plan's payment $ 180 This Plan's payment

Medicare

The Plan has specific rules for coordinating benefits with Medicare which are described on pages 81 through 83. The chart in that section explains terms used specifically for Medicare COB such as Earned Active coverage and Earned Inactive coverage.

You should know that traditional Medicare involves three parts. Part A, which covers hospital charges, costs you nothing. Part B, which covers doctors' bills and other medical care, involves a monthly premium. Part D, which covers prescription drugs, requires a monthly premium in most cases.

MEDICARE PART A – HOSPITAL CHARGES

Enrollment in Part A is no longer automatic because eligibility for Medicare occurs at age 65, while the Social Security Retirement Age is now higher than age 65. If you and/or your spouse or domestic partner are not enrolled in Medicare Part A when Medicare is primary, Health Plan benefits will be reduced and you are responsible for the remainder of the charges. **You are strongly urged to enroll for Medicare Part A at age 65, even if you are still working and even if you have Earned Active coverage under the Health Plan.** We suggest you contact Medicare at least three months before your 65th birthday. This will eliminate the possibility that you could be subject to benefit reductions for hospital charges during any period after your Earned Active coverage ends and you become eligible for the Senior Performers Plan, the Self-Pay Program or Earned Inactive coverage. Remember, there is no premium for Part A.

MEDICARE PART B – DOCTOR BILLS AND OTHER MEDICAL CARE

Enrollment in Part B is not automatic. You must apply and pay a monthly premium and there are limits to the enrollment period. Because Part B requires a premium, it is understandable that you would not want to enroll until Medicare becomes your primary plan – when your Earned Active coverage ends and you become eligible for the Senior Performers Plan or the Self-Pay Program or Earned Inactive coverage. However, if you wait too long, there will be a gap before Medicare begins. If this happens, Health Plan benefits will be reduced. To avoid this reduction, contact the Plan Office and Medicare to make sure that you enroll as soon as you know that your coverage under the Health Plan is no longer Earned Active. We suggest you contact Medicare at least three months before your 65th birthday.

MEDICARE PART D – PRESCRIPTION DRUGS

Prescription drug coverage is available through Medicare Prescription Drug Plans (PDPs). You may enroll in a PDP when you become eligible for Medicare or during the annual open enrollment period, which runs from October 15th through December 7th. Most people have to pay a monthly premium for Part D.

Unlike Parts A and B, however, the Health Plan does not recommend that you enroll in a PDP. This is because the prescription drug benefits offered under the Health Plan are considered "creditable coverage". This means they are comparable to the standard Medicare drug benefits except under very limited circumstances. Because of this, you can choose to stay covered under the Health Plan and not be subject to a higher premium if you enroll in a Medicare PDP later. You can be in **either** the SAG – Producers Health Plan **or** a Medicare PDP, **but not both.**

There are three possible situations in which you may be better off enrolling in a Medicare PDP:

- People with Limited Resources – Medicare includes special provisions for people with limited income and resources. The special provisions may allow you to receive Medicare prescription drug benefits with no premium and low or no deductibles and copays. If you think you may qualify, you should contact the Social Security Administration or complete their worksheet found on their website (www.ssa.gov) or the Plan's website (**www.sagph.org**, then click "Medicare").

- Self-Pay Program Participants – If you are currently enrolled in the Self-Pay Extended Coverage Program and are also Medicare-eligible, it is possible that, with the monthly self-pay premiums and prescription drug deductible and copays, you may pay more for the Plan's coverage than through a Medicare PDP. Keep in mind that if you decide to enroll in a Medicare PDP and stop paying your Health Plan self-pay premiums, you will have no coverage – hospital, medical, prescription drug or dental – under the Plan. You cannot drop just the prescription drug benefits and retain the other coverage. Also, if you terminate your self-pay coverage, you will not be able to get back into the Self-Pay Program unless you requalify for Earned Eligibility.

- Medicare HMOs – If you are enrolled in a Medicare HMO, that plan may have automatically enrolled you in their Medicare PDP. The HMO may not allow you to drop just the prescription drug coverage without dropping the hospital and medical coverage as well.

When making your decision to enroll, you should compare the Plan's coverage, including what medications are covered, with the coverage and cost of the Medicare PDPs in your area. **If you enroll in a Medicare PDP and you have Earned Inactive, Self-Pay, Senior Performer or Extended Spousal eligibility, you will no longer receive prescription drug coverage under the Plan.**

If you enroll in a Medicare PDP and later drop that coverage, you can again receive prescription drug coverage from the Health Plan, provided you still have Earned Inactive, Self-Pay, Senior Performers or Extended Spousal eligibility. Your Health Plan prescription drug coverage will be effective the first of the month after your Medicare PDP coverage ends.

If you are eligible for Medicare, the Plan will periodically mail you a Notice of Creditable Coverage. This Notice is also available upon request to the Plan Office and on the website: **www.sagph.org**. It advises you that the Plan's prescription drug coverage is on average, comparable to the standard Medicare prescription drug coverage. You will need a copy of the Notice if you lose coverage under the Plan and want to enroll in a PDP without paying a higher premium.

COORDINATION OF BENEFITS WITH MEDICARE

If you are age 65 or older and you have Self-Pay, Senior Performer or Extended Spousal eligibility, Medicare is your primary plan and this Plan pays as secondary. However, federal law requires that this Plan be primary to Medicare for "active" participants who are age 65 or older. If you qualify for Alternative Earned Eligibility under the Days of Employment rule, you are "active". With respect to Covered Earnings, Medicare does not consider residual earnings as "active" earnings. Only sessional earnings are considered "active". Accordingly, in determining whether you are "active" under Medicare's rules and, therefore, whether this Plan or Medicare is primary, the rules in the following table apply.

If Your Earned Eligibility is Based on	You Are	Primary Plan	Secondary Plan
All Sessional Earnings	Active	SAG – Producers Plan	Medicare
All Residual Earnings	Inactive	Medicare	SAG – Producers Plan
Combination Residual and Sessional Earnings but less than $15,100* in Sessions	Inactive	Medicare	SAG – Producers Plan
Days of Employment	Active	SAG – Producers Plan	Medicare
For participants at least age 40 with at least 10 years of Earned Eligibility - Combination Residual and Sessional Earnings but less than $10,900* in Sessions	Inactive	Medicare	SAG – Producers Plan

* These are the minimum amounts currently required to establish or continue Earned Eligibility. The minimum earnings requirements are subject to change from time to time by the Trustees.

It is possible for your status to change from year to year. For example, if you return to work for the minimum Days of Employment (currently 76) the Plan becomes your primary plan. If you do not work the minimum days in the next year and your sessional earnings are less than the minimum requirement, Medicare would become your primary plan. The Plan Office will let you know of any change in your eligibility and can tell you which plan is primary at any time.

Once you lose all eligibility under the Health Plan, Medicare would be your only coverage and, therefore, your primary coverage. The Plan Office will notify you when your eligibility type changes.

IMPORTANT NOTES:

The following special rules apply to any participant or dependent who is eligible for Medicare, including participants or dependents age 65 or older and participants or dependents who are eligible for Medicare due to disability.

- With the exception of life insurance and AD&D benefits, no distinction is made between sessional and residual earnings in determining your eligibility for benefits. All earnings count the same toward Earned Eligibility. The distinction is made only for purposes of COB with Medicare, the amount of life insurance and eligibility for AD&D benefits.

- Medicare is primary for Medicare-disabled dependents of participants younger than age 65 whose Earned Eligibility is based on less than $15,100 in sessions (or $10,900 in sessions if you meet the Age and Service requirement). These amounts will increase when the minimum earnings requirement increases.

- Medicare is primary for all Medicare-eligible same-sex domestic partners.

- Special rules apply to individuals with End Stage Renal Disease. Call or email the Plan Office for details.

If you or your dependent are eligible for other health insurance in addition to SAG – Producers and Medicare, please contact the Plan Office to determine the order of claims payment. The Plan's EICOB rules will apply in this situation and can be very challenging to understand (see pages 77 and 78).

There are three situations in which Plan benefits will be reduced for Medicare beneficiaries.

1. **If you fail to enroll in Medicare Parts A and B when the SAG – Producers Plan is secondary.**

   If you fail to enroll in Medicare Parts A and B when this Plan is secondary to Medicare, this Plan's benefits will be reduced by 80% because the Plan will coordinate benefits as though you received reimbursement from Medicare. **You should contact Medicare at least three months before you turn age 65 to enroll in Medicare.**

2. **If you use a doctor who has opted out of Medicare.**

   Medicare allows doctors the opportunity to opt out of the Medicare system and contract directly with patients to provide treatment outside of Medicare. A doctor who has opted out of Medicare must inform the patient that his or her services will not be covered by Medicare, and the doctor and patient must sign a written contract in which the patient agrees that the doctor's charges will not be paid by Medicare. If you or your spouse or domestic partner use the services of a doctor who has opted out of Medicare, this Plan's benefits will be reduced because the Plan will coordinate benefits as though you received reimbursement from Medicare.

