



spotlight on **benefits**

the benefits newsletter of the dga-producer pension and health plans

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Health Care Reform: How Will It Affect Our Plan?

Health Plan participants that have been watching the national debate on the future of health care may be left wondering how the various proposals will affect our Plan.

At this newsletter's time of printing, Congress was currently considering several different pieces of health care reform legislation.

There are many steps in the legislative process that have yet to be taken. It is impossible to know what form the final legislation (if any) will take. Therefore, we can't be sure how (or if) the Health Plan and its participants will be affected.

The Health Plan's Board of Trustees and Plan staff are diligently monitoring the progress of health care reform legislation through our lobbyists, trade coalitions and Health Plan consultants. As we learn more, we will continue to communicate with participants through this newsletter, on www.dgaplans.org and other special mailings.

Over the last decade, we have seen, first-hand, the effects

of the rising costs of health care in America. However, in the face of this challenge, the Board of Trustees has taken decisive action to ensure that DGA members and their families continue to receive quality, industry-leading health benefits. Such actions include:

► **Structuring the Health Plan to encourage the continued use of network**

doctors. Health Plan participants can visit any provider. However, the Health Plan pays a higher percentage when participants utilize network providers. Staying within the network saves participants and the Health Plan money.

► **Switching the provider network outside California to the larger BlueCard network.** Because of greater buying power, BlueCard is able to negotiate more favorable rates with doctors and hospitals. Also,



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The Pension and Health Plans were created as a result of the Directors Guild of America's collective bargaining agreements with producer associations representing the motion picture, television and commercial production industries.

The DGA-Producer Pension and Health Plans are separate entities from the DGA and are administered by a Board of Trustees made up of DGA representatives and Producers' representatives.

Health Plan Amendments

The Board of Trustees has recently amended the Health Plan regarding dependent eligibility as follows:

- ▶ Effective January 1, 2010, college students covered as dependents who take a medically necessary leave of absence can continue health coverage for up to one year. This amendment conforms the Health Plan to Michelle's Law, which was signed into law by President Bush on October 9, 2008.

To verify eligibility, the participant or their dependent would be required to provide certification from the treating physician that the illness or injury necessitates the leave of absence, and proof of full-time enrollment immediately prior to the medically necessary leave.

Coverage during a medically necessary leave of absence from school because of a serious medical condition or injury could continue until the earlier of:

1. One year from the start of the leave of absence; or
2. The date on which such coverage would otherwise be terminated under the terms of the Health Plan.

- ▶ Effective April 1, 2009, the Health Plan Booklet has been amended to include the biological child (unmarried, under age 19) of a same-sex domestic partner as an eligible dependent when the participant is listed as a parent on the child's birth certificate. Previously, the Health Plan required the participant as a non-birth parent in a same-sex domestic partnership to adopt the child before the child could be considered an eligible dependent.

This amendment conforms the Health Plan to California and New York state law, which provides a non-birth parent with parental rights if a same-sex couple registers the non-birth parent as a parent on the child's birth certificate.

Participants not listed as a parent on the child's birth certificate are still required to adopt the child before the child can be considered an eligible dependent.

If you have any questions regarding dependent eligibility, please contact the Participant Services Department at (323) 866-2200, Extension 401 or toll-free outside the Los Angeles area at (877) 866-2200, Extension 401. **PH**

Personalized Medicine Program

This New Program Incorporates Genetic Testing to Optimize Tamoxifen and Warfarin Prescription Drug Therapies



When it comes to prescription drugs, there are many factors, such as height, weight, diet, metabolism, and even your genes that could potentially affect how your body will respond to a particular medication. The field of pharmacogenomics studies how genetic variations affect an individual's response to medications. Personalized medicine takes the latest advances in medicine and enables physicians to more precisely, effectively and safely prescribe medications by:

- ▶ Helping patients obtain the right drug and/or dose faster;
- ▶ Eliminating "trial and error" prescribing and dosing;
- ▶ Reducing the potential for harmful side effects; and
- ▶ Avoiding unnecessary expenses associated with ineffective and costly treatments.

Medco's voluntary Personalized Medicine Program takes the latest advances in medicine and enables physicians to more precisely, effectively and safely prescribe medications.

