SAG·AFTRA
HEALTH PLAN

Benefits Summary - Effective January 1, 2021

Benefit	Active Plan (Formerly Plan I)		Plan II^	
Hospital	**In-Network Provider**	**Out-of-Network Provider**	**In-Network Provider**	**Out-of-Network Provider**
Calendar Year Deductible	**The Industry Health Network** - $150 / person; $300 / family **BlueCard PPO/Beacon Health Options** - $500 / person; $1,000 / family (combined w/ Medical)	Not covered	**The Industry Health Network** - $150 / person; $300 / family **BlueCard PPO/Beacon Health Options** - $1,000 / person; $2,000 / family (combined w/ Medical)	Not covered
Inpatient (Room and Board and Ancillary Services)	90% of contract rate after $100 copay	Not covered*	80% of contract rate after $100 copay	Not covered*
Outpatient Surgery	90% of contract rate after $100 copay	Not covered	80% 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*	80% 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	$3,200 / person; $6,400 / family Combined Hospital and Medical (including MHSA)	None
Medical**	**In-Network Provider**	**Out-of-Network Provider**	**In-Network Provider**	**Out-of-Network Provider**
Calendar Year Deductible	**The Industry Health Network** - None **BlueCard PPO/Beacon Health Options** - $500 / person; $1,000 / family (combined w/ Hospital)	$500 / person; $1,000 / family	**The Industry Health Network** - None **BlueCard PPO/Beacon Health Options** - $1,000 / person; $2,000 / family (combined w/ Hospital)	$1,000 / person; $2,000 / family
Office Visit	No deductible; 100% of contract rate after $25 copay	Medical: 60% of Plan's allowance MHSA: 70% of Plan's allowance	No deductible; 100% of contract rate after $25 copay	Medical: 50% of Plan's allowance MHSA: 60% of Plan's allowance
Surgeon	90% of contract rate	60% of Plan's allowance	80% of contract rate	50% of Plan's allowance
X-ray and Lab	90% of contract rate	60% of Plan's allowance	80% of contract rate	50% of Plan's allowance
Therapy (Occupational, Osteopathic, Physical, Speech, Vision)	90% of contract rate	60% of Plan's allowance	80% of contract rate	50% of Plan's allowance
Maternity Care -				
Prenatal Visits	No deductible; 100% of contract rate	60% of Plan's allowance	No deductible; 100% of contract rate	50% of Plan's allowance
Delivery	90% of contract rate	60% of Plan's allowance	80% of contract rate	50% of Plan's allowance
Routine Physical Exam	No deductible; 100% of contract rate	60% of Plan's allowance	No deductible; 100% of contract rate	50% of Plan's allowance
Routine Child Exam	No deductible; 100% of contract rate	60% of Plan's allowance	No deductible; 100% of contract rate	50% of Plan's allowance
Routine Mammogram/Pap	No deductible; 100% of contract rate	60% of Plan's allowance	No deductible; 100% of contract rate	50% of Plan's allowance
Hearing Aids	90% of contract rate up to a maximum payment of $1,500 per device; one device per ear 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	80% of contract rate up to a maximum payment of $1,000 per device; one device per ear per three-year period	50% of Plan's allowance up to a maximum payment of $1,000 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	$3,200 / person; $6,400 / family Combined Hospital and Medical (including MHSA)	None
Hospital / Medical / Rx Out-of-Pocket Maximum (includes Deductibles, Copays, Coinsurance)	$8,550 / person; $17,100 / family	None	$8,550 / person; $17,100 / family	None

*Emergency treatment within 72 hours after an accident or within 24 hours of a sudden and serious illness will be covered at the In-Network Level of Benefits.
**Mental Health and Substance Abuse (MHSA) Out-of-Network Provider services are covered at 70% of Plan's allowance for Active Plan (Formerly Plan I).
^ Note: Plan II runs out September 30, 2021