3. **If you fail to use a Medicare HMO provider when Medicare is primary.**

   Medicare beneficiaries have a choice between traditional Medicare (Parts A and B) or a Medicare HMO. If you or your spouse or domestic partner are enrolled in a Medicare HMO as your primary plan, but do not use the HMO network providers, this Plan's benefits will be reduced by 80%.

Remember, the Health Plan does not coordinate with Medicare for prescription drug coverage. If you have Earned Inactive, Self-Pay, Senior Performer or Extended Spousal eligibility and you enroll in a Medicare PDP you will not be eligible for the Health Plan's prescription drug benefits.

For more information on the Health Plan, please visit:

www.sagph.org

Screen Actors Guild – Producers Health Plan

Filing A Claim For Benefits

A claim for benefits is a request for benefits made in accordance with the Health Plan's claims procedures. Simple inquiries about the Plan's provisions that are unrelated to a specific claim are not treated as claims for benefits. Neither are requests for prior approval of benefits that do not require such an approval by the Plan. In addition, when you present a prescription to a pharmacy to be filled under the terms of the Plan, that request is not a claim under these procedures. However, if your prescription request is denied, in whole or in part, you may file an appeal of the denial by using the procedures outlined under "Health, Disability and Retroactive Removal of Coverage Appeals" on pages 90 through 94.

HOSPITAL AND MEDICAL BENEFITS

When you use network providers, the providers will file the claim for you. For non-network claims, claim forms may be obtained from any Plan Office, requested through the Automated Information Center or downloaded from the Plan's website: **www.sagph.org**. All claims from California providers and facilities should be sent to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Claims from providers and facilities in states outside California should be sent to the local Blue Cross Blue Shield Plan.

The Plan will accept hospital expenses for up to 18 months after the date of service and medical expenses for up to 15 months after the date of service. *Hospital claims more than 18 months old and medical expenses more than 15 months old will not be paid.*

If you receive treatment *outside* of the United States, submit a detailed, translated bill to the Plan Office. The bill should include the date services were provided, a description of each service, the charge for each service and the reason treatment was provided. Be sure to also include the type of currency that was used when you paid for these services.

Before submitting a claim form, be sure it is filled out properly. To avoid delay in the processing of your claims, follow these steps:

1. Be sure to complete Part 1 of the Plan's claim form in full. Attach your doctor's itemized bill to the completed claim form.

2. You and the doctor should complete a separate form for each family member for each illness.

3. If you are seeing a doctor(s) for more than one illness or injury, you must submit a form for each illness or injury.

4. Please answer all questions completely.

5. Make sure you or your designated representative answer all questions about other insurance. Provide the name(s) of the other insurance, the address, identifying codes, and the name of the policyholder. Failure to supply information about other insurance and to answer questions truthfully may constitute fraud.

6. When you are covered under more than one plan, each plan will require a copy of all itemized bills with diagnosis and corresponding payment sheets. A copy of the operative and pathology reports are required for most surgical procedures. Please submit copies of the reports when you submit the surgeon's bill.

7. Be sure to complete Part 3 of the claim form if you wish the Plan to make payment directly to the provider of services. An updated assignment of benefits is required every 12 months. Only the participant can assign payment of benefits.

This cannot be done by any other person, including your eligible dependent(s). The Plan accepts "Signature on File" as a valid assignment of benefits.

8. If reimbursement for medical expenses and correspondence are to be handled by your business manager or accountant, please let us know in writing at the time you submit your first claim form. We cannot give information to a third party without your written permission. An Authorization for Release of Health Information is available from the Plan Office or on the Plan's website: **www.sagph.org**.

9. Do not forget to sign the form. Your business manager or legal representative cannot sign for you unless he or she has power of attorney. If that is the case, please send a copy of the authorizing document.

10. If you have questions, contact the Plan Office:

    (818) 954-9400
    (800) 777-4013
    psd@sagph.org

MENTAL HEALTH AND SUBSTANCE ABUSE

When you use network providers, they will file the claim for you. When you use a non-network provider, you or your provider should submit claims directly to ValueOptions. DO NOT SEND CLAIM FORMS TO THE PLAN OFFICE.

ValueOptions, Inc.
Latham Claims
P.O. Box 1290
Latham, NY 12110

Claim forms may be downloaded from the Plan's website: **www.sagph.org** or obtained from the Plan Office.

Follow the instructions on the claim form carefully and answer all questions completely. This will expedite the processing of the claim. If you wish benefits to be paid directly to the provider, be sure to sign the form in the space provided.

PRESCRIPTION DRUGS

If you use a non-participating retail pharmacy for your prescription drugs you need to file a claim with Express Scripts. Claim forms may be obtained from the Plan Office or downloaded from the Plan's website: **www.sagph.org**. Or you may call Express Scripts at (800) 903-4728.

Non-participating retail pharmacy claims should be submitted to:

Express Scripts, Inc.
P.O. Box 2187
Lee's Summit, MO 64063-2187

You will be reimbursed the amount that would have been charged by a participating pharmacy less the required copay.

If your prescription drug coverage is provided under the medical benefits, submit your claims to the Plan Office. A prescription drug claim should include a claim form, copy of the prescription and the original receipt.

DENTAL CLAIMS

When you use a network dentist, the dentist will file the claim for you. When you use a non-network dentist, you or your dentist should submit claims directly to Delta Dental. DO NOT SEND CLAIM FORMS TO THE PLAN OFFICE.

Delta Dental of California
Claims Department
P.O. Box 997330
Sacramento, CA 95899-7330

Claim forms may be downloaded from the Plan's website: **www.sagph.org**, or from Delta's website: www.deltadentalins.com/sagph, or obtained from the Plan Office.

Follow the instructions on the claim form carefully and answer all questions completely. This will expedite the processing of the claim. If you wish benefits to be paid directly to the dentist, be sure to sign the form in the space provided.

If your estimated charges are less than $300, the claim form serves as a statement of actual charges. You complete the employee section and your dentist completes the dentist's section and sends the form to Delta Dental after services are performed.

If your estimated charges are $300 or more, the form may serve as a pretreatment estimate of charges. You complete the employee section and your dentist completes the dentist's section before treatment commences. The form should then be sent to Delta Dental. After review, a statement indicating the benefits payable under the Plan will be returned to you and your dentist. When the work is completed, your dentist should indicate on the statement the specific services performed, the date performed and the actual charges.

VISION CLAIMS

If an Exam Plus eye exam is received through a VSP provider, the provider will file the claim for you. If you use a non-VSP provider, you should request a copy of the bill showing the amount of the eye examination. Send the bill to:

VSP
Attention: Non-Member Doctor Claims
P.O. Box 997105
Sacramento, CA 95899-7105

Be sure to include the participant's name, mailing address and ID number, and the patient's name, relationship to participant and date of birth.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Provide a certified copy of the death certificate, and, if appropriate, evidence of the accidental nature of death, to the Plan Office. In the event of dismemberment, notify the Plan Office promptly. You should also contact the Plan Office if you are applying for an accelerated life insurance payment. A claim form will be sent to you.

AUTHORIZED REPRESENTATIVES

An authorized representative may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form to designate an authorized representative can be obtained from the Plan Office or downloaded from the Plan's website: **www.sagph.org**.

TYPES OF CLAIMS

A **Pre-Service Claim** is a claim for a benefit for which the Plan requires approval before medical care is obtained. For hospital and medical benefits, prior approval is required for organ transplants, bariatric surgery, eyelid, nasal and certain breast surgeries, outpatient private duty nursing, psychological testing and sleep studies. Certain prescription drugs also require prior authorization.

An **Urgent Care Claim** is any claim for medical care or treatment where the application of the time period for making a Pre-Service Claim determination:

- Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
- In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether your claim is an Urgent Care Claim is generally determined by the Health Plan. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above shall be treated as an Urgent Care Claim.

A **Concurrent Care Claim** is a claim involving an approved ongoing course of treatment either for a specific period of time or for a specific number of treatments. If the claim involves urgent care it will be treated as an Urgent Care Claim. Otherwise it will be subject to the time periods for Pre-Service Claims as outlined on the following page.

A **Post-Service Claim** is a claim submitted for payment after health treatment has been obtained.

Disability Claims are claims that require a finding of total disability as a condition of eligibility. Under the Health Plan, this would be a claim for the waiver of the life insurance premium or coverage under the Total Disability Extension. The Plan reserves the right to have a physician examine you (at the Plan's expense), as often as is reasonable while a Disability Claim is pending.

INITIAL DETERMINATION

When you submit a claim, the Plan has a certain amount of time to make a determination regarding payment of the claim. The time to make a determination may be extended if necessary due to matters beyond the Plan's control. For example, an extension may be available if the Plan needs additional information from you or your doctor to make its determination. You will be notified of the circumstances requiring the extension. The table on the following page outlines these time periods and any available extensions.

NOTICE OF DETERMINATION

For Pre-Service and Urgent Care Claims, you will receive written notice of the Plan's determination. For Post-Service and Disability Claims, you will be provided with written notice for denials, including:

1. The specific reason(s) for the determination and reference to any specific Plan provision(s) on which the determination is based.
2. A description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary.
3. A description of the appeal procedures and applicable time limits.

4. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

5. If an internal rule, guideline or protocol was relied upon in making the determination, a statement that a copy of the rule is available upon request at no charge.

6. If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

7. For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. Urgent Care determinations may be provided orally and followed with written notification.

	Health Claims			Disability Claims
Claims Procedures	**Pre-Service**	**Urgent Care**	**Post-Service**	
How long does the Plan have to make a determination when you file a claim?	15 days.	72 hours.	30 days.	45 days.
Are there any extensions available?	Yes, one 15-day extension.	No.	Yes, one 15-day extension.	Yes, two 30-day extensions. You will be notified of the first extension within 45 days. You will be notified of the second extension within the first 30-day extension.
What happens if the Plan needs additional information?	The Plan will tell you what information is needed within 5 days of receipt of the claim. You have 45 days to respond.	The Plan will tell you what information is needed within 24 hours of receipt of the claim. You have 48 hours to respond.	The Plan will tell you what information is needed within 30 days of receipt of the claim. You have 45 days to respond.	The Plan will tell you what information is needed within the time periods outlined above. You have 90 days to respond.
If additional information is requested, when must the Plan make its determination?	Within 15 days of the earlier of: • the day you respond, or • the end of the 45-day response period.	Within 48 hours of the earlier of: • the time you respond, or • the end of the 48-hour response period.	Within 15 days of the earlier of: • the day you respond, or • the end of the 45-day response period.	Within 30 days of the earlier of: • the day you respond, or • the end of the 90-day response period.

Claim Appeal Procedures

The Health Plan Trustees are authorized and empowered to construe the meaning of any doubtful or ambiguous provisions of the Health Plan, and any construction thereof adopted by the Health Plan Trustees in good faith shall be binding upon SAG-AFTRA, the Producers, the participants and all beneficiaries.

The Health Plan Trustees are authorized and empowered to decide on a participant's entitlement to or application for benefits under the Health Plan, and any such decision of the Health Plan Trustees shall be final and binding upon all affected parties, except where federal law allows for an external appeal to an Independent Review Organization (IRO).

The Health Plan Trustees are authorized and empowered generally to do all things, execute all such agreements, adopt and promulgate all such reasonable rules and regulations, take all such proceedings and exercise all such rights and privileges as are necessary in the establishment, maintenance and administration of the Health Plan.

ELIGIBILITY, LIFE INSURANCE AND AD&D APPEALS

If your claim for Health Plan eligibility or for life insurance or AD&D benefits is denied in whole or in part, you will be notified, in writing, within 90 days of receipt of your claim. In some instances, an additional 90 days may be required for study. If additional time or information is needed you will be notified in writing of the reasons. In no case will the extension exceed 180 days from the date your claim was received.

The notice of determination will contain specific reasons for the determination and a specific reference to the provisions of the Plan or policy on which the determination is based.

If you have not been notified of action taken on your claim within the 180-day period, you may treat the claim as having been denied and may make an appeal in the following ways:

- **Administrative Review of a Determination to Deny.** If your claim was denied and you have additional medical or other information, you may request an administrative review. Your request must be submitted in writing to the Chief Executive Officer within 60 days of the denial of the claim, and accompanied by the additional medical or other information upon which you rely.

- **Appeal of a Determination to Deny.** If you have no additional medical or other information or you feel the claim has been incorrectly denied, initially or after administrative review as outlined above, you may appeal to the Benefit Appeals Committee of the Board of Trustees. An appeal to the Benefit Appeals Committee must be submitted in writing to the Chief Executive Officer within 60 days of the initial denial of the claim or 60 days of the administrative review denial, whichever is later, and accompanied by a statement giving the reasons the denial is believed to be incorrect.

A determination by the Chief Executive Officer on an administrative review or by the Benefit Appeals Committee on an appeal shall be made within 60 days after the receipt of the request. An additional 60 days may be required for special study. However, the determination will be made no later than 120 days after your request is received. The notice of the determination will contain specific reasons for the determination and a specific reference to the provisions of the Health Plan on which the determination is based.

If you have not been notified of action taken on your appeal within the 120-day period, you may treat the appeal as having been denied and may initiate a lawsuit as described under the heading "Statement Of ERISA Rights" on pages 102 and 103.

HEALTH, DISABILITY AND RETROACTIVE REMOVAL OF COVERAGE APPEALS

If your health claim or Disability Claim is denied in whole or in part, you may ask for a review. You may also request a review if the Plan has retroactively removed your health coverage. In accordance with federal law, the Plan provides both an internal and external appeals process; however, the external appeals process is only available in certain circumstances. Please see page 92 for additional information.

Under the internal process, your claim determination notice will tell you where to send an appeal. If your denied claim is for hospital or medical benefits, or for coverage under the Total Disability Extension, you may appeal one time to the Benefit Appeals Committee of the Board of Trustees. You may also appeal to the Benefit Appeals Committee if your health coverage was retroactively removed.

If your denied claim is for another type of benefit there are two levels of internal appeal. The first is to the appropriate carrier listed below. If your claim is denied after the first review you may file a second appeal with the Benefit Appeals Committee.

Benefit	Company
Dental	Delta Dental
Hospital/Medical Utilization Management Review	Anthem Blue Cross
Life Insurance Premium Waiver	MetLife
Mental Health and Substance Abuse	ValueOptions
Prescription Drug	Express Scripts
Vision	Vision Service Plan

Your initial request for review must be made in writing within 180 days after you receive notice of the denial. Specific information on how to file an appeal with these carriers is contained in their claim denial notices.

Appeals involving Urgent Care Claims may be made verbally by calling one of the following numbers:

Urgent Care Appeals		
Benefit	**Company**	**Phone Number**
Hospital	Anthem Blue Cross	(800) 274-7767
Mental Health and Substance Abuse	ValueOptions	(866) 277-5383
Prescription Drugs – Clinical Appeals	Express Scripts	(800) 864-1135
All Other Benefits	Health Plan Office	(818) 954-9400 or (800) 777-4013

If your appeal is for a Concurrent Care Claim, the Plan will provide continued coverage for the course of treatment during the appeal process.

Internal Appeal Process

You have the right to review documents relevant to your claim and will be provided with any new material considered during the appeal.

Your appeal will be reviewed by someone other than the person who originally denied the claim. The determination will be made on the basis of the record, including any additional documents and comments submitted by you. If your claim was denied on the basis of a medical judgment, such as lack of medical

necessity, a health care professional with appropriate training and experience in a relevant field of medicine will be consulted. Any such health care professional shall not be an individual who was consulted in connection with the claim denial, nor a subordinate of any such individual.

Notice of Determination on Internal Appeal

The table below outlines the timing for the internal appeal determination.

The Plan may waive the internal appeal process and proceed to the expedited external review procedures if your attending provider determines that your appeal is urgent because it involves a medical condition for which the time period for completion of the appeal would seriously jeopardize your life or health, or your ability to regain maximum function.

The determination on any review of your claim will be given to you in writing. If the internal appeal is denied, the notice will explain the reason for the determination as described in items 1, 4, 5 and 6 under "Notice of Determination" on pages 87 and 88. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim.

	Health Claims			Disability Claims
Appeals Procedures for Denied Claims	**Pre-Service**	**Urgent Care**	**Post-Service (including Retroactive Removal of Coverage)**	
How much time do I have to appeal?	180 days.	180 days.	180 days.	180 days.
How may I make the appeal?	Anthem – Verbally or in writing. All other – In writing.	Verbally or in writing.	In writing.	In writing.
How long does the Plan have to make a determination on my appeal?	One level - 30 days. Two levels - 15 days for each level.	One level only - 72 hours.	One level - Usually appeals will be decided at the next Benefit Appeals Committee meeting.* You will be notified within 5 days of the determination. Two levels - 30 days for each level.	One level - Usually appeals will be decided at the next Benefit Appeals Committee meeting.* You will be notified within 5 days of the determination. Two levels - 30 days for each level.

* If your internal appeal is received within 30 days of the next regularly scheduled Benefit Appeals Committee meeting, it will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances a delay until the third regularly scheduled meeting following receipt of your internal appeal may be necessary.

External Review Process

Please note: *External review is not available for every claim denial or internal appeal denial.*

If your internal appeal is denied, you may file a request for external review with the Plan. As of July 1, 2013 the external review process is **only** available under the circumstances outlined below. The Plan will accept claims for external review in accordance with federal law.

- The initial claim denial or internal appeal denial involved medical judgment. Examples include determinations of medical necessity, appropriateness, health care setting, level of care and experimental or investigational status.
- Your health coverage was retroactively removed, unless this occurred because you did not meet the Health Plan's eligibility requirements. Retroactive removal of coverage due to eligibility reasons is not eligible for external review.