Beginning November 1, 2009, Health Plan participants who are prescribed Tamoxifen for breast cancer or Warfarin for blood clotting will have the option to participate in the Medco's Personalized Medicine Program. This voluntary program enables patients prescribed Tamoxifen or Warfarin to receive appropriate treatments and dosages based on their unique genetic makeup.

Patients Prescribed Tamoxifen or Warfarin

Tamoxifen is used to treat breast cancer, or reduce the risk in women who have an increased risk of developing breast cancer, but has been determined to only be effective in treating estrogen receptor-positive breast cancer. There is a genetic test that determines whether a patient has estrogen receptor-positive breast cancer. This test enables the patient to begin appropriate treatment immediately while potentially avoiding serious side effects.

Warfarin is an anticoagulant or blood thinner used to treat patients following heart attacks, strokes or blood clots. When first prescribed, it is necessary to determine the appropriate dosage based on the patient's individual metabolism, which can result in hospitalization due to incorrect and experimental dosing. There is a genetic test that determines how a patient metabolizes this drug. This

SEE **PERSONALIZED MEDICINE PROGRAM** ON PAGE 8



Keep Us In the Loop

Whether you are getting married, having a baby or moving, when there is a change in your family status or personal information, you should contact us to keep your information up-to-date and your benefits on track.

Marriage, New Child, Retirement, Death, Disability, Divorce

When you experience a life event such as marriage, the birth of a child, retirement, divorce or disability there are documents that must be submitted to the Plan office. Failure to provide the necessary documents could result in Health Plan eligibility and claims processing issues. In addition, if you wait until retirement to locate required documents, your pension benefit payments could be delayed.

For your convenience, we have developed the Life Events Fact Sheets (available at www.dgaplans.org) to provide information regarding how these events could impact your benefits as well as what forms or documents you need to submit.

Beneficiary Designation

You may want to file a new Beneficiary Designation Form with the Plan office if you:

- ▶ **Get divorced.** Your former spouse will remain your named beneficiary unless you file a new Beneficiary Designation Form. If you do not want your former spouse to receive your pension death benefit, you should file a new form with the Plan office.
- ▶ **Get married.** If you want someone other than your spouse to be your primary beneficiary (such as a Trust or your children), you must obtain spousal consent on your Beneficiary Designation Form.

To update your beneficiary, simply complete a new Beneficiary Designation Form and submit it to the Plan office. Once we receive your new Beneficiary Designation Form any previously submitted beneficiary designation becomes invalid.

You can download a Beneficiary Designation Form from www.dgaplans.org, or call the Participant Services Department at (323) 866-2200, Extension 401 or toll-free outside the Los Angeles area at (877) 866-2200, Extension 401 to request a form be sent to you.

Change of Address

By updating the Plan office with your current phone number and address, you help to ensure that you will receive all important Pension and Health Plan communications. Remember that the Plans and the DGA are separate entities, so address changes filed with the DGA are not automatically filed with the Plans.

You can download a Change of Address Form from www.dgaplans.org, or call the Change of Address Department at (323) 866-2200, Extension 306 or toll-free outside the Los Angeles area at (877) 866-2200, Extension 306.

Questions

If you have any questions, please contact the Participant Services Department at (323) 866-2200, Extension 401 or toll-free outside the Los Angeles area at (877) 866-2200, Extension 401. **PH**



Maximum Carry-Over Account Bankable Earnings Increased

Participants can now bank more earnings into their carry-over accounts. The Board of Trustees increased the maximum balance of permitted covered earnings to \$420,000, effective benefit periods starting on or after April 1, 2009.

Carry-over credit is accumulated when you have earnings during an earnings period in excess of the carry-over threshold, currently \$120,000. If you have sufficient carry-over credit in your account, and you do not meet the minimum earnings requirement for earned coverage during an earnings period, the Health Plan will automatically deduct enough carry-over credit for one year for earned coverage (currently \$120,000) from your carry-over account.

For a more detailed explanation of carry-over credit, please refer to page 13 of the Health Plan Booklet.

