SAG·AFTRA
HEALTH PLAN

Benefits Summary - Effective January 1, 2027

Benefit		
Hospital	**In-Network Provider**	**Out-of-Network Provider**
Calendar Year Deductible	**BlueCard PPO** $500 / person; $1,000 / family (combined w/ Medical)	Not covered
Inpatient (Room and Board and Ancillary Services)	90% of contract rate after $100 copay	Not covered*
Outpatient Surgery	90% of contract rate after $100 copay	Not covered
Emergency Room	90% of contract rate after $100 copay; emergency room copay is waived if immediately confined	Not covered*
Coinsurance Out-of-Pocket Limit	$2,750 / person; $5,500 / family Combined Hospital and Medical (including MHSA)	None
Medical* **	**In-Network Provider**	**Out-of-Network Provider**
Calendar Year Deductible	**BlueCard PPO** $500 / person; $1,000 / family (combined w/ Hospital)	$500 / person; $1,000 / family
Office Visit	No deductible; 100% of contract rate after $25 copay (including telehealth)**	Medical: 60% of Plan's allowance MHSA: 70% of Plan's allowance
Surgeon	90% of contract rate	60% of Plan's allowance
X-ray and Lab	90% of contract rate	60% of Plan's allowance
Therapy (Occupational, Osteopathic, Physical, Speech, Vision)	90% of contract rate	60% of Plan's allowance
Maternity Care -		
Prenatal Visits	No deductible; 100% of contract rate	60% of Plan's allowance
Delivery	90% of contract rate	60% of Plan's allowance
Routine Physical Exam	No deductible; 100% of contract rate	60% of Plan's allowance
Routine Child Exam	No deductible; 100% of contract rate	60% of Plan's allowance
Routine Mammogram/Pap	No deductible; 100% of contract rate	60% of Plan's allowance
Hearing Aids	90% of contract rate up to a maximum payment of $1,500 per device; one device per year per three-year period	60% of Plan's allowance up to a maximum payment of $1,500 per device; one device per ear per three-year period
Coinsurance Out-of-Pocket Limit	$2,750 / person; $5,500 / family Combined Hospital and Medical (including MHSA)	None
Hospital / Medical / Rx Out-of-Pocket Maximum (includes Deductibles, Copays, Coinsurance)^^	$12,000/ person; $24,000 / family	None

*Emergency treatment as defined in the Health Plan Summary Plan Description to be covered at the In-Network Level of Benefits.
***Behavioral Health Out-of-Network Provider services are covered at 70% of Plan's allowance.
**Telehealth includes medical and mental health office visits conducted virtually.
^^Certain specialty medications are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed will not be applied towards satisfying your out-of-pocket maximums by the manufacturer at no cost to you)

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Benefits Summary (continued) - Effective January 1, 2027

Benefit		
Prescription Drugs	**CVS Caremark Participating Retail Pharmacy**	**CVS Caremark Home Delivery (includes Specialty)**
Calendar Year Deductible	$75 / person; $150 / family	
Supply	Up to a 30 day supply / prescription or refill	Up to a 90 day supply / prescription or refill
Copay	The greater of:	The greater of:
Generic	(Tier 1)- $10 or 10%	(Tier 1) - $20 or 10% ; max copay is $50 / prescription
Preferred Brand	(Tier 2) - $25 or 25%	(Tier 2) - $50 or 25% ; max copay is $125 / prescription
Non-Preferred Brand	(Tier 3) - $40 or 40%	(Tier 3) - $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.	In addition to the maximum copays listed above, 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 preventive services medications, including contraceptives, are covered at 100% with no deductible or copay.	Generic preventive services medications, including contraceptives, are covered at 100% with no deductible or copay.
Specialty Medications^^	Generic - 30% Preferred Brand - 30% Non-Preferred Brand - 30% Note: Copay applies to all drugs in Specialty contract at all network pharmacies ****Additional savings on drugs may be available through Rx Savings Solutions	Generic - 30% Preferred Brand - 30% Non-Preferred Brand - 30% Note: Copay applies to all drugs in Specialty contract at all network pharmacies ****Additional savings on drugs may be available through Rx Savings Solutions
Behavioral Health	**Anthem Behavioral Health Network**	**Out-of-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 Out-of Network Providers**
Calendar Year Deductible	$75 / person; $200 / family	$75 / person; $200 / family
Diagnostic and Preventive Benefits	No deductible; 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**	**Out-of-Network Provider**
Eye Exams	100% after $10 copay; one exam / calendar year	80% up to a maximum payment of $50; one exam / calendar year
Glasses	20% discount	No benefit
Professional Services for Contact Lenses	15% discount	No benefit

^^Certain specialty medications are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed will not be applied towards satisfying your out-of-pocket maximums by the manufacturer at no cost to you)
**Alternative levels of care include Residential Treatment Center, Partial Hospital Program and Intensive Outpatient Program.
***Emergency treatment as defined in the Health Plan Summary Plan Description to be covered at the In-Network Level of Benefits.
****Rx Savings Solutions is an online service through which you and your enrolled Dependents can find prescription medications at a lower cost. Register at myrxss.com.
^There is no dental maximum for individuals under age 19.