Preliminary Review. The Plan will complete a preliminary review of the request. In addition, to the requirements outlined above, **all** of the following factors must be met:

1. For Pre-Service and Urgent Care Claims you were covered under the Plan at the time the health care item, service, or other benefit was requested. For Post-Service Claims, you were covered under the Plan at the time the health care item, service, or other benefit was provided.
2. The initial claim denial or the internal appeal denial do not relate to the failure to meet the Plan's eligibility requirements.
3. You have exhausted the Plan's internal appeal process unless not required to do so under federal law or in accordance with a request for an expedited external review.
4. You have submitted a completed External Appeals Form.

Notice of Preliminary Review. The Plan will issue a written notice after completion of the preliminary review. If your internal appeal denial is not eligible for external review, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If your request for external review is not complete, the notice will describe the information or materials needed to make it complete.

The table below outlines the timing for the preliminary external review steps.

External Review Step	Responsible Party	Time to Complete
Request external review	Patient*	4 months after receipt of internal appeal denial.
Preliminary review	Plan	5 business days after receipt of request.
Notice of preliminary review decision	Plan	1 business day after making decision.
Provide additional information for external review request	Patient*	The later of: • The end of the 4-month filing period; or • 48 hours following receipt of notice of preliminary review decision.

* The patient's authorized representative may complete these steps.

Assignment to IRO. In accordance with federal law, the Plan will assign an accredited IRO to conduct the external review. The IRO will notify you, in writing when they receive the external review request. This notice will include a statement that you may submit additional information in writing for the IRO to consider. The information should be submitted within 10 business days of receiving the notice. The IRO may accept and consider additional information submitted after 10 business days but it is not required to do so.

The Plan will provide the IRO any documents and information used in denying the claim or denying the internal appeal within five business days after the external review is assigned to the IRO. If the Plan fails to do so, the IRO may terminate the external review and make a decision to reverse the denial. Within one business day after making such decision, the IRO must notify you and the Plan.

Upon receipt of any information submitted by you in connection to the external review, the IRO will forward it to the Plan within one business day. Upon receipt, the Plan may reconsider its claim denial or internal appeal denial. The Plan will provide written notice to you and the IRO if it reverses its previous decision within one business day of such reversal. Thereafter the IRO will terminate the external review proceedings.

External Review Decision. The IRO will review all information and documents timely received and use experts where appropriate to make coverage determinations under the Plan. The IRO is not bound by any decisions or conclusions reached during the initial benefit denial or the internal appeal. In addition to the documents and information provided, the IRO will consider the following, as it determines appropriate, when making its decision:

- Your medical records.
- The attending health care professional's recommendation.
- Reports from appropriate health care professionals and other documents submitted by the Plan, you or your treating provider(s).
- The terms of the Plan (unless contrary to applicable law).
- Appropriate medical practice guidelines, including evidence-based standards.
- Any applicable clinical review criteria developed and used by the Plan (unless contrary to the Plan or applicable law).
- The opinion of the IRO's clinical reviewer.

The IRO will provide written notice of the final external review decision to you and the Plan within 45 days after the IRO receives the external review request. Such notice will include: (i) an explanation of the primary reason(s) for the IRO's decision, (ii) references to the evidence or documentation considered in reaching the decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision, (iii) the binding effect of the decision with a statement that judicial review may be available to you, and (iv) current contact information for any applicable office of health insurance consumer assistance or ombudsman.

Expedited External Review. Expedited external review is available for the following cases:

- You or your dependent has a medical condition for which the time period for completion of the standard external review would seriously jeopardize your or your dependent's life, health or ability to regain maximum function, as determined by your attending provider; or
- The internal appeal denial concerns an admission, availability of care, continued stay, or health care item, service, or other benefit for which you or your dependent received emergency services, but have not been discharged from a provider's facility.

You must file a request for expedited external review. The request should be filed with the following vendors:

Expedited External Review		
Benefit	**Company**	**Phone Number**
Hospital	Anthem Blue Cross	(800) 274-7767
Mental Health and Substance Abuse	ValueOptions	(866) 277-5383
Prescription Drugs	Express Scripts	(800) 864-1135
All Other Benefits	Health Plan Office	(818) 954-9400 or (800) 777-4013

Upon receipt of the request the preliminary review will be performed as soon as possible without regard to the five business days. A notice of determination will be sent as soon as the preliminary review is completed.

If the request is eligible for expedited external review, the Plan or its designee shall assign an IRO in accordance with the external review procedures and transmit or provide all required documents and information electronically or by telephone or facsimile or by any other available expeditious method.

The IRO must provide its final external review decision in accordance with the external review standards described previously and provide notice of such decision as expeditiously as you or your dependent's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request.

Reversal of Denial. In the event the claim denial or the internal appeal denial is reversed by the Plan, its designee or the IRO, the Plan will provide coverage or payment for the claim in accordance with applicable law and regulations, but reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law and regulations.

90 Day Limitation on When a Lawsuit May Be Filed

You may file a lawsuit to obtain benefits after you have exhausted the internal review process and the external review process if applicable, and a final decision has been reached. You may also file a lawsuit if the Plan or IRO does not reach a decision, or notify you that an extension is necessary within the appropriate time periods described previously.

A lawsuit may not be filed more than 90 days after the earlier of: (i) the date you receive the Plan's or IRO's written decision on your appeal, or (ii) the end of the appeals and extension time periods described previously.

Contribution And Dependent Verification Program

CONTRIBUTION VERIFICATION AUDITS

Periodically the Plan discovers that reported earnings are intentionally misrepresented in order to obtain Health Plan eligibility. In essence, signatory companies are fraudulently contributing on behalf of performers who do not perform services covered by a SAG-AFTRA Collective Bargaining Agreement or misrepresenting the amount of compensation the performer received for covered services and the basis for the compensation reported. They are "buying" health coverage for participants by contributing the minimum necessary to qualify for Earned Eligibility. Companies and participants who engage in this conduct are liable to the Plan for any overpaid benefits and administrative fees mistakenly or improperly paid by the Plan.

The verification of contributions to the Health Plan is an important aspect of the Plan's integrity because fraudulently obtained benefits deplete the Plan's assets and affect the benefits available to the rest of the participants.

You should maintain and be prepared to supply, upon the Plan's request, copies of employment contracts, proof of service, proof of payments, including payroll stubs, W2 forms, income tax returns and bank records. You bear the burden of demonstrating that you provided services of the type covered by the Collective Bargaining Agreement, and the failure to provide access to such documents may be deemed by the Plan as the basis to disallow any contributions reported for your services.

DEPENDENT VERIFICATION AUDITS

You may be selected for an audit to verify the eligibility of your dependents under the Health Plan. Failure to comply with an audit request can lead to a loss of benefits for your dependents.

By participating in the Health Plan, you are agreeing to cooperate with the Plan's reasonable efforts to audit the status of any dependent. Timely providing information or documents that are required or requested is a condition of your dependent's eligibility for benefits. Therefore, if the information or documents are not provided, the Health Plan in its sole discretion may determine that your dependent does not qualify as a dependent or loses continued eligibility as a dependent. You may be held responsible for any overpayments made as a result of the failure to provide such information or documentation.

When you become eligible for benefits under the Health Plan, you must file a Performer Information Form with the Plan Office. This confidential legal document must be signed by the participant. If the participant is under the age of 18, the parent or legal guardian must sign for the child.

In order to verify dependent eligibility, the Plan performs routine audits. These audits are for your protection to assure that Plan benefits are reserved for eligible participants and their eligible dependents.

If you are selected for an audit, the Plan Office will send you an initial inquiry specifying the documents needed for dependent verification. For example, a copy of a recorded marriage certificate to verify your spouse or a recorded birth certificate for a child. If you cannot locate a requested document, contact the Plan Office which can assist you in contacting the issuing agency. If the Plan Office does not receive a response to its initial request, a follow-up notice will be sent. The failure to respond will be deemed an admission of fraudulent conduct. If there is no response to our second request you will receive a Notice of Termination of Benefits for the unverified dependents. Additionally, you will be responsible for paying back any medical expense paid out by the Health Plan on behalf of non-qualified dependents.

If you need to update your dependents, contact the Plan Office for the proper form.

OVERPAYMENTS

The Health Plan has the right to recover any mistaken payment, overpayment, or any payment made to any individual who was not eligible for that payment. All together, these overpayments are referred to in this SPD as an "overpayment". You will receive written notification if a reimbursement to the Plan is required.

You can be held individually liable for reimbursing the Health Plan for the amount of the overpayment if your eligibility was established because of fraud or intentional misrepresentation of material fact. In addition, the Health Plan has the right to collect the overpayment from you, your eligible dependents (or any individual you have claimed to be your eligible dependent), or your employer, or to pursue each or all of you for reimbursement. The Board of Trustees can take all actions as it determines appropriate, in its sole discretion, to recover the overpayment. Such actions may include:

- Reducing the amount owed to the Health Plan by applying the amount of contributions made by your employer on your behalf during the relevant period;
- Entering into written agreements for the repayment of overpaid benefits, with interest if applicable; and
- Requiring that the amount of overpayment be deducted from all future benefit payments for you and your eligible dependents until the full amount is paid.