If you have any questions regarding carry-over credit, please contact the Participant Services Department at (323) 866-2200, Extension 401 or toll-free outside the Los Angeles area at (877) 866-2200, Extension 401. **PH**

Coordination of Benefits

Board of Trustees Amends Health Plan's Guidelines to Clarify Requirements

Coordination of Benefits (COB) guidelines are used by the Health Plan to determine primary and secondary coverage when a participant and/or their dependents are insured under multiple health plans.

In an effort to clarify the COB requirements for participants and their dependents, the Board of Trustees amended the Coordination of Benefits Section of the Health Plan Booklet, effective June 19, 2009, as follows:

Coordination of Benefits

In many families, both husband and wife work. Each may be covered by a group health plan and each may include the other and/or their children as dependents.

Coordination of benefits is simply a way of dividing responsibility for payment among the separate health plans that cover an individual. Charges include all items of care covered under at least one of the plans. Types of plans with which the Health Plan coordinates benefits include:

- ▶ group insurance coverage;
- ▶ government-provided programs;
- ▶ coverage provided by statute;
- ▶ employer-sponsored Blue Cross/Blue Shield or other pre-payment coverage; and
- ▶ any coverage under labor-management trustee plans or employer benefit organization plans.

General Rules

The first of the following rules that applies to your situation is used to determine which plan is primary:

1. The plan covering a person as a participant is primary to the plan covering the person as a dependent, with one exception: In the case of



a participant with inactive coverage who is a Medicare recipient and is also covered as a dependent by a working spouse, the plan which covers him or her as the dependent of a working spouse is primary, Medicare is secondary, and his or her own inactive plan is tertiary. (For more information on Medicare, please see the section entitled Medicare and Plan Benefits beginning on page 42 of the Health Plan Booklet.)

2. The plan covering the person as an active employee pays benefits before the plan covering that person as an inactive, laid-off, self-pay or retired employee.
3. The plan under which you have had the longest continuous eligibility as a participant is your primary plan and pays benefits first. If you have the same effective date in both plans, each plan is responsible for 50% of the allowable charges.

Guidelines



Note: If a participant who is eligible for group health benefits is required to pay a premium but declines to pay that premium, and then at a later date begins to pay the premium, the period during which the premium was unpaid does not constitute a break in eligibility for the purpose of determining the carrier with the longest continuous eligibility as a participant.

Rules for Dependent Children

1. If the claim is for a child, the plan of the parent whose birthday falls earlier in the year is primary.
2. If both parents have the same birthday, the plan which covered the parent longer is primary.
3. If the claim is for a child of divorced or separated parents, the plan of the parent with custody is primary, the plan of the spouse of the parent with custody is secondary, and the plan of the parent not having custody is tertiary. Notwithstanding the foregoing, court rulings will be followed. A copy of the court ruling will be required.

Payment of Coordinated Claims

Once responsibility for first payment is established, the Health Plan proceeds in one of two ways:

COB Q&A

Q What is Coordination of Benefits?

A Coordination of Benefits (COB) guidelines are used by the Health Plan to determine primary and secondary coverage when a participant and/or their dependents are insured under two health plans, basically allowing the two health plans to share the costs of a claim.

Q How do I qualify for COB?

A If you are a Health Plan participant and you or your dependents are insured under two health plans, COB guidelines apply to you.

For example, you may qualify for COB if:

- ▶ You are a Health Plan participant and your spouse has their own group health plan, and you cover each other as dependents on your respective plans;
- ▶ You and your spouse each qualify for earned coverage from the Health Plan, and you both pay the dependent premium to cover each other as dependents; or
- ▶ You qualify for earned active coverage with the Health Plan and another entertainment industry health plan.

Q Does the Health Plan coordinate benefits with an individual insurance plan?

A No, the Health Plan does not coordinate benefits with an individual insurance plan.

Q How do I inform the Health Plan if I am covered under an additional group health plan?

A Each year, a Coordination of Benefits form is mailed to participant's during their open

Personalized Medicine Program

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test will allow a patient's doctor to determine the appropriate dosage immediately while reducing the risks associated with dosages that are too low or high.

