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IMPORTANT REMINDER: New Health Plan Premium Structure

Effective July 1, 2011

This is a reminder that beginning July 1, 2011, the Health Plan will transition to a new premium rate structure for participants with Earned Eligibility. The new structure will offer different premium payments based on the number of dependents you choose to enroll for coverage.

The new quarterly rates are outlined below.

Earned Premiums Effective July 1, 2011

	Plan I	Plan II	Plan II Age & Service*
Single (Participant Only)	\$273	\$324	\$414
Two-Party (Participant and 1 dependent)	\$315	\$372	\$477
Participant and 2+ (Participant and 2 or more dependents)	\$342	\$405	\$519

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

The new premium structure does not apply to participants covered under the Senior Performers Plan or the Extended Spousal Benefit. Self-Pay rates will move to the tiered structure effective January 1, 2012.

Each time you qualify for health coverage, you will be mailed an Open Enrollment Packet. This packet will include a listing of your dependents on file who are currently covered under the Health Plan and the Tier Rate based on this number of covered dependents. You will be given the opportunity to enroll or dis-enroll dependents for coverage during the Open Enrollment Period. Open Enrollment is the 40-day period prior to the start of your new eligibility period. All enrollments or dis-enrollments must be made during the Open Enrollment Period and are set for your entire eligibility period unless you incur a life event. Life events include divorce, dissolution of a same-sex domestic partnership, adoption or birth of a child, or death of a dependent.

If you choose to continue to cover all of your listed dependents (no change), you simply need to submit your premium payment prior to the deadline.

If you wish to make changes to your covered dependents, you will need to complete the Enrollment/Dis-Enrollment Form included in your Open Enrollment Packet or visit the Plan's website at www.sagph.org and complete the form online. Again, enrollments and dis-enrollments can only be made during the Open Enrollment period outlined in your packet. **We strongly encourage use of our website as this is the quickest method to update your dependents during Open Enrollment and to submit your premium payment to ensure coverage for you and your dependents.**

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Reminder of Coordination of Benefits Rules

Special Rules for Coordination of Benefits with Other Entertainment Industry Health Plans

Beginning January 1, 2005 the Trustees adopted special rules for coordinating benefits with other entertainment industry health plans. If you are eligible for primary coverage with another entertainment industry plan, but fail to pay the premium in that plan, the SAG-Producers Health Plan will maintain its secondary position. This means the Plan will pay no more than 20% of the allowed amount on the claim. The balance of the bill is your responsibility. For this rule, the entertainment industry health 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 Plan. **Please see pages 68-70 of the 2007 Summary Plan Description or visit our website at www.sagph.org for detailed information.**

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. Coordination of Benefits rules, which apply when you qualify for coverage under more than one health plan, 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 coordination of benefits.

Determining Which Plan Is Primary

If you are covered as a participant under both the SAG-Producers Health Plan and another entertainment industry plan, your primary plan is the plan under which you have had the longest continuous eligibility (or qualification for coverage), regardless of whether or not you paid the premium for coverage under that plan. For example, suppose you do not qualify for any entertainment industry cover-



age. On July 1, 2011 you qualify for Earned Eligibility with the SAG-Producers Health Plan and then on October 1, 2011 you qualify for Earned Eligibility with another entertainment industry health plan. In this case, the SAG-Producers Health Plan is your primary plan. A plan remains in primary position regardless of whether or not you have gaps in coverage due to non-payment of a premium. A plan can move out of primary position only when you fail to earn eligibility (or qualify for coverage) in that plan.

Special COB Rules

When the date of longest continuous coverage is exactly the same for both plans:

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 at (800) 777-4013.

Equity-League Health Plan:

The Plan will not apply the special coordination of benefits rule to Equity-League Health Plan participants who choose to defer their coverage under the January 1, 2007 deferral rule.

Individual coverage only plans:

If your primary plan provides individual coverage only and excludes coverage for your dependents, the SAG-Producers Health Plan will continue to pay primary for your dependents. Currently, the only

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Reminder of Coordination of Benefits Rules, *continued from page 2*

entertainment industry plan that offers individual coverage is the AFTRA Individual Plan. The other entertainment industry plans, including the AFTRA Family Plan, offer family coverage, even though they may require you to pay an additional amount to cover your family. **If you qualify for family coverage under your primary plan, you must pay that plan's premium for you and your dependents or else the SAG-Producers Health Plan will pay only 20% of the allowed amount on claims.**

If you are married and both you and your spouse are eligible for SAG-Producers Health Plan coverage and coverage under another entertainment industry plan:

If the SAG-Producers Health Plan is primary for one or both participants, the Plan will not penalize the family for failure to pay all three premiums. This means you can choose to pay for only one SAG-PHP coverage and you and your family will receive primary coverage.