In addition, the Board of Trustees may in their discretion, seek payment of such amounts through filing a lawsuit or taking any other measure they deem necessary and appropriate. You, your eligible dependent(s) (or any individual you have claimed to be your eligible dependent), and your employer are also responsible for paying the Health Plan all expenses incurred collecting the overpayment, audit fees, attorneys' fees and interest calculated from the date of the initial overpayment.

FALSE OR FRAUDULENT CLAIMS

Anyone who submits any false or fraudulent claim or information to the Health Plan may be subject to criminal penalties including a fine or imprisonment or both as well as damages in a civil action under California or federal law. Furthermore, the Board of Trustees reserves the right to impose such restrictions upon the payment of further benefits to any such participant or dependent as may be necessary to protect the Health Plan, including the deduction from such future benefits of amounts owed to the Health Plan because of the payment of any false or fraudulent claim. The participant, dependent or any individual you have claimed to be your eligible dependent must pay the Health Plan for all its legal and collection costs as well as benefit payments made (with interest).

If it is determined that a participant became eligible for Health Plan benefits as a result of earnings which are determined to be non-Covered Earnings, the participant's coverage could be cancelled immediately. Also, to the extent permitted by law, the participant may be obligated to refund all benefits received in excess of contributions by the participant's employer to the Health Plan on the participant's behalf. If the participant also loses Screen Actors Guild – Producers Pension Plan Pension Credit as a result, improper pension contributions may be utilized as an offset against benefits paid to the participant.

Termination of eligibility as a result of a contribution or dependent verification audit does not constitute a Qualifying Event for purposes of the Self-Pay Program.

Notice Of Privacy Practices

The Screen Actors Guild – Producers Health Plan is required by law to maintain the privacy of your medical information and to provide you with notice of its legal duties and privacy practices with respect to that information. The Plan understands that your medical information is personal and we are committed to protecting it. This Notice of Privacy Practices gives you information on how the Plan protects your medical information, when we may use and disclose it, your rights to access and request restrictions to the information, and the Plan's obligation to notify you if there has been a breach of your medical information.

USES AND DISCLOSURES

In many instances, the Plan requires a court order or your written authorization to disclose your medical information. However, the Plan is permitted by law to disclose your medical information without your authorization or court order, as follows:

- **Treatment**: The Plan may share your medical information with doctors and other health care providers for treatment purposes or for the coordination or management of your care. For example, if you are in the hospital due to an accident or illness, the Plan may share your medical information with all health care providers involved in your care and treatment.

- **Payment**: The Plan may use or disclose your medical information for purposes of processing medical claims, verifying your eligibility, determining medical necessity, utilization review and authorizing services. For example, your medical information will be used in making a claim determination.

  In some circumstances it may be necessary for the Plan to disclose your medical information, including your eligibility for health benefits and specific claim information to other covered entities such as health plans in order for the Plan to coordinate benefits between this Plan and another plan under which you may have coverage. We may also disclose your health information and your dependents' health information, on Explanation of Benefit (EOB) forms and other payment-related correspondence, such as pre-certifications which are sent to you.

- **Health Care Operations**: The Plan may use or disclose your medical information for purposes of case management, underwriting/premium rating, quality improvement and overall Plan operations. For example, the Plan periodically obtains proposals from health care companies in an effort to select appropriate provider networks or insurance arrangements for Plan participants. It may be necessary to provide the companies with certain health information, particularly in regard to catastrophic illnesses. Please be aware that the Plan is prohibited from using or disclosing your genetic health information for underwriting purposes.

- **Reminders**: The Plan may use your health information to provide you with reminders. For example, we may use your child's date of birth to remind you that your dependent, who would otherwise lose coverage under the Plan, may enroll in the Self-Pay Program.

- **Business Associates**: The Plan may disclose your medical information to Business Associates. Business Associates are entities retained or contracted by the Plan, such as Anthem Blue Cross, Delta Dental, Express Scripts, ValueOptions and VSP. The Plan has a contract with each Business Associate, whereby they agree to protect your medical information and keep it confidential.

- **Trustees for Purposes of Fulfilling their Fiduciary Duties**: The Plan may disclose your medical information to the Trustees of the Plan who serve on the Benefit Appeals Committee in connection with appeals that you file following a denial of a benefit claim or a partial payment. Trustees may also receive your health information if necessary for them to fulfill their fiduciary duties with

respect to the Plan. Such disclosures will be the minimum necessary to achieve the purpose of the use of disclosure. In accordance with the Plan documents, such Trustees must agree not to use or disclose your health information with respect to any employment-related actions or decision, or with respect to any other benefit plan maintained by the Trustees.

- **Personal Representatives**: The Plan will disclose your medical information to personal representatives appointed by you, and, in certain cases, a family member, close friend or other person in an emergency situation when you cannot give your authorization.

- **Workers' Compensation**: The Plan may disclose your medical information to comply with laws relating to workers' compensation or other similar programs that provide benefits for work-related injuries and illnesses.

- **Legal Proceedings**: The Plan may disclose your health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal. In addition, we may disclose your health information under certain conditions in response to a subpoena, discovery request or other lawful process, in which case, reasonable efforts must be undertaken by the party seeking the health information to notify you and give you an opportunity to object to this disclosure.

- **Secretary**: The Plan will disclose your medical information to the Secretary of Health and Human Services (HHS) or any other officer or employee of HHS to whom authority has been delegated for purposes of determining the Health Plan's compliance with required privacy practices.

- **Health Care Oversight**: The Plan may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and legal actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Military Activity and National Security**: When the appropriate conditions apply, the Plan may use or disclose health information of individuals who are Armed Forces personnel for activities deemed necessary by military command authorities, or to a foreign military authority if you are a member of that foreign military service. We may also disclose your health information to authorized federal officials conducting national security and intelligence activities including the protection of the President.

- **Public Health**: The Plan may disclose your medical information to a public health authority in connection with public health activities.

- **Coroners, Funeral Directors and Organ Donation**: The Plan may disclose your health information to a coroner or medical examiner for identification purposes or other duties authorized by law. The Plan may also disclose your health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his or her duties. We may disclose such information in reasonable anticipation of death. Your health information may be used and disclosed for cadaveric organ, eye or tissue donation and transplant purposes.

- **Disaster Relief**: The Plan may disclose your health information to any authorized public or private entities assisting in disaster relief efforts.

- **Food and Drug Administration**: The Plan may disclose your health information to a person or company subject to the jurisdiction of the Food and Drug Administration (FDA) with respect to a

FDA-regulated product or activity for which that person has responsibility, or for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity.

- **Abuse or Neglect**: The Plan may disclose your health information to any public health authority authorized by law to receive reports of child abuse or neglect. In addition, if the Plan reasonably believes that you have been a victim of abuse, neglect or domestic violence we may disclose your health information to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Inmates**: If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may disclose your health information to the institution or law enforcement official if the health information is necessary for the institution to provide you with health care or protect the health and safety of you or others, or for the security of the correctional institution.

- **Criminal Activity**: Consistent with applicable federal and state laws, we may disclose your health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **As required by law**: The Plan will disclose your medical information as required by law.

The Plan may not use or disclose your medical information for any purposes other than the ones outlined above without your written authorization. Types of uses and disclosures which require your written authorization include:

- **Personal Representatives**: In situations where you wish to appoint a Personal Representative to act on your behalf or make medical decisions for you in situations where you are otherwise unable to do so, the Plan will require your written authorization before disclosing your health information to that individual. The Plan will recognize your previous written authorization designating such individual to act on your behalf and receive your health information until you revoke the authorization in writing.

- **Trustee(s) as Your Representative**: In some circumstances you may request that a Trustee receive your health information if you request the Trustee to assist you in your filing or perfecting of a claim for benefits under the Plan. In these situations the Plan will first request that you complete a written authorization before disclosing the health information.

- **Disclosure to Others Involved in Your Care or Payment of Your Care**: You may designate a manager, agent, accountant, personal assistant or other third party to receive EOBs and other written communications from the Plan with respect to you and your eligible dependents. In such cases the Plan requires that you first file a written authorization with the Plan Office. The Plan will recognize your previous written authorization designating such individuals and will continue to send EOBs and other communications from the Plan to such parties. If you do not want the Plan to continue such communications you must notify the Plan in writing to such effect and give us an alternate address or third party, if any, to whom you would like us to send your information.

- **Psychotherapy notes**: The Plan may not use or disclose the contents of psychotherapy notes without your written authorization.

- **Marketing**: Marketing means situations where the Plan receives financial compensation from

a third party to communicate with you about a product or service and is only allowed if you give your written authorization. Marketing would include instances when an individual or entity tries to sell you something based on your health information. The Plan does not engage in Marketing and will not use your health information for this purpose.

- **Sale of Health Information**: The sale of an individual's health information for financial compensation requires that individual's written authorization. The Plan does not sell health information.

