



spotlight on **benefits**

The Benefits Newsletter of the DGA-Producer Pension and Health Plans | Volume 18, Number 3 | Fall 2010

Pension and Health Update



State of the Pension Plans

The Board of Trustees has worked diligently to maintain the long-term financial stability of the Basic and Supplemental Pension Plans. Despite the recession that officially began in 2007 and volatile market conditions, the Plans are doing well. Not only have we adhered to a proven investing philosophy that helped us weather the financial turmoil of the last few years, we also regained a considerable amount of assets lost during that time. It's times like these when we know our Board of Trustees has built an industry-leading retirement plan that will continue to meet the needs of current and future retirees.

See [State of the Pension Plans](#) on page 6

Health Care Reform Update

Effective January 1, 2011, the Health Plan is required to make certain changes mandated by the Affordable Care Act. Specifically, the Plan will be required to:

- ▶ Provide dependent coverage for adult children up to age 26;
- ▶ Eliminate lifetime limits and annual limits on essential benefits; and
- ▶ Eliminate rescissions of coverage except in instances of fraud or intentional misrepresentation.

See [Health Care Reform Update](#) on page 7

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Health Plan Minimum Earnings Requirement Established for 2011


The minimum earnings thresholds to qualify for earned coverage for four-quarter earnings periods beginning January 1, 2011, are as follows:

- ▶ For the DGA Choice Plan, the minimum earnings requirement will remain at \$33,400; and
- ▶ For the DGA Premier Choice Plan, the new minimum earnings requirement will be \$103,900.

Since the Health Plan's minimum earnings thresholds apply to the earnings periods beginning on January 1, 2011, the first benefit period that will be affected is the April 1, 2012 to March 31, 2013 benefit period. See the chart on page 12 for a detailed illustration of how Health Plan earnings periods apply to their corresponding benefit periods.

Health Plan earnings periods begin on January 1, April 1, July 1 or October 1. Once you meet the minimum earnings threshold during your earnings period, there is a one-quarter waiting period before the start of your benefit period.

If you have any questions regarding the Health Plan's minimum earnings thresholds or eligibility rules, please contact the Participant Services Department at (323) 866-2200, Extension 401 or toll-free at (877) 866-2200, Extension 401. [PH](#)



See the Earning and Benefit Period Chart on page 12 for additional information.

Carry-Over Bank & Earnings Threshold Increases

The Health Plan's carry-over coverage allows participants to bank earnings that can be used to qualify for health coverage in a future earning period. The carry-over bank and earnings provisions can be found beginning on page 14 of the January 2010 Health Plan Booklet. The amount of banked earnings for one year of carry-over coverage has not increased since 2003.