If you have coverage with any plan other than the SAG-Producers Health Plan, please always inform the Plan Office. If your other coverage terminates, please submit a copy of your termination letter, including a HIPAA certification of coverage.

Coordination of Benefits with Medicare

The same general rule applies for Medicare claims. If you have primary coverage with Medicare and secondary with the SAG-Producers Health Plan, but you fail to enroll in Medicare, the SAG-Producers Health Plan will only pay up to 20% of the allowed charges. If you have any questions regarding the Plan's coordination of benefits with Medicare, please see pages 72 and 73 of the January 1, 2007 Health Plan Summary Plan Description or contact the Plan Office at (800) 777-4013.

Cervical Traction Units Covered

Retroactive to January 1, 2010

Cervical traction units are listed in the January 1, 2007 Health Plan Summary Description as a specific exclusion. Effective retroactive to January 1, 2010, the Plan will consider coverage of a cervical traction unit under the major medical benefit if it is determined to be medically appropriate and prescribed by a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.). Cervical traction units prescribed by a chiropractor (D.C.) will not be covered. This benefit is subject to the calendar year major medical deductible.

If you were charged for the use of a cervical traction unit on or after January 1, 2010 and you believe it might be covered under this new benefit, please submit your claim directly to the Plan Office.

Important Reminder: New Health Plan Premium Structure,

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If you and your dependents are currently eligible for health coverage, you will have the opportunity to dis-enroll all or some of your dependents prior to the rate change on July 1st. You will receive instructions and forms beginning in April for this purpose. Please make sure to review the important information in this packet carefully.

IMPORTANT NOTE: If you are also eligible for coverage with another entertainment industry health plan and you select Single (Participant only) coverage, your non-covered dependents may be affected by the "Special Rules for Coordination of Benefits with Other Entertainment Industry Health Plans." Please see the article on page 2 for more information. If you have any questions, please call the Participant Services Department at (800) 777-4013 and also make sure to call customer service at your other plan to discuss your individual situation.

Preventive Care Services *Under The Affordable Care Act*

Effective January 1, 2011 services specifically identified under the ACA as “preventive services” will be paid at 100% with no cost share if they are rendered by a network provider. A list of these preventive services was contained in the December 2010 Special Edition Take 2 and additional detail regarding these items may be found online at www.healthcare.gov/center/regulations/prevention/taskforce.html.



The Plan will also continue to offer its wellness benefit which covers preventive care received at non-network providers as well as certain services received from network providers that are not on the ACA preventive services list. Examples of wellness services are annual mammograms for women under age 40 and bone density tests for women under age 60.

There may be times when your claim will be partially paid under the preventive services benefit and partially paid under the wellness benefit. For example, if you go to your doctor for an annual physical, not only do you have a physical examination, but your doctor will usually also order several tests. Some of those tests are on the list of preventive services, and depending on your age or other factors as outlined on the list, are considered preventive care. These tests would be paid at 100% of the network contract allowance. Some of the tests ordered by your doctor might not be on the preventive services list. If these tests qualify under the Plan’s wellness benefit they would be subject to any applicable deductibles, co-pays, or co-insurance.

To avoid cost sharing you must use a network provider, the primary purpose of your office visit must be for preventive care, and the services provided must meet the criteria and be on the list of preventive services at www.healthcare.gov/center/regulations/prevention/taskforce.html.

Clarification Regarding Anesthesia During Colonoscopy or Other Endoscopic Procedure

What The Plan Covers

The Health Plan encourages participants to take advantage of the wellness benefits offered by the Plan, one of which is a routine colonoscopy for participants beginning at age 50. Colonoscopies are an important health-screening tool, but the procedure can cause anxiety in some people because they fear it might be painful. The pain control method routinely used during this procedure is called moderate sedation. It is generally rendered by the gastroenterologist or a member of his team and is included in the fee for the colonoscopy.