In situations where your written authorization is required in order for the Plan to use or disclose your health information, you may revoke that authorization, in writing, at any time, except to the extent that the Plan has already taken action based upon the authorization. Thereafter, the Plan will no longer use or disclose your health information for the reasons covered by your written authorization.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Right to Inspect and Copy: You may inspect and request copies of your medical information by writing to the Plan's Privacy Officer. You may also have the right to a copy of your medical information in electronic format, but only if it is contained in an Electronic Health Record (EHR). A fee may be charged to cover copying and mailing costs and in the case of a request for a copy of your medical information maintained in an electronic format, we may charge you the amount of our labor costs.

Right to Receive Confidential Communications: The Plan normally provides medical information to participants via U.S. mail. You may request that the Plan communicate your medical information to you in a different way. Your request must be made in writing to the Plan's Privacy Officer and explain the reasons for your request. In certain cases, the Plan may deny your request.

Right to Request Restrictions: You have the right to request additional restrictions on how your medical information is used and disclosed. Your request must be made in writing to the Plan's Privacy Officer and explain the reasons for your request.

Right to Amend: If you believe the medical information the Plan maintains about you is incorrect, you have the right to request an amendment to it. Your request must be made in writing to the Plan's Privacy Officer and explain the reasons for your request. In certain cases, the Plan may deny your request.

Right to Receive an Accounting of Disclosures: You have the right to request a listing of the disclosures we have made of your medical information without your authorization for purposes other than treatment, payment of claims and health care operations (unless such disclosures of your medical information are made through an EHR). Your request must be made in writing to the Plan's Privacy Officer and cannot be for a period longer than six years. In certain cases, the Plan may charge a fee for this request.

Right to Notification in the Event of Breach: A breach occurs where there is an impermissible use or disclosure that compromises the security or privacy of your health information such that the use or disclosure poses a significant risk of financial, reputational or other harm to you. The Plan takes extensive measures to ensure the security of your health information; but in the event that a breach occurs or the Plan learns of a breach by a Business Associate, the Plan will promptly notify you of such breach.

Right to Obtain a Paper Copy of the Plan's Privacy Notice: If you received this Notice electronically (via email or the Internet), you have the right to request a paper copy at any time.

GENETIC INFORMATION

Genetic information is information about an individual's genetic tests, the genetic tests of family members of the individual, the manifestation of a disease or disorder in family members of the individual, or any request for or receipt of genetic services by the individual or a family member of the individual. The term genetic information also includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information about the fetus and with respect to the individual using assisted reproductive technology, genetic information about the embryo.

Federal law prohibits the Plan and health insurance issuers from discriminating based on genetic information. To the extent that the Plan uses your health information for underwriting purposes, federal law also prohibits the Plan from disclosing any of your genetic information. The Plan will not use or disclose any of your genetic information for this purpose.

COMPLAINTS

If you believe your privacy rights have been violated, you have the right to file a formal complaint with the Plan's Privacy Officer and/or with the Secretary of the U.S. Department of Health and Human Services. You cannot be retaliated against for filing a complaint.

EFFECTIVE DATE

The effective date of this Notice is March 25, 2013. The Plan is required by law to abide by the terms of this Notice until replaced. We reserve the right to make changes to this Notice and to make the new provisions effective for all medical information the Plan maintains. If revised, a new Notice will be provided to all participants eligible for or covered by the Plan at that time.

CONTACT

To request additional copies of this Privacy Notice, obtain further information regarding our privacy practices and your rights, or to file a complaint, please contact the Plan's Privacy Officer. This Notice is also posted on our website: **www.sagph.org**.

Name: Privacy Officer
Screen Actors Guild – Producers
Health Plan

Address: *Mailing Address:*
P.O. Box 7830
Burbank, CA 91510-7830

Street Address:
3601 West Olive Avenue
Burbank, CA 91505

Telephone: (818) 954-9400
(800) 777-4013

Email: privacyofficer@sagph.org

Statement Of ERISA Rights

As a participant in the Screen Actors Guild – Producers Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Office, all Plan documents, including insurance contracts, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

Obtain, upon written request to the Chief Executive Officer, copies of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements and copies of the latest annual report (Form 5500 Series). The Chief Executive Officer may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary period of coverage for preexisting conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusions for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the Plan or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a benefit under the Plan is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not

sent because of reasons beyond the control of the Chief Executive Officer.

If you have a claim for health benefits which is denied or ignored, in whole or in part, you may request an external review of the decision by an Independent Review Organization (IRO), following the exhaustion of the Plan's appeal process. External review may also be available if your health coverage has been retroactively terminated unless the decision to terminate coverage was made because you did not meet the Health Plan's eligibility rules. Not all claims are eligible for external review. See pages 92 through 94 for additional information.

You must request an external review within four months after the Plan Trustees' written decision on appeal has been provided. You may also have the right to file suit in state or federal court. However, no legal action may be commenced against the Plan more than 90 days after the final written decision on appeal or external review has been provided. The Plan Trustees' written decision on appeal and the IRO decision on external review, if applicable, will be deemed to have been provided on the fifth business day following the postmark date, if mailed, or the date of delivery, if personally delivered or delivered by facsimile. A copy of this Statement of ERISA Rights, which shall constitute written notice of any applicable limitations period, shall be provided to the applicant along with the written notification of the Plan Trustees' decision on appeal.

If Plan fiduciaries are misusing the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

If you have any questions about your Plan, you should contact the Chief Executive Officer. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Pension and Welfare Benefits Administration at (866) 444-EBSA (3272).

For more information on the Health Plan, please visit:

www.sagph.org

Screen Actors Guild – Producers Health Plan

Facts About Your Plan

NAME AND TYPE OF PLAN

Screen Actors Guild – Producers Health Plan for Motion Picture Actors.

This Plan is a collectively-bargained, joint-trusteed labor-management trust.

PLAN'S IDENTIFICATION NUMBERS

The Employer Identification Number (EIN) assigned to the Plan by the Internal Revenue Service is 95-6024160. The Plan number is 501.

PLAN YEAR

The fiscal year runs from January 1 through December 31.

ADMINISTRATOR

The administrator is the Board of Trustees, made up of an equal number of representatives from the Producers and SAG-AFTRA.

The routine administrative functions are performed by The Screen Actors Guild – Producers Health Plan. The Chief Executive Officer is Christopher S. Dowdell who may be reached at the same address and telephone number as the Board of Trustees (see right).

The Plan is sponsored by various Producers who make contributions on your behalf under SAG-AFTRA Collective Bargaining Agreements. If you want to know whether a particular producer is a sponsor, contact the Plan Office.

NAMES AND ADDRESSES OF THE CURRENT BOARD OF TRUSTEES

To contact the Board of Trustees, write, call, fax or email:

Screen Actors Guild – Producers Health Plan
P.O. Box 7830
Burbank, California 91510-7830
(818) 954-9400 or (800) 777-4013
Fax: (818) 953-9880
Website: **www.sagph.org**
Email: psd@sagph.org

As of July 1, 2013 the Trustees of this Plan are:

Union Trustees	Producer Trustees
Mr. Daryl Anderson	Mr. Jay Barnett
Ms. Amy Aquino	Mr. Ted Bird
Ms. Timothy Blake	Ms. Tracy Cahill
Mr. Jim Bracchitta	Ms. Eryn Doherty
Mr. John Carter Brown	Ms. Marla Johnson
Mr. Duncan Crabtree-Ireland	Mr. Robert W. Johnson
Ms. Leigh French	Mr. Sheldon Kasdan
Mr. Barry Gordon	Ms. Shelley Landgraf
Mr. Al Hubbs	Ms. An T. Le
Mr. Bob Kaliban	Ms. Carol Lombardini
Mr. Richard Masur	Ms. Stacy K. Marcus
Mr. John T. McGuire	Ms. Diane P. Mirowski
Mr. Joseph Ruskin	Mr. Paul Muratore
Mr. John H. Sucke	Mr. Alan H. Raphael
Ms. Kathryn Swink	Mr. John E. Rhone
Ms. Kim Sykes	Mr. Robert Todd
Mr. Ned Vaughn	Mr. David Weissman
Mr. David P. White	Mr. Samuel P. Wolfson

AGENT FOR SERVICE OF LEGAL PROCESS

Legal process may be served on the Trustees or the Chief Executive Officer at:

Screen Actors Guild – Producers Health Plan

Street Address:
3601 West Olive Avenue
Burbank, CA 91505

Mailing Address:
P.O. Box 7830
Burbank, CA 91510-7830

COLLECTIVE BARGAINING AGREEMENTS

Contributions to the Plan are made on behalf of each employee in accordance with Collective Bargaining Agreements between SAG-AFTRA and employers in the industry.

The Collective Bargaining Agreements are available on the SAG-AFTRA website: www.sagaftra.org. Or, you may request that the Plan Office provide you with a copy of the applicable Collective Bargaining Agreement. You will be charged a reasonable amount for copying. The agreement is available for inspection at the office of the Chief Executive Officer.

SOURCE OF FINANCING

The Collective Bargaining Agreements require contributions by Producers to the Plan based on a percentage of a participant's compensation. In addition, the Plan requires participants to pay a premium for coverage. Participants and dependents whose eligibility under the Plan has terminated may continue coverage by making self-payments in accordance with the rules of the Self-Pay Program.

