

Spotlight

on

BENEFITS



Volume 12, Number 1

Summer 2004

Recent Health Plan Changes Announced

The Board of Trustees recently announced changes to the Health Plan.

Effective April 1, 2004

- Participants on carry-over coverage are now covered under the DGA Premier Choice Plan.
- The maximum bankable amount in a participant's carry-over account has been increased from \$360,000 to \$390,000. Please note that the amount of carry-over compensation necessary for earned coverage has not changed.

Effective April 16, 2004

- Ambulatory surgical center facility charges will be reimbursed up to a maximum allowable charge of, and not to exceed, \$1,500. If the actual charge is less than \$1,500, the allowable charge will be the actual charge. Please note that deductibles, co-payments and co-insurance, where applicable, still apply.
- Health Plan rules have been relaxed as to when a participant is required to notify the Plan of a

new dependent. If a participant is not required to pay a premium for a new dependent (*i.e.* the premium has already been paid on behalf of the participant's existing dependents), the participant may add the new dependent at any time. The new dependent's coverage will be effective the later of:

- (1) 12 months before the Health Plan office receives the request to add the new dependent or;
- (2) the date as of which no additional premium would be required to cover the dependent.

- Eligible dependent children of retirees will now be offered self-pay coverage at a reduced self-pay rate. These dependent children must have been covered by the Plan at the time of the participant's retirement. In addition, dependent children who have reached the maximum allowable age are not eligible for this coverage. Please see the *Dependent Children of Retirees Now Eligible for Special Self-Pay Rate* article in this newsletter for more information.

- The Health Plan recovery incentive limit has been raised from \$500 to \$2,500. Please see the article on page 3 of this newsletter for more information.

Effective July 1, 2004

- Medco Health will become the Health Plan's prescription drug benefit manager. For additional information, please refer to the flyer inserted in this newsletter.
- The Specialty Drug tier in the prescription drug plan will include all erectile dysfunction drugs.

Effective January 1, 2005

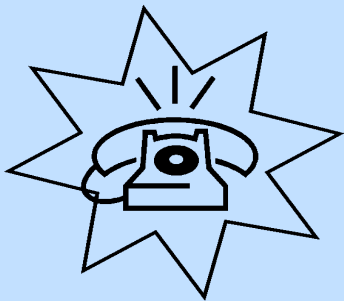
- The Health Plan's deductible carry-over provision (detailed on page 38 of the July 1, 2003 Health Plan Booklet) will be eliminated.

If you have any questions regarding these changes, please contact the Plan at:

In the Los Angeles Area
(323) 866-2200, Option 1

Outside the Los Angeles Area
(877) 866-2200, Option 1

Important Phone Numbers



If you are a participant and you believe that pension or health contributions may have been incorrectly paid on your behalf, you can contact the Pension and Health Plans' Collection Department at one of the following telephone numbers:

In the Los Angeles Area
(323) 866-2200, Option 2

Outside the
Los Angeles Area
(877) 866-2200, Option 2

If you would like to leave an anonymous message regarding underpaid pension or health contributions, you can contact the Plans' Hotline at one of the following telephone numbers:

In the Los Angeles Area
(323) 866-2200, Option 711

Outside the
Los Angeles Area
(877) 866-2200, Option 711

Contribution Rate Increases to 7.5%

For the period July 1, 2004 to June 30, 2005, the health contributions rate increases from 7% to 7.5% for projects produced under the following agreements:

- **2002-2005 Basic Agreement;**
- **Freelance Live and Tape Television Agreement of 2002;**
- **2002 Network Freelance Director Agreement (entertainment programs only);**
- **2002 Network Freelance Associate Director and Network Stage Manager Appendices (entertainment programs only).**