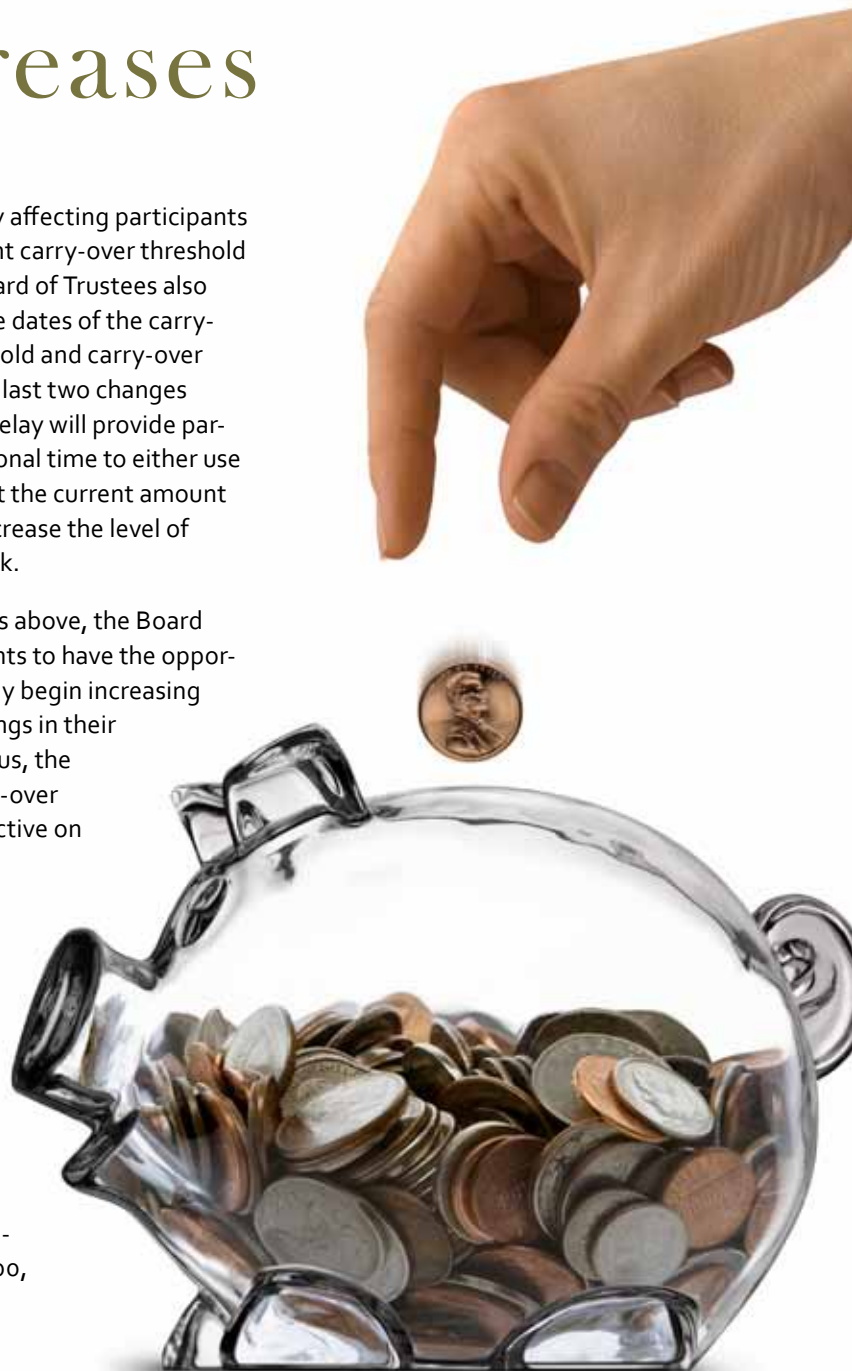
The Board of Trustees recently approved the following changes to the Health Plan's carry-over coverage rules:

- ▶ The carry-over bank maximum (the maximum balance permitted in an individual's carry-over account) was increased to \$450,000, effective retroactively to benefit periods beginning on or after July 1, 2010;
- ▶ The amount of banked earnings that are needed for one year of carry-over coverage will increase to \$130,000, effective with benefit periods beginning on or after July 1, 2011; and
- ▶ The carry-over threshold (the amount of earnings after which covered earnings will be credited to your carry-over account) will also increase to \$130,000, effective with benefit periods beginning on or after July 1, 2011.

To prevent adversely affecting participants who meet the current carry-over threshold of \$120,000, the Board of Trustees also delayed the effective dates of the carry-over earnings threshold and carry-over credit increases (the last two changes listed above). This delay will provide participants with additional time to either use a carry-over credit at the current amount of \$120,000 or to increase the level of earnings in their bank.

By the same token as above, the Board wanted all participants to have the opportunity to immediately begin increasing the amount of earnings in their carry-over bank. Thus, the increase to the carry-over bank was made effective on July 1, 2010.

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





Medco Prior Authorizations for Specialty Drugs

Beginning October 1, 2010, the DGA-Producer Health Plan began instituting new prior-authorization rules for specialty medication. This means that a small subset of certain highly specialized medications must be authorized by Medco, the Health Plan's pharmacy benefit manager, before they can be covered under Health Plan benefits. This helps to prevent off-label drug use, which is not covered by the Health Plan.