POWERS OF THE BOARD OF TRUSTEES

The benefits provided under the Plan are not contractual benefits. Therefore, the Board of Trustees reserves the right, in its sole discretion at any time and from time to time:

- To terminate or amend the amount or condition of any benefits even though such termination or amendment affects claims which have already been incurred.
- To alter or postpone the method of payment of any benefit.
- To amend or rescind any other provisions of the Plan.

The Trustees do not promise to continue the benefits and coverage in full or in part in the future, and rights to future benefits and coverages are not vested. In particular, retirement or the completion of the requirements to receive a pension benefit under the SAG – Producers Pension Plan does not give any participant or former participant any vested right to continued benefits or coverages under the Health Plan.

The Board of Trustees are authorized and empowered to:

- Construe the meaning of any doubtful or ambiguous provision of the Plan.
- Decide on a participant's entitlement to or application for benefits under the Plan.
- Execute all such agreements, adopt and promulgate all such reasonable rules and regulations, take all such proceedings and exercise all such rights and privileges as are necessary in the establishment, maintenance and administration of the Plan.

Decisions on doubtful or ambiguous provisions or a participant's entitlement to or application for benefits shall be final and binding upon all affected parties.

TYPE OF BENEFITS PROVIDED BY THE PLAN

The Plan provides hospital, medical, prescription drug, mental health and substance abuse, dental, vision, life insurance and accidental death and dismemberment benefits. It also provides access to discount eye wear.

ORGANIZATIONS THROUGH WHICH BENEFITS ARE PROVIDED

The carrier listed below provides fully insured benefits under the Plan.

Company	Benefits
Metropolitan Life Insurance Company Group Life Claims 123 Wyoming Avenue Scranton, PA 18503	Life insurance and accidental death and dismemberment benefits

The Plan is fully self-insured for the benefits obtained through the carriers listed below. These carriers administer at least a portion of the benefits for the Plan, but do not insure or otherwise guarantee any of the benefits of the Plan.

Company	Benefits
Anthem Blue Cross 21555 Oxnard Street Woodland Hills, CA 91367	Administers the hospital and medical benefits and provides access to its network of hospital and medical providers
The Industry Health Network 23388 Mulholland Drive Woodland Hills, CA 91364-2792	Provides access to its network of medical providers inside California
Express Scripts, Inc. One Express Way St. Louis, MO 63121	Administers the prescription drug benefit and provides access to its network of retail and home delivery pharmacies
ValueOptions 10805 Holder Street Cypress, CA 90630	Administers the mental health and substance abuse benefit and provides access to its network of providers
Delta Dental of California 100 First Street San Francisco, CA 94105	Administers the dental benefit and provides access to its network of dental providers
VSP 3333 Quality Drive Rancho Cordova, CA 95670	Administers the vision benefit and provides access to its network of vision providers

Individual hospital and medical conversion policies are provided by Anthem Blue Cross in California or the local Blue Cross Blue Shield plan for states outside of California. Metropolitan Life Insurance Company provides life insurance conversion policies.

REQUIREMENTS WITH RESPECT TO ELIGIBILITY FOR PARTICIPATION AND BENEFITS

The Eligibility requirements are outlined on pages 1 through 15 of this book.

CIRCUMSTANCES RESULTING IN DISQUALIFICATION, INELIGIBILITY OR DENIAL OR LOSS OF BENEFITS

Loss of Earned Eligibility is described on page 16 of this book.

Loss of Self-Pay coverage is described on page 24 of this book.

Audit verification procedures and the recovery and offset of future benefit payments are described on pages 61, 95 and 96 of this book.

EXPIRED CHECK LIMIT

Replacement checks will not be issued for any lost or expired checks if more than four years have elapsed from the date of issue.

PROCEDURES TO FOLLOW FOR FILING A CLAIM

The procedure to be followed in filing a claim for benefits is described on pages 84 through 86 of this book.

IV. GLOSSARY OF TERMS

The following definitions apply whether or not such terms are capitalized when used in this book.

Allowable Charges or Allowed Amount or Allowance. The amount established by the Board of Trustees from time to time, for the area in which they are incurred, but not to exceed the incurred charges.

Case Management. A program in which a coordinator works with the patient, his or her physician, his or her family, and the Health Plan to decide an appropriate treatment plan in the event of catastrophic or chronic sickness or injury.

Collective Bargaining Agreement. The agreement or agreements in force and effect from time to time between SAG-AFTRA and Producers with respect to the employment and services of actors in the production of motion pictures and which provide for contributions by such Producers into the Health Plan.

Contract Allowance. The amount a network provider must accept as the total charge. Network providers cannot bill you for covered charges in excess of the Contract Allowance.

Coordination of Benefits (COB). The method of dividing responsibility for payment among the health plans that cover an individual so that the total of all reasonable expenses for covered services will be paid. Special rules apply to coordination with other entertainment industry health plans (EICOB).

Copay and Coinsurance. These refer to the amounts you pay for provider services after the deductible has been satisfied. Copays are generally flat dollar amounts, such as the $15 copay for office visits to network physicians under Plan I or the $200 emergency room copay under Plan II. Coinsurance is generally a percentage of the Plan's Allowance, such as the 30% coinsurance a participant who sees non-network physicians must pay.

Cosmetic Surgery. Any surgery or procedure which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. Surgery to correct birth defects of individuals under age 19, or prompt repair of accidental injury, or mammoplasty following a mastectomy shall not be considered cosmetic under the Health Plan.

Custodial Care. Treatment or services, regardless of who recommends them or where they are provided, that could be given safely and reasonably by a person not medically skilled and are designed mainly to help the patient with daily living. Examples include help with walking, bathing, dressing, and using the toilet.

Deductible. This refers to the amount of covered expenses you must pay before the Plan begins to pay. There are separate deductibles for hospital, medical, prescription drug and dental coverage. Deductibles may be higher when you use non-network providers.

Dentist. A person duly licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered.

Durable Medical Equipment. Includes medical supplies such as bandages and surgical dressings obtained in a physician's office, surgical supplies such as appliances to replace lost physical organs or parts or to aid in their functions when impaired, oxygen and equipment for the administration of oxygen, wheelchairs or hospital-type beds, mechanical equipment for the treatment of respiratory paralysis and blood and blood plasma. Payment will be made only if the supplies and/or equipment:

1. Are prescribed by a covered provider; and
2. Are provided by a qualified DME supplier; and
3. Are used by the eligible individual for whom a claim has been made; and

4. Cannot be used where sickness or injury is not present; and

5. Can withstand repeated use; and

6. Are not general use items which can be used by other family members.

Entertainment Industry Coordination of Benefits (EICOB). EICOB refers to the special rules for coordinating benefits for individuals who are covered under the Screen Actors Guild – Producers Health Plan and another entertainment industry health plan(s).

Experimental or Investigative Procedures. A drug, device, medical treatment or procedure is experimental or investigative if:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

3. Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, or is the research, experimental, study or investigative arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

4. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Explanation of Benefits (EOB). The EOB statement is a summary of services provided and the amounts paid.

Health Plan or Plan. The Health Plan, or Plan, means the benefits provided by the Screen Actors Guild – Producers Health Plan. The Health Plan is subject to change or termination by the Board of Trustees at any time.

Hospital. An institution legally operating as a hospital which (i) is primarily engaged in providing, for compensation from its patients, inpatient medical and surgical facilities for diagnosis and treatment of sickness or injury and the care of pregnancy, and (ii) operated under the supervision of a staff of physicians and continuously provides nursing services by graduate Registered Nurses for 24 hours of every day.

The term Hospital shall not include any institution which is operated primarily as a rest, nursing or convalescent home, or any institution or part thereof which is principally devoted to the care of the aged or the treatment of drug or alcohol abuse or any institution engaged in the schooling of its patients.

Medically Necessary. The Plan determines if a service or supply is medically necessary for the diagnosis or treatment of an accidental injury, sickness, pregnancy or other medical condition. This determination is based on and consistent with standards approved by the Plan's medical consultants. These standards are developed, in part, with consideration as to whether the service or supply meets the following:

1. It is appropriate and required for the diagnosis or treatment of the accidental injury, sickness, pregnancy or other medical condition.

2. It is safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications.

3. There is not a less intensive or more appropriate diagnostic or treatment alternative that could have been used in lieu of the service or supply given.

Network. This refers to providers in one of the Plan's provider networks which are outlined on page 31. Services from network providers give you the best value for your health dollar.

Network Level of Benefits. There are certain times the Plan pays the network level of benefits when you use non-network providers. In these cases, you are responsible for the lower network deductibles, copays and coinsurance **plus** the difference between the Plan's Allowance and the billed amount.

Non-Network. This refers to providers who are not in one of the Plan's networks. Your out-of-pocket expenses are usually greater using these providers.

Notice of Eligibility (NOE). Your NOE is sent to you after you pay your premium during the Open Enrollment Period. Your NOE contains your Health Plan ID cards, information regarding your benefit coverage and a list of your enrolled dependents.

Physician. A duly licensed doctor of medicine authorized to perform a particular medical or surgical service within the lawful scope of his or her practice.