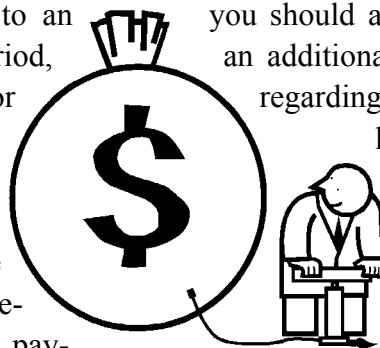
Generally, the effective date of this increase applies to an individual's work period, not to the remittance or receipt date of the contributions. For example, if you work on a project from June 30 to July 1 and subsequently receive your paycheck on July 9, the new health contributions rate would only apply to the work performed on July 1. Please note that there is an exception to this rule for Directors whose prep period begins prior to July 1, 2004, but whose work period on the same project extends beyond July 1, 2004. In those

cases, the contributions rate is the rate in effect at the beginning of the Director's prep period. **This exception only applies to Directors.**

Please note that the health contributions increase only applies to compensation paid for work performed under the agreements listed. Contributions in connection with work under the Commercial Agreement or other collective bargaining agreements continue to be calculated at 7%. Contributions on residual compensation should be based on the contribution rate that was in effect at the time of commencement of principal photography for each specific project.

If you are the owner of a DGA-signatory company under one of the aforementioned agreements, you should already have received an additional information packet regarding the increase in the health contributions rate.

If you need additional information, please contact the Plans' Contributions Department at one of the telephone numbers listed below.



In the Los Angeles Area
(323) 866-2200, Option 2

Outside the Los Angeles Area
(877) 866-2200, Option 2

Properly Submitted Claim Forms Can Help Expedite Mental Health and Substance Abuse Claims

When submitting a mental health or substance abuse claim to the Health Plan, a fully completed HCFA-1500 claim form (available online at www.PBHI.com) will expedite the processing of your claim.

A fully completed claim form helps PacifiCare Behavioral Health (the Plan's mental health and substance abuse benefit manager) and the Health Plan to reimburse you or your provider without delays.

Often, the Health Plan receives claims submitted on provider letterhead or a receipt of payment. In these cases, the necessary information to process the claim may not be included. As a result, PacifiCare or the Health Plan may have to further research the claim in order to determine the proper amount of the benefit.

As with any medical claim, certain information is required in order to process and pay a claim. By using a standard HCFA-1500 claim form, you and your provider can be assured that the necessary information has been submitted to the Health Plan on your behalf.

Please make sure the following information is completed when filling out the form: Participant Name, Patient Name, Participant ID Number, Patient Date of Birth, Address, Date(s) of Service, Place of Service, CPT Codes, Diagnosis, Cost of Service, Provider Tax ID Number or Social Security Number and Provider Address and Phone Number.

While you are not required to submit a HCFA-1500 claim form when submitting a claim, the information listed above is required. Please make sure that you or your provider is submitting the required information when submitting a claim. It will expedite the processing of your claims and assist with timely reimbursement.

To obtain a claim form on PacifiCare's Web site, please go online to www.PBHI.com.

- 1) Click the Provider section.**
- 2) Under the Helpful Resources section, click on Printable Forms.**
- 3) Scroll down to Claims & Billing Forms.**
- 4) Click on HCFA-1500.**
- 5) Print the form.**

Rewarding Participants Who Help the Plans

Did you know that you can receive cash from the Health Plan? The Plan features a Recovery Incentive Program that pays participants for notifying the Health Plan of overcharges or bills for services or supplies that were not received.

The Board of Trustees recently voted to increase the Health Plan recovery incentive limit. The following are the new, revised guidelines:

- For an overcharge that is less than \$100, the cash incentive will be the actual amount of the overcharge.
- For an overcharge of \$100 or more, the cash incentive will be 50% of the overcharge, but not more than \$2,500 (previously, this limit was \$500), or less than \$100.
- An overcharge greater than \$5,000 will be reviewed by the Board of Trustees for consideration of an additional incentive over the \$2,500 maximum.