How the Personalized Medicine Program Works

The Personalized Medicine Program is completely voluntary. Medco identifies patients who would benefit from genetic testing, and contacts their physician to inform them about the test, and offer advice on genetic testing and personalized medicine.

After obtaining permission from their physician, Medco contacts the patient to discuss genetic testing. If the patient decides to participate in the program, Medco will



arrange for home delivery of the simple, one-step cheek swab test. After receiving the swab test kit from the lab, the patient administers a one-step cheek swab and mails the kit back to the lab.

The physician receives the test results, and a Medco specialist pharmacist contacts the physician to review the results and discuss, if necessary, drug or dosage changes. Any dosing or medication changes are in the sole discretion of the patient's physician.

Completely Confidential

The clinical laboratory that facilitates the processing of the genetic testing only shares the results of the test with your physician and Medco. In addition, the laboratory only looks at and stores the information required to test for the one specific enzyme that metabolizes the specific drug. No other genetic information is stored.

All information is kept confidential. This program is in full compliance with recent genetic testing laws such as the Genetic Information Nondiscrimination Act (GINA), the Health Insurance Portability and Accountability Act (HIPAA) and federal or state law.

Completely Voluntary

This benefit is being provided to help optimize the treatment of Health Plan participants who will be taking Tamoxifen and Warfarin. Participation is limited to participants who will be taking those drugs and is completely voluntary. If you choose not to participate in the program, your benefits will not be affected.

Costs for Testing

If the testing is ordered through Medco's program, it is provided to you at no cost. If the testing is ordered by your physician outside of Medco's program, your benefit is subject to the applicable Health Plan limits, including any deductible and co-insurance.

Questions

For more information, please see Personalized Medicine Program FAQs on page 9. If you have additional questions, please contact a Medco customer service representative toll-free at (800) 987-7828. **PH**

Personalized Medicine Program

What is the Personalized Medicine Program?

The Health Plan's Personalized Medicine Program is a voluntary program offered by Medco, the Health Plan's prescription benefit manager, which enables patients using certain medications to receive appropriate treatments and dosages based on their unique genetic makeup.

What drugs are covered under the Personalized Medicine Program?

The Personalized Medicine Program is available to participants who are prescribed Tamoxifen for breast cancer or Warfarin for blood clotting.

Am I required to have this test if I am prescribed the covered medications?

No, this program is completely voluntary. Medco will contact your physician for authorization to contact you to enroll in the program.

How are my test results kept confidential?

The clinical laboratory that facilitates the processing of the genetic testing only shares the results of the test with your physician and Medco. In addition, the laboratory only looks at and stores the information required to test for the one specific enzyme that metabolizes the specific drug. No other genetic information is stored.

All information is kept confidential. This program is in full compliance with recent genetic testing laws such as the

Genetic Information Nondiscrimination Act (GINA), the Health Insurance Portability and Accountability Act (HIPAA) and federal or state law.

How much will the test cost?

If the testing is ordered through Medco's program, it is provided to you at no cost. If the testing is ordered by your physician outside of Medco's program, your benefit is subject to the applicable Health Plan limits, including any deductible and co-insurance.

Do I have to go through Medco to have this genetic test?

No, your physician can order the testing outside of Medco's program, but your benefit is subject to the applicable Health Plan limits, including any deductible and co-insurance, whereas, testing ordered through Medco's program is provided to you at no cost.

Will more medications be included in this program in the future?

If additional drugs are included in this program, we will communicate these changes through this newsletter, our website at www.dgaplans.org and other special mailings.

How can I find out more information about this genetic test?

For more information on Medco's Personalized Medicine Program, contact a Medco customer service representative toll-free at (800) 987-7828. **PH**



COB Guidelines

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1. If the Health Plan is the primary plan, we determine and pay benefits in the regular manner, with no consideration of what the secondary plan may or may not pay.
2. If the Health Plan is the secondary plan, we begin by determining how much we would have paid had there been no other group coverage. Next we find out what the primary plan paid. Then we make a payment for the difference, if any, between the total allowable expense and the amount paid by the primary plan, but not to exceed the liability under our own coverage.