Benefits Summary (continued) - Effective January 1, 2021

Benefit	Active Plan (Formerly Plan I)		Plan II^	
Prescription Drugs	**CVS Caremark Participating Retail Pharmacy**	**CVS Caremark Home Delivery**	**CVS Caremark Participating Retail Pharmacy**	**CVS Caremark Home Delivery**
Specialty medications must be obtained by mail through the specialty pharmacy, CVS Specialty, beginning with the first fill. Long-term medications must be obtained by mail through the home delivery pharmacy or any CVS pharmacy beginning with the third fill. Non-formulary drugs are not covered. Certain specialty medications are considered non-essential health benefits* and fall outside the out-of-pocket limits. Therefore, the cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied toward satisfying your out-of-pocket maximums. These non-essential health benefits will have variable copays. A list of non-essential specialty drugs will be provided once it becomes available at **CVSspecialty.com/DrugList.**				
Calendar Year Deductible	$75 / person; $150 / family		$175 / person; $350 / family	
Supply	Up to a 30 day supply / prescription or refill	Up to a 90 day supply / prescription or refill	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:	The greater of:	The greater of:
Generic	(Tier 1)- $10 or 10%	(Tier 1) - $20 or 10% ; max copay is $50/ prescription	(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	(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	(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. Generic preventive services medications, including contraceptives, are covered at 100% with no deductible or copay.	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.	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 preventive services medications, including contraceptives, are covered at 100% with no deductible or copay.	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.
Specialty Medications	$0 copay if enrolled in Prudent Rx, otherwise **Generic** - 30% **Preferred Brand** - 30% **Non-Preferred Brand** - 30%	$0 copay if enrolled in Prudent Rx, otherwise **Generic** - 30% **Preferred Brand** - 30% **Non-Preferred Brand** - 30%	$0 copay if enrolled in Prudent Rx, otherwise **Generic** - 30% **Preferred Brand** - 30% **Non-Preferred Brand** - 30%	$0 copay if enrolled in Prudent Rx, otherwise **Generic** - 30% **Preferred Brand** - 30% **Non-Preferred Brand** - 30%
Mental Health and Substance Abuse	**Beacon Health Options Provider**	**Out-of-Network Provider**	**Beacon Health Options Provider**	**Out-of-Network Provider**
Hospital and Alternative Levels of Care **	Covered under the Hospital Benefit	Not covered***	Covered under the Hospital Benefit	Not covered***
Medical	Covered under the Medical Benefit	Covered under the Medical Benefit	Covered under the Medical Benefit	Covered under the Medical Benefit
Dental	**Delta Dental PPO Provider**	**Delta Premier and Out-of-Network Providers**	**Delta Dental PPO Provider**	**Delta Premier and Out-of-Network Providers**
Calendar Year Deductible	$75 / person; $200 / family	$75 / person; $200 / family	$100 / person; no family maximum	$100 / person; no family maximum
Diagnostic and Preventive Benefits	No deductible; 100%	75%	No deductible; 100%	60%
Basic Benefits	75%	75%	60%	60%
Major Benefits	50%	50%	50%	50%
Calendar Year Maximum^^	$2,500	$2,500	$1,000	$1,000
Vision - Exam Plus Plan	**Vision Service Plan Provider**	**Out-of-Network Provider**	**Vision Service Plan Provider**	**Out-of-Network Provider**
Eye Exams	100% after $10 copay; one exam / calendar year	80% up to maximum payment of $50; one exam / calendar year	Not covered	Not covered
Glasses	20% discount	No benefit	Not covered	Not covered
Professional Services for Contact Lenses	15% discount	No benefit	Not covered	Not covered

* The Affordable Care Act (ACA) defines certain care as essential benefits that must fall under health insurance covered. All other benefits and certain specialty medications are defined as non-essential.
**Alternative levels of care include Residential Treatment Center, Partial Hospital Program and Intensive Outpatient Program.
***Emergency treatment within 72 hours after an accident or within 24 hours of a sudden and serious illness will be covered at the In-Network Level of Benefits.
^ Note: Plan II runs out September 30, 2021

^^There is no dental maximum for individuals under age 19.