What is off-label drug use?

According to the January 1, 2010 Health Plan booklet, Off Label Drug Use is defined as:

...the use of a drug approved by the United States Food and Drug Administration (FDA) for other uses than those listed in the FDA-approved labeling or in treatment

regimens or patient populations that are not included in approved labeling.

Put simply, if a drug is used in a manner not specifically approved by the FDA, it is considered off-label drug use. Off-label drug use is not covered by the Health Plan. Therefore, if a Health Plan participant is prescribed a medication for a purpose other than its FDA-approved purpose, the

participant will be responsible for 100% of the cost of that medication.

What are specialty medications?

Specialty medications are prescription medications that require special administration, handling, and clinical support. They are typically injectable medications with complex dosing regimens, temperature sensitive delivery, and side effect management. These drugs are intended to treat complex, chronic and often costly conditions, including:

- ▶ Cancer
- ▶ Multiple Sclerosis
- ▶ Osteoporosis

[See Prior Authorizations on page 10](#)

TIHN Co-Payment Quick Reference Chart

The chart below details the co-payment for benefits received through The Industry Health Network (TIHN) facility and primary care physicians (PCP). This chart should have been included on page 53 of the January 2010 Health Plan Booklet.

TIHN is a wholly-owned subsidiary of the Motion Picture and Television Fund (MPTF). Southern California residents can reduce out-of-pocket expenses for covered services by utilizing MPTF Health Centers. When you use a TIHN facility and PCP, you have a fixed co-pay of \$10. In addition, when your physician refers you to a specialist, you also have to pay \$10 as a co-pay. For surgeries, there is a \$100 co-pay. For hospitalization you will pay the regular 10% co-insurance. As an added incentive, when you use a TIHN physician and referred specialist, your deductible is waived for those visits.

To find an MPTF Health Center near you, please contact the MPTF customer service department at (800) 876-8320 or visit their website www.mptvfund.org. **PH**



Benefits Through a TIHN Facility and PCP	Co-Payment
Primary Care Visits	\$10
Specialist Visits, referred by your PCP	\$10
Well Child Care	\$10
Pediatric Visits	\$10
Physical Therapy	\$10
Surgery, including Assistant Surgeon* (inpatient and hospital-based outpatient)	\$100

*Does not include hospitalization fees.

State of the Pension

Regaining Lost Ground

The Board of Trustees, led by the Finance Committee's guidance, oversees an investment portfolio featuring many different asset classes designed to adhere to the time-tested investing principles of diversification and balance. The Board consistently monitors our investment managers' near-term and long-term performance, investment strategy, and outlook.

For the period of January 1, 2010 through September 30, 2010, the Basic Plan enjoyed a positive return of 6.36%, which is above the policy benchmark of 4.26%. Similarly, the Supplemental Plan had a positive return of 6.53% during that same period, which is above its policy benchmark of 4.62%.

As you can see, the Plans' portfolios have done quite well thus far.

The Supplemental Plan

The Supplemental Plan has done particularly well year-to-date, due to investment in fixed-income securities, which have performed well this year. Since the Supplemental Plan is a defined contribution pension plan, the contributions made on your behalf are allocated to an Individual Account, which operates much like a savings account or Individual Retirement Account. In combination with the Basic Plan, these two plans continue to provide significant retirement benefits for our participants.

Measuring the Health of the Basic Plan

The Board of Trustees use different measures to gauge the health of the Basic Plan. At the heart of a healthy plan is the ability to adequately fund promised benefits based on anticipated contributions. On an annual basis, we test our Basic Plan's long-term stability using a snapshot of the Plan's demographics to determine liabilities and funding status.

The funding level of a plan is one important measure of health. By dividing the Plan's actuarial value of assets by the liability for benefits earned to date, we determine the Basic Plan's funded

percentage. The higher the percentage, the better funded the plan. As of December 31, 2009 the Plan's funded percentage was 97.2%, so we can say without a doubt that we have a well-funded plan. That's compared with 90.7% as of December 31, 2008.