The Health Plan will soon be mailing out its first Health Plan Annual Statement. The annual statement will summarize all of your family's health claims for 2003. Please carefully review the Health Plan Annual Statement as well as the Explanations of Benefits that you receive in connection with all Health Plan claims. If you notice any potential errors, please contact the Health Plan. You could get paid for it!

Utilizing Network Providers

Staying in the PPO Network is Good for You and Good for the Plan

Utilizing in-network (PPO) providers is one of the best ways for each participant to help the Health Plan control rising health care costs. For example:

- In addition to charging a reduced, negotiated rate, PPO providers guarantee assignment of benefits (*i.e.* the provider will bill the Health Plan directly).
- In order to be part of the Plans' PPO networks, PPO providers are required to meet strict accreditation and credentialing requirements.
- When a PPO provider is used, there is no difference between DGA Choice Plan coverage and DGA Premier Choice Plan coverage.

You can access an up-to-date list of PPO providers from the following Web sites and toll-free phone numbers:

Delta Dental
www.deltadentalca.org
(800) 427-3237

Blue Cross
www.bluecrossca.com
(800) 888-4825

PHCS
www.phcs.com
(888) 847-7427

Getting Stuck in Grace Period Limbo

Paying Self-Pay Premiums Prior to the Due Date Can Prevent Headaches

Health Plan self-pay premiums are due on the first of each month. Under the terms of the Health Plan, participants have a 30-day grace period from the date on which the premium is due to remit payment to the Plan. Once this grace period expires, the participant's self-pay coverage is terminated and cannot be reinstated on a self-pay basis.

While payments received during the 30-day grace period are accepted by the Plan, they can cause problems for the participant.

Each week, the Health Plan sends out its eligibility list to its benefit managers (*e.g.* Delta Dental, PacificCare Behavioral Health, Vision Service Plan, etc.). This eligibility list details all participants that are eligible to receive Health Plan benefits for the next week.

For example, when your dentist submits a dental claim to Delta Dental on your behalf, Delta Dental will check the most recent eligibility list received from the Health Plan to confirm that you were eligible for dental benefits during that period.

If you are a self-paying participant and do not remit your self-pay premium to the

Plan by the first of the month, you will not be listed on any of the eligibility lists until your self-pay premium has been paid. Therefore, you will not be eligible to receive the Health Plan's benefits at the time of service.

If you remit payment of the self-pay premium within the 30-day grace period, you are still eligible for the benefit, but you will have to pay full price for the services rendered or supplies received and then submit your claim to the Health Plan for reimbursement. For example, if you visit a network (PPO) pharmacy to fill a prescription, you will have to pay full price for the prescription and later submit the claim to the Health Plan for reimbursement.

If you have any questions regarding self-pay coverage or premiums, please refer to pages 15-23 of the July 1, 2003 Health Plan Booklet or contact the Health Plan's Health and Eligibility Department at one of the following telephone numbers:

In the Los Angeles Area
(323) 866-2200, Option 1

Outside the Los Angeles Area
(877) 866-2200, Option 1

Dependent Children of Retirees Now Eligible for Special Self-Pay Rate

The Health Plan's Board of Trustees recently established a special self-pay rate for the eligible dependent children of retirees that retire on or after July 1, 2003.

This new self-pay rate is similar to the special rate that was offered to the eligible dependent children of retirees who lost coverage as a result of a participant's retirement prior to July 1, 2003, when coverage for the dependent children of retirees was eliminated. Please note that the dependent children of retirees on Active Coverage (*i.e.* coverage earned as a result of health contributions based on current earnings) are still covered under the Health Plan.

Under this new self-pay rate, dependent children of retirees who were in existence and covered by the Health Plan at the time of retirement are eligible to self-pay for health coverage at a special rate for up to 36 months or when the child reaches age 19, whichever is sooner.