In some cases, however, a patient may have a medical condition that necessitates the use of certain drugs, which can only be administered by an anesthesiologist. If your surgeon recommends that an anesthesiologist be present during your colonoscopy, it is suggested that you contact the Plan Office to find out if this service might be covered. **The Plan will not cover a separate anesthesiologist’s charges unless it is determined to be medically necessary.** If you have any concerns or questions regarding your comfort during the procedure, talk with your surgeon in advance. Also, check with your surgeon before the procedure to determine if he or she intends to use an anesthesiologist, as this may increase your out-of-pocket expense. It is always a good idea to call the Plan Office and clarify your coverage before undergoing a medical procedure.

Removal of Annual Maximum for Pediatric Dental Services

The ACA also requires that “pediatric dental services” be covered with no annual dollar limit. Although these services have not yet been defined, the Trustees have adopted a conservative compliance approach and have eliminated the calendar year dental maximum for individuals under age 19 effective January 1, 2011. This change applies to both Plan I and Plan II dental benefits. Orthodontia benefits are still excluded.

Visit Limits Removed for Certain Therapies

As part of the on-going compliance effort with the Affordable Care Act (ACA), the Trustees are pleased to announce the removal of the limitation on the number of covered visits for the following types of therapy effective January 1, 2011:

- Occupational
- Osteopathic manipulation
- Physical or physical medicine
- Speech
- Vision

Although the visit limits will be removed, the Plan will continue to apply its medical necessity requirement. All therapy visits must be medically necessary for the diagnosis or treatment of an accidental injury, sickness, pregnancy or other medical condition. The complete definition for “medically necessary” appears on page 92 of the 2007 Health Summary Plan Description. **These visits will also count toward the visit maximums for other therapies. For example, if you have 12 sessions of physical therapy, then want to see a chiropractor, you will have already met your visit maximums and any chiropractic visits will not be covered.**

Quarterly visit limits will remain in place for acupuncture, biofeedback and chiropractic treatment.

The table below outlines the Plan’s therapy allowances and visit maximums as of January 1, 2011. Therapy benefits are subject to the major medical deductible and applicable co-pays/co-insurance.

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

* The Plan will not consider more than 12 outpatient visits 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 used five physical therapy visits during a calendar quarter and then wanted to visit a chiropractor, you would have seven visits remaining for the quarter.

Coverage for Remicade Now Available

Through Accredo, Medco’s Specialty Pharmacy

Remicade is a specialty medication used to treat inflammatory disorders such as Crohn’s disease and rheumatoid arthritis. It is generally administered in a hospital or doctor’s office and has been covered under the Health Plan’s major medical benefit. Effective January 1, 2011, the Trustees moved coverage for Remicade to the Plan’s specialty drug program. As is the case with other specialty drugs, Remicade must be obtained through Accredo, Medco’s specialty pharmacy. It is subject to the prescription drug deductible and the mail order co-pay.

When you fill your specialty drug prescriptions through Accredo, you receive access to nurses and pharmacists trained in specialty medications 24 hours a day, 7 days a week. Accredo can also arrange for your prescription to be delivered directly to your doctor’s office for administration. For more information, call Medco’s Member Services at (800) 903-4728.





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PO Box 7830
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Moving???

When you move, you must notify the Pension and Health Plan Office so that you will continue to receive information about your eligibility and benefits. This is especially important now that premium payment coupons are mailed every quarter to your address on file.

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

- Online at www.sagph.org
- Call the Plan Office
- File a Change of Address Card
- Write or FAX a letter to the Plan Office

The Screen Actors Guild is a separate entity from the Pension and Health Plans and requires a separate notice for change of address.

PENSION AND HEALTH PLANS DIRECTORY

Burbank Plan Office: (818) 954-9400 or (800) 777-4013
Fax: (818) 953-2525
E-mail address: psd@sagph.org
website: www.sagph.org

IF YOU NEED:ASK FOR:

Benefit and Eligibility Information..... Participant Services

Pension Plan Information Pension Department,
Ext. 2020

Information on Medical Claims..... Participant Services

Information on Dental Claims
Delta Dental – Member Services..... (800) 846-7418
– Directories..... (800) 846-7418

Information on Prescription Drugs
MedcoHealth..... (800) 903-4728
PrescriptionPre-Authorizations..... (800) 753-2851

24/7 Toll-Free Nurseline (866) 670-0691

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