This percentage is also one of the measures used to determine the Plan's status under the Pension Protection Act (PPA). The PPA requires that defined benefit plans, like the Basic Plan, analyze their obligations annually so plans that fall into the endangered or critical categories can take corrective action to address their deficiencies. As we recently reported, the Basic Plan comfortably maintained green zone status, which means by PPA standards our Plan is considered healthy.

Another important factor we look at when measuring the Basic Plan's health is the contribution margin. This is the difference between contributions received for the year and the expected annual plan cost. Our contribution margin is positive and is expected to remain positive for the foreseeable future, which means we have sufficient funds available to cover our promised pension benefits.

Looking Ahead

By taking our key funding measurements (contribution margin, PPA funded percentage, and PPA zone status), and evaluating them against reasonable assumptions, we can forecast how our Plan will fare in the years to come. Through projections, we can determine if we need to take action to keep the Plans on track.

Key assumptions for the projections are the expected investment return and projected contributions. The Plans use an estimate of 7.5% for future annual investment returns. For contribution projections, it is important to remember that approximately 70% of the Basic Plan's funding comes from residual contributions from the sale of Theatrical and Free TV projects to supplemental markets, such as the Pay TV and DVD markets. Accordingly, growth of these contributions, or lack thereof, can have a significant impact on the Plan's funding.

Plans

Even after factoring in the effects of the 2008 investment loss, which will not be fully recognized until January 2013, we have an optimistic outlook of the future of our Pension Plan. Recent projections prepared by the Plan's actuary indicate the following:

Contribution Margin. This margin is expected to remain positive, even with a 0% growth scenario in residual contributions.

PPA Funded Percentage. The funded percentage is expected to grow steadily, potentially reaching 100% in 2021, even with a 0% growth scenario in residual contributions.

PPA Zone Status. The Basic Plan is expected to remain in the green zone through at least 2024, so long as future contributions and investment returns meet current expectations.

Funding Relief

As part of the government's pension relief effort, Congress passed the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 on June 25, 2010. This new law helps the Plans maintain its overall health by allowing us to:

- ▶ Amortize and spread the recognition of 2008 investment losses over a longer period;
- ▶ Maintain our positive funding status; and
- ▶ Return our focus to the key funding policy of maintaining a positive contribution margin.

Questions

If you have any questions regarding the Pension Plans, please contact the Pension Department at (323) 866-2200, Extension 404 or toll-free at (877) 866-2200, Extension 404.

Continued from Cover

When will the Affordable Care Act take effect?

There has been some misinformation as to the effective date of the changes listed on the cover. Specifically, some outlets have reported that these changes are to be effective on September 23, 2010. However, the Affordable Care Act requires health plans to make these changes effective **for Plan or Policy Years beginning on or after September 23, 2010**. Our Health Plan's next Plan Year (which is described on page 125 of the Health Plan booklet) begins on January 1, 2011. That is our Health Plan's mandated effective date for these changes.

As the Board of Trustees is currently working on the amendments necessary to bring our Health Plan in compliance with the Affordable Care Act, no changes have yet been made to the Health Plan. Once the Plan is officially amended by the Board of Trustees, we will communicate with all Health Plan participants via www.dgaplans.org, the Plan's *Spotlight on Benefits* newsletter and other special mailings. In those communications, we will detail the process for enrolling adult dependent children under your health coverage.

If you have any questions, you can contact the Health Plan at (323) 866-2200 or toll-free at (877) 866-2200. **PH**



Medco Health Store

Order Nonprescription Items 24/7 at Medco's New Online Drugstore

As first reported online at www.dgaplans.org, Medco, the Health Plan's pharmacy benefit provider, recently introduced the Medco Health Store - an online drugstore offering the convenience of 24/7 access to an array of nonprescription health, wellness and personal care products. Now, Health Plan participants who order over-the-counter medication from the Medco Health Store can have their purchases automatically checked against their other Medco prescriptions for potential negative drug interactions.