If you retired on or after July 1, 2003, and have been self-paying for COBRA coverage under the Health Plan for your dependent

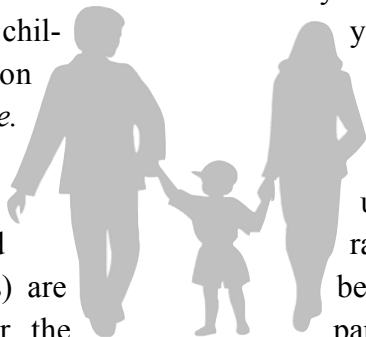
children, you may be eligible to receive a refund of the difference between the premiums due under the COBRA self-pay rate and the premiums due under the new self-pay rate for the dependent children of retirees. The Health Plan will be sending notification to participants that are eligible for this refund.

In addition, if you retired on or after July 1, 2003, and chose not to self-pay for health coverage for your dependent children, you may be eligible to retroactively self-pay for your dependent children's health coverage under the new self-pay rate. The Health Plan will be sending notification to participants that are eligible to retroactively self-pay for their dependent children's health coverage.

For more information regarding the new self-pay rate for the dependent children of retirees, please contact the Health Plan at:

In the Los Angeles Area
(323) 866-2200, Option 1

Outside the Los Angeles Area
(877) 866-2200, Option 1



Pension Plans Post Positive Returns in 2003

The Directors Guild of America-Producer Basic Pension Plan and the Directors Guild of America-Producer Supplemental Pension Plan posted impressive returns in 2003.

The Basic Pension Plan, a defined benefit plan, posted a 24.6% return (unaudited) for 2003.

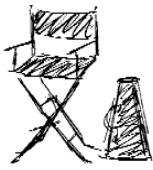
The Supplemental Pension Plan, a defined contribution plan, posted a 22.6% return (unaudited) for 2003.

Pension Plan annual statements (detailing each participant's estimated Basic Pension Plan benefit as well as each participant's Supplemental Plan account balance) were mailed to all participants in mid-April.

If you have not received your annual statement or if you have any other questions regarding the Pension Plans, please contact the Plans at one of the phone numbers listed below:

In the Los Angeles Area
(323) 866-2200, Option 1

Outside the Los Angeles Area
(877) 866-2200, Option 1



DIRECTORS GUILD OF AMERICA - PRODUCER

PENSION AND HEALTH PLANS

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MEDCO HEALTH CHOSEN AS PLAN'S NEW PRESCRIPTION DRUG BENEFIT MANAGER

Please see the **BENEFITS UPDATE** in this newsletter for more information.

PENSION AND HEALTH PLANS DIRECTORY

Phone Numbers

In the Los Angeles Area
(323) 866-2200

Outside the Los Angeles Area
(877) 866-2200

Fax Numbers

General Office
(323) 653-2375

Health and Eligibility Department
(323) 782-9287

Pension Department
(323) 866-2372

TELEPHONE MENU

Dial	To reach the...
0	Operator
1	Participant Services Department
2	Contributions and Collections Department
3	Address Change Representative
4	Audit Department
5	Privacy Officer
6	Other Departments Submenu
711	Delinquent Employer and Fraudulent Claims Hotline



Benefits Update

Medco Chosen as Plan's New Prescription Drug Benefit Manager

In light of the continued rise in health care costs and as part of the constant effort by the Plan's Board of Trustees to address these skyrocketing costs, a prescription drug coalition was recently formed by several entertainment industry health plans. The goal of the coalition was to use the combined purchasing power of the plans to generate savings beyond that which could have been negotiated by any single plan. That savings, in turn, will be used to protect the benefits available to our participants.

As a result of the coalition's efforts, Medco has been hired to replace Express Scripts as the Plan's prescription drug benefit provider.

When does the change go into effect?

Effective for prescriptions filled on July 1, 2004 and later, you will no longer be able to obtain prescription medication using your Express Scripts prescription drug card or through the Express Scripts Mail Order Prescription Program. Prescriptions filled prior to July 1, 2004 should still be processed through Express Scripts.

Does the switch to Medco change my drug benefit?