For example:

IF THE HEALTH PLAN IS PRIMARY		IF THE HEALTH PLAN IS SECONDARY	
\$500	Allowable Charges (PPO)	\$500	Allowable Charges
<u>x 90%</u>		<u>-400</u>	Primary Plan Pays 80%
\$450	The Health Plan Will Pay	\$100	The Health Plan Will Pay
\$50	You Pay	\$0	You Pay

*These examples assume that the annual deductible has been met.

The Dependent Premium and Coordination of Benefits

In a case where both a husband and wife each qualify for earned coverage from the Health Plan, the dependent premium must be paid by each participant in order to receive full coordination of benefits. If no dependent premium is paid, both husband and wife are covered as participants under their own coverage, but will not be covered as a dependent under their spouse's coverage and there will be no coordination of benefits. If both husband and wife pay the dependent premium, they will each be covered as a participant under their own coverage and as a dependent under their spouse's coverage and will receive full coordination of benefits. In addition, any dependent children will be covered under the health coverage of both parents and will receive full coordination of benefits. The coverage of the participant whose birthday falls earlier in the year will be considered primary. The coverage of the other participant will be considered secondary. If both participants have the same birthday, the coverage of the parent that has been covered for a longer period of time under the Health Plan will be considered primary.

If only one spouse pays the dependent premium, the spouse paying the premium will be covered only as a participant and the spouse not paying the premium will be covered as both a participant and a dependent. In addition, any dependent

children will be covered only under the health coverage of the spouse that paid the dependent premium and will receive no coordination of benefits.

Coordination of Benefits with Other Entertainment Industry Health Plans

If you or your dependent are eligible for earned active primary coverage with another entertainment industry health plan that requires a premium and you fail to pay or decline to pay the premium in that plan, the DGA Producer Health Plan will maintain its secondary position. This rule serves to maintain the correct primary/secondary positions of the Health Plan based on the longest continuous coverage. The other entertainment industry plans include AFTRA Health Plan, the Motion Picture Industry Health Plan, Screen Actors Guild – Producer Health Plan and the Writers Guild Industry Health Fund. For hospital and major medical benefits the Plan will calculate the benefit at 20% of the allowable charge.

Questions

For more information please see Coordination of Benefits Q&A on page 7 & 11. If you have any additional questions regarding COB, please contact the Participant Services Department at (323) 866-2200, Extension 401 or toll-free outside the Los Angeles area at (877) 866-2200, Extension 401. **PH**

Health Care Reform

CONTINUED FROM PAGE 1

BlueCard's larger network means that more participants have convenient access to network doctors and hospitals.

These are just two examples among the many actions over the years that the Board has taken to ensure the strength and viability of the Health Plan going forward. You can be assured that, if something substantive comes out of Washington that will affect the Health Plan and its participants, the Board will continue with their efforts to ensure that Health Plan participants and their families receive the highest quality health benefits. **PH**

COB Q&A

CONTINUED FROM PAGE 7

enrollment period. You should fill out the form and submit it to the Health Plan with your claim. If you have already filled out the Coordination of Benefits form but the information on the form has changed, you need to re-submit this form to the Health Plan. This form is also available online at www.dgaplans.org or by calling the Health Plan office.

Q How is COB applied to my claim if I am covered by Medicare or another group insurance plan?

A If you are covered by Medicare or another group insurance plan and the other plan is your primary plan, you must file your claim with the other plan first. Once Medicare or the other plan processes your claim, you can send a copy of the itemized bill and the Explanation of Benefits to our office.

If you are covered by Medicare or another group insurance plan and the other plan is your secondary plan, you should file your claims with us first. The Health Plan will be primary to Medicare if you are on active earned coverage as a result of meeting the minimum earnings requirement based on recent DGA-covered services.

Q Are there any fees associated with COB?

A Other than paying your dependent premiums, deductibles, and co-payments, the Health Plan does not charge a fee to apply COB guidelines to your claims.

Q Do you have additional questions?

A If you have any additional questions regarding COB, please contact the Participant Services Department at (323) 866-2200, Extension 401 or toll-free outside the Los Angeles area at (877) 866-2200, Extension 401. **PH**

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Visit the DGA Plans website at www.dgaplans.org for recent news, to download documents and forms, find a network provider, pay your dependent premium, and more.