Logging into the Medco Health Store

If you are a registered user at medco.com, you can log into that site and access the Medco Health Store simply by clicking on the “Medco Health Store” tab at the top of the page. Alternatively, you can go directly to medcohealthstore.com and click on the “Login” link at the top of the page. You will then be prompted to enter your medco.com login credentials.

Drug Interaction Checker

Once you are logged in, when you purchase over-the-counter (OTC) products

from the Medco Health Store, you will be asked if you would like Medco to review your prescription drug record to search for drug interactions. If you approve this search, the Medco Drug Interaction Checker will run the OTC medications in your shopping bag against your Medco prescription records and inform you of potential interactions prior to completing your purchase.

This service will help ensure that OTC purchases in your shopping bag will not have adverse effects when used with any of your prescription medications.

The Drug Interaction Checker only runs

against the prescription records of the customer currently logged into medco.com. It cannot simultaneously check other members of your household.

Questions

If you have any questions regarding the Medco Health Store or the Drug Interaction Checker, please contact Medco at (866) 375-4780. **PH**

Medicaid/CHIP Special Enrollment Right Insert

This issue of Spotlight on Benefits contains an insert. Here’s a brief explanation of what it is.

Many states have premium assistance programs that can help participants pay for coverage from the Health Plan. The Health Plan is legally required to notify participants of these programs via the enclosed insert.

If you or your dependents are already enrolled in Medicaid or the Children’s Health Insurance Program (CHIP) or would like to find out if you’re eligible, you can contact your state Medicaid or CHIP office. If you and your dependents are eligible but not enrolled in the Health Plan, you may qualify for special enrollment.

Please see the insert for additional information, and a list of participating states.

If you have any questions or would like to request special enrollment, please contact the Health Plan’s Participant Services Department at (323) 866-2200, Extension 401 or toll-free at (877) 866-2200, Extension 401. **PH**

The Children’s Health Insurance Program (CHIP) is a state and federal partnership that provides low-cost health insurance coverage for children in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage. Within federal guidelines, each state determines the design of its individual CHIP program, including eligibility parameters, benefit packages, payment levels for coverage, and administrative procedures.

Medicaid is the United States health program for eligible individuals and families with low incomes and resources. It is a state administered program and each state sets its own guidelines regarding eligibility and services.

Medco Prior Authorizations

- ▶ Plaque Psoriasis
- ▶ Rheumatoid Arthritis

If you have an active prescription for a specialty medication, you should have received a letter in August from Medco detailing the Health Plan's new prior-authorization process.

What is prior-authorization?

Prior-authorization is the process by which a participant obtains approval before receiving certain medications.

This process is not intended to limit access to medications, but to help ensure that high-cost medication therapies are safe, effective and appropriate for treating a particular condition, and prescribed for their intended, FDA-approved use. This program will also prevent participants from unknowingly receiving a costly drug that is not covered by the Health Plan.

How does it work?

The process works as follows:

- ▶ Medco receives a prescription for a specialty medication.
- ▶ Medco contacts the prescribing physician for evaluation.
- ▶ The prescription is then:
 - approved and dispensed as written;
 - approved and dispensed with a modified allowed quantity; or
 - denied.

How long will it take?

The specialty drug approval process typically takes one to three days, depending on the prescribing physician's response time. However, 50% are completed within 24 hours of the original request and 80% are completed within 48 hours.

Questions

If you have any questions regarding specialty medication prior-authorization rules, please contact the Participant Services Department at (323) 866-2200, Extension 401 or toll-free at (877) 866-2200, Extension 401. **PH**





Member Vision Card

Have you ever wanted the convenience of a personalized vision insurance card in your wallet? VSP, the Health Plan's vision benefits provider, recently introduced the Member Vision Card. Participants with vision care coverage, who want a vision insurance card, can print one from VSP's website at www.vsp.com.

The Member Vision Card provides easy access to a summary of your benefits including member name, coverage type (i.e., member only, family, etc), client ID number, doctor network name, co-pays for exam and materials, and space to record your eyecare provider's name and phone number.