Producers. A person or entity signatory to a Collective Bargaining Agreement between SAG-AFTRA and the person or entity or producer representatives requiring contributions to the Health Plan. Producer also means SAG-AFTRA, the SAG Foundation and the Screen Actors Guild – Producers Pension and Health Plans as employers required to make contributions to the Health Plan.

Reasonable Charge. For services rendered by or on behalf of a physician, the Reasonable Charge is an amount not to exceed the amount determined by the Plan in accordance with the applicable fee schedule adopted by the Board of Trustees. For all other charges, the Reasonable Charge is an amount measured and determined by the Plan by comparing the actual charge for the services or supply with the prevailing charges made for it. In determining the prevailing charge the Plan takes into account all pertinent factors including the complexity of the service, the range of services provided and the prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

While the Plan staff will do its best to answer any questions you have concerning the Reasonable Charge over the phone, you may not rely on any information obtained in that manner. Only information in writing signed on behalf of the Board of Trustees can be considered official.

Totally Disabled. With respect to an adult participant or adult dependent, a person who is prevented, solely because of sickness or accidental bodily injury, from performing the material and substantial duties of their regular occupation. With respect to a minor participant or minor dependent, Totally Disabled means a person who is presently suffering from a sickness or accidental bodily injury, the effects of which are likely to be of long or indefinite duration and which will prevent him or her from engaging in most of the normal activities of a person of like age and sex in good health.

Trust Agreement. This is the Screen Actors Guild – Producers Health Plan Trust Agreement entered into as of February 1, 1960 and any modification, amendment, extension or renewal thereof.

Trustees. The Board of Trustees (and its respective authorized agents) as established and constituted from time to time in accordance with the Health Plan Trust Agreement

Plan I Benefits Summary

Hospital and Medical

Benefit	Plan I	
Hospital	**Network Provider**	**Non-Network Provider**
Calendar Year Deductible	**The Industry Health Network** - $150 / person; $300 / family **BlueCard PPO / ValueOptions** - $250 / person; $500 / family	Not covered
Inpatient (Room and Board and Ancillary Services)	90%	Not covered*
Outpatient Surgery	90%	Not covered
Emergency Room	90% after $100 copay; copay is waived if immediately confined	Not covered*
Out-Of-Pocket Maximum (excludes Deductible and Copays)	$1,750 / person; $3,500 / family	Not covered
Medical	**Network Provider**	**Non-Network Provider**
Calendar Year Deductible	**The Industry Health Network** - None **BlueCard PPO / ValueOptions** - $250 / person; $500 / family	$500 / person; $1,000 / family
Office Visit (including X-ray and Lab)	90% after $15 copay	70%
Surgeon -		
Inpatient	90% after $100 copay	70%
Outpatient Hospital, Surgical Center, Surgical Suite	90% after $100 copay	70%
Doctor's Office	90% after $15 copay	70%
Maternity Care -		
Prenatal Visits	No deductible; 100%	70%
Delivery	90% after $100 copay	70%
Routine Physical Exam	No deductible; 100%	No deductible; 70%
Routine Child Exam	No deductible; 100%	No deductible; 70%
Mammogram/Pap	No deductible; 100%	No deductible; 70%
Out-Of-Pocket Maximum (excludes Deductible and Copays)	$1,000 / person; $2,000 / family	$2,500 / person; $5,000 / family
Hospital / Medical Lifetime Maximum	None	None

* Emergency treatment within 72 hours after an accident or within 24 hours of a sudden and serious illness will be covered at the Network Level of Benefits.

Plan II Benefits Summary

Hospital and Medical

Benefit	Plan II	
Hospital	**Network Provider**	**Non-Network Provider**
Calendar Year Deductible	**The Industry Health Network** - $150 / person; $300 / family **BlueCard PPO** - $500 / person; $1,000 / family	Not covered
Inpatient (Room and Board and Ancillary Services)	90%	Not covered*
Outpatient Surgery	90%	Not covered
Emergency Room	90% after $200 copay; copay is waived if immediately confined	Not covered*
Out-Of-Pocket Maximum (excludes Deductible and Copays)	$1,750 / person; $3,500 / family	Not covered
Medical	**Network Provider**	**Non-Network Provider**
Calendar Year Deductible	**The Industry Health Network** - None **BlueCard PPO** - $500 / person; $1,000 / family	$750 / person;$1,500 / family
Office Visit (including X-ray and Lab)	90% after $25 copay	70%
Surgeon -		
Inpatient	90% after $100 copay	70%
Outpatient Hospital, Surgical Center, Surgical Suite	90% after $100 copay	70%
Doctor's Office	90% after $25 copay	70%
Maternity Care -		
Prenatal Visits	No deductible; 100%	70%
Delivery	90% after $100 copay	70%
Routine Physical Exam	No deductible; 100%	Not covered
Routine Child Exam	No deductible; 100%	Not covered
Mammogram/Pap	No deductible; 100%	70%
Out-Of-Pocket Maximum (excludes Deductible and Copays)	$1,000 / person; $2,000 / family	$2,500 / person;$5,000 / family
Hospital / Medical Lifetime Maximum	None	None

* Emergency treatment within 72 hours after an accident or within 24 hours of a sudden and serious illness will be covered at the Network Level of Benefits.

Plan I Benefits Summary

Prescription Drugs, Mental Health and Substance Abuse, Dental and Vision

Benefit	Plan I	
Prescription Drugs	**Express Scripts Participating Retail Pharmacy**	**Express Scripts Home Delivery (includes Specialty)**
	Specialty medications must be obtained by mail through the specialty pharmacy, Accredo.	
Calendar Year Deductible	$150 / person; $300 / family	
Supply	Up to a 30 day supply / prescription or refill	Up to a 90 day supply / prescription or refill
Copay	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. Generic prescription contraceptives are covered at 100% with no deductible or copay.	The greater of: Generic - $20 or 10%; max copay is $50 / prescription Preferred Brand - $50 or 25%; max copay is $125 / prescription Non-Preferred Brand - $100 or 40%; max copay is $300 / 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 subject to the maximum copays listed above. Generic prescription contraceptives are covered at 100% with no deductible or copay.
Mental Health and Substance Abuse	**ValueOptions Provider**	**Non-Network Provider**
Hospital and Alternative Levels of Care	Covered under the Hospital Benefit	Not covered
Medical	Covered under the Medical Benefit	Covered under the Medical Benefit
Dental	**Delta Dental PPO Provider**	**Delta Premier and Non-Network Providers**
Calendar Year Deductible	$75 / person; $200 / family; waived for diagnostic and preventive	$75 / person; $200 / family
Diagnostic and Preventive Benefits	100%	75%
Basic Benefits	75%	75%
Major Benefits	50%	50%
Calendar Year Maximum*	$2,500	$2,500
Vision - Exam Plus Plan	**Vision Service Plan Provider**	**Non-Network Provider**
Eye Exams	100% after $10 copay; one exam / calendar year	80% up to maximum payment of $50; one exam / calendar year
Glasses	20% discount	No benefit
Professional Services for Contact Lenses	15% discount	No benefit

* There is no maximum for individuals under age 19.

Plan II Benefits Summary

Prescription Drugs, Mental Health and Substance Abuse, Dental and Vision

Benefit	Plan II	
Prescription Drugs	**Express Scripts Participating Retail Pharmacy**	**Express Scripts Home Delivery (includes Specialty)**
	Mental health/substance abuse medications are not covered. Specialty medications must be obtained by mail through the specialty pharmacy, Accredo.	
Calendar Year Deductible	$150 / person; $300 / family	
Supply	Up to a 30 day supply / prescription or refill	Up to a 90 day supply / prescription or refill
Copay	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. Generic prescription contraceptives are covered at 100% with no deductible or copay.	The greater of: Generic - $20 or 10%; max copay is $50 / prescription Preferred Brand - $50 or 25%; max copay is $125 / prescription Non-Preferred Brand - $100 or 40%; max copay is $300 / 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 subject to the maximum copays listed above. Generic prescription contraceptives are covered at 100% with no deductible or copay.
Mental Health and Substance Abuse	**ValueOptions Provider**	**Non-Network Provider**
Hospital and Alternative Levels of Care	Not covered	
Medical		
Dental	**Delta Dental PPO Provider**	**Delta Premier and Non-Network Providers**
	Must have three or more years of prior Earned Eligibility.	
Calendar Year Deductible	$100 / person; no family maximum; waived for diagnostic and preventive	$100 / person; no family maximum
Diagnostic and Preventive Benefits	100%	60%
Basic Benefits	60%	60%
Major Benefits	50%	50%
Calendar Year Maximum*	$1,000	$1,000
Vision - Exam Plus Plan	**Vision Service Plan Provider**	**Non-Network Provider**
Eye Exams	Not covered	
Glasses		
Professional Services for Contact Lenses		

* There is no maximum for individuals under age 19.

GENERAL INDEX

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For more information on the Health Plan, please visit:

www.sagph.org

Screen Actors Guild – Producers Health Plan

Screen Actors Guild–Producers
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