SAG·AFTRA
HEALTH PLAN

Benefits Summary - Effective January 1, 2019

Benefit	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** - $250 / person; $500 / family	Not covered	**The Industry Health Network** - $150 / person; $300 / family **BlueCard PPO/Beacon Health Options** - $500 / person; $1,000 / family	Not covered
Inpatient (Room and Board and Ancillary Services)	90% after $100 copay	Not covered*	80% after $100 copay	Not covered*
Outpatient Surgery	90% after $100 copay	Not covered	80% after $100 copay	Not covered
Emergency Room	90% after $100 copay; emergency room copay is waived if immediately confined	Not covered*	80% after $100 copay; emergency room copay is waived if immediately confined	Not covered*
Coinsurance Out-of-Pocket Limit	$1,750 / person; $3,500 / family	Not covered	$2,000 / person; $4,000 / family	Not covered
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** - $250 / person; $500 / family	$500 / person; $1,000 / family	**The Industry Health Network** - None **BlueCard PPO/Beacon Health Options** - $500 / person; $1,000 / family	$1,000 / person; $2,000 / family
Office Visit	No deductible; 100% after $25 copay (including LiveHealth Online)**	70%	No deductible; 100% after $25 copay (including LiveHealth Online)**	60%
Surgeon	90%	70%	80%	60%
X-ray and Lab	90%	70%	80%	60%
Therapy (Occupational, Osteopathic, Physical, Speech, Vision)	90%	70%	80%	60%
Maternity Care -				
Prenatal Visits	No deductible; 100%	70%	No deductible; 100%	60%
Delivery	90%	70%	80%	60%
Routine Physical Exam	No deductible; 100%	70%	No deductible; 100%	60%
Routine Child Exam	No deductible; 100%	70%	No deductible; 100%	60%
Routine Mammogram/Pap	No deductible; 100%	70%	No deductible; 100%	60%
Hearing Aids	90% up to a maximum payment of $1,500 per device; one device per ear per three-year period	70% up to a maximum payment of $1,500 per device; one device per ear per three-year period	80% up to a maximum payment of $1,000 per device; one device per ear per three-year period	60% up to a maximum payment of $1,000 per device; one device per ear per three-year period
Coinsurance Out-of-Pocket Limit	$1,000 / person; $2,000 / family	$2,500 / person; $5,000 / family	$1,200 / person; $2,400 / family	$3,000 / person; $6,000 / family
Hospital / Medical / Rx Out-of-Pocket Maximum (includes Deductibles, Copays, Coinsurance)	$7,900 / person; $15,800 / family	None	$7,900 / person; $15,800 / 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.
**LiveHealth Online is for medical office visit only (not behavioral health).

Benefits Summary (continued) - Effective January 1, 2019

Benefit	Plan I		Plan II	
Prescription Drugs	**Express Scripts Participating Retail Pharmacy**	**Express Scripts Home Delivery (includes Specialty)**	**Express Scripts Participating Retail Pharmacy**	**Express Scripts Home Delivery (includes Specialty)**
	Specialty medications must be obtained by mail through the specialty pharmacy, Accredo, beginning with the first fill. Long-term medications must be obtained by mail through the home delivery pharmacy or any Walgreens Network pharmacy beginning with the third fill. Non-formulary drugs are not covered.		Specialty medications must be obtained by mail through the specialty pharmacy, Accredo, beginning with the first fill. Long-term medications must be obtained by mail through the home delivery pharmacy or any Walgreens Network pharmacy beginning with the third fill. Non-formulary drugs are not covered.	
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	$10 or 10%	$20 or 10%; max copay is $50 / prescription	$10 or 10%	$20 or 10%; max copay is $50 / prescription
Preferred Brand	$25 or 25%	$50 or 25%; max copay is $125 / prescription	$25 or 25%	$50 or 25%; max copay is $125 / prescription
Non-Preferred Brand	$40 or 40%	$100 or 40%; max copay is $300 / prescription	$40 or 40%	$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.	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.	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.
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	
Glasses	20% discount	No benefit		
Professional Services for Contact Lenses	15% discount	No benefit		

*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.

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