No. The switch to Medco has not changed the Plan's prescription drug

benefit. The generic, brand name and specialty drug co-payments remain the same. For more information on the Plan's prescription drug co-payments as well as the Health Plan's prescription drug benefit, please see the reverse side of this flyer or refer to pages 58-60 of the July 1, 2003 Health Plan Booklet.

Will I be receiving a new prescription drug ID card?

Yes. In mid-June, all eligible Health Plan participants will be receiving new ID cards issued by Medco. If you have not received a new prescription drug ID card from Medco by the end of June, please contact the Health Plan office.

What if I currently receive medication via the Express Scripts Mail Order Prescription Program?

If you are receiving medication through the Express Scripts Mail Order Program, your prescription will be switched to the Medco Home Delivery Pharmacy Service. Prescriptions obtained through the Medco Home Delivery Pharmacy Service do not have to be shipped to your home. You can have the prescriptions shipped to any address within the United States. If you notice any interruption in your mail order service, please do not hesitate to contact the Health Plan office.

Will I have to go to a different pharmacy?

Due to the high correlation between the Express Scripts pharmacy network and Medco's network, it is highly unlikely that you will have to change pharmacies. Also, the switch to Medco's larger network has increased the amount of network pharmacies available to participants. Effective July 1, 2004, you can visit Medco's Web site (www.medco-health.com) to locate a Medco pharmacy near you.

Participants also have access to a wide variety of online services at Medco's Web site, including the ability to order existing prescription refills from Medco's Home Delivery Pharmacy Service.

If you have any questions, please do not hesitate to contact the Health Plan office at the phone numbers listed below.

HEALTH PLAN PHONE NUMBERS

In the Los Angeles Area

(323) 866-2200, Option 1

Outside the Los Angeles Area

(877) 866-2200, Option 1

YOUR DGA-PHP PRESCRIPTION DRUG BENEFIT



As a DGA-PHP participant, you have access to one of the finest prescription drug plans available.

Please note that the switch to Medco will be effective for all prescriptions filled on July 1, 2004 or later.

The Prescription Drug program features:

- **No deductible**
- **Access to over 55,000 Medco pharmacies across the United States**
- **Hassle-free mail order delivery of prescription medication via the Medco Home Delivery Pharmacy Service**
- **Access to information about your benefit as well as health and wellness resources via www.medcohealth.com**
- **Coverage of specialty drugs, which currently includes Viagra and non-sedating antihistamines (effective July 1, 2004, all erectile dysfunction drugs will be covered under the Specialty Drug category)**
- **Separate co-payments for generic, brand name and specialty drugs**
- **Reimbursement for drugs purchased at non-Medco participating pharmacies (drugs are reimbursed at the Medco discounted rate, less the applicable co-payment)**

If you have any questions regarding your prescription drug benefit, please contact the Health Plan at one of the phone numbers listed on the front of this flyer.

YOUR PRESCRIPTION DRUG CO-PAYMENTS

The Health Plan currently features separate co-payments for generic, brand name and specialty drugs.

GENERIC DRUGS

- There is a \$10 co-payment for up to a 30-day supply of generic drugs obtained through a Medco participating retail pharmacy.
- There is a \$25 co-payment for up to a 90-day supply of generic drugs obtained through the Medco Home Delivery Pharmacy Service.

BRAND NAME DRUGS

- There is a \$24 co-payment for up to a 30-day supply of brand name drugs obtained through a Medco participating retail pharmacy.
- There is a \$60 co-payment for up to a 90-day supply of brand name drugs obtained through the Medco Home Delivery Pharmacy Service.

SPECIALTY DRUGS

- Specialty drugs currently include Viagra and non-sedating antihistamines. Effective July 1, 2004, the Specialty Drug tier will include all erectile dysfunction drugs.
- Specialty drugs are covered at 50% with a \$40 minimum co-payment for up to a 30-day supply when obtained through a Medco participating retail pharmacy.
- Specialty drugs are covered at 50% with a \$60 minimum co-payment for up to a 90-day supply when obtained through the Medco Home Delivery Pharmacy Service.