To print your card, simply log into your account at www.vsp.com, and click the Member Vision Card link.

If you do not have an online account, go to the Members site at www.vsp.com, click the Register Now link, and follow the steps to create an account. You will need the primary member's Member ID or last four digits of their social security number to create an account. Registering online gives you access to your personal benefit information such as reviewing your coverage, locating a doctor, seeing past visits and more.

Printing this card is optional and not required for service or to receive benefits. In addition, protected health information (PHI), such as social security number or date of birth, is not included on the card.

If you have any questions about your VSP coverage, please contact VSP at (800) 877-7195 or visit their website at www.vsp.com. **PH**

Spotlight on Benefits

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Spotlight on Benefits is published up to four times a year for the benefit of Health Plan and/or Pension Plans participants.

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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.

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*See corrected Earnings and Benefit Periods Chart on Page 13.

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Earning and Benefit Periods Chart

A new Health Plan minimum earnings threshold has been established for 2011. Please [see the article on page 2](#) for additional information. This chart illustrates the four earnings periods and their corresponding benefit periods. A participant that meets the minimum earnings threshold during one of the four earnings periods will qualify for one year of health coverage following the three-month waiting period.

October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	July 2012	August 2012	September 2012	October 2012	November 2012	December 2012	January 2013	February 2013	March 2013	April 2013	May 2013	June 2013	July 2013	August 2013	September 2013
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*Corrected Earnings and Benefit Periods Chart:

The chart on the previous page (which appeared in the published version of the Fall 2010 issue of Spotlight on Benefits) incorrectly states that the minimum earnings threshold for DGA Premier Choice Plan coverage during the October 2010 - September 2011 earnings period is \$98,000. The correct threshold is \$101,000. A corrected chart appears below.

Earning and Benefit Periods Chart

A new Health Plan minimum earnings threshold has been established for 2011. Please [see the article on page 2](#) for additional information. This chart illustrates the four earnings periods and their corresponding benefit periods. A participant that meets the minimum earnings threshold during one of the four earnings periods will qualify for one year of health coverage following the three-month waiting period.

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New Medicaid/Children's Health Insurance Program (CHIP) Special Enrollment Right

If you are eligible for health coverage from the Health Plan, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you and your dependents are eligible, but not already enrolled in the Health Plan, you may enroll in the Health Plan, if either of two events occur:

- You or your eligible dependent's Medicaid or CHIP coverage is terminated because you or your dependent are no longer eligible; or
- Your eligible dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of the triggering event** set forth above.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 22, 2010. You should contact your State for further information on eligibility.

ALABAMA – Medicaid

Website: <http://www.medicaid.alabama.gov>
Phone: 1-800-362-1504

ALASKA – Medicaid

Website: <http://health.hss.state.ak.us/dpa/programs/medicaid/>
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP

Website: <http://www.azahcccs.gov/applicants/default.aspx>
Phone: 602-417-5422

ARKANSAS – CHIP

Website: <http://www.arkidsfirst.com/>
Phone: 1-888-474-8275

CALIFORNIA – Medicaid

Website: <http://www.dhcs.ca.gov/services/Pages/>
Phone: 1-866-298-8443

COLORADO – Medicaid and CHIP

Medicaid Website: <http://www.colorado.gov/>
Medicaid Phone: 1-800-866-3513
CHIP Website: <http://www.CHPplus.org>
CHIP Phone: 303-866-3243

FLORIDA – Medicaid

Website: <http://www.fdhc.state.fl.us/Medicaid/index.shtml>

Phone: 1-866-762-2237

GEORGIA – Medicaid

Website: <http://dch.georgia.gov/>

Click on Programs, then Medicaid

Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP

Medicaid Website: www.accesstohealthinsurance.idaho.gov

Medicaid Phone: 208-334-5747

CHIP Website: www.medicaid.idaho.gov

CHIP Phone: 1-800-926-2588

INDIANA – Medicaid

Website: <http://www.in.gov/fssa/2408.htm>

Phone: 1-877-438-4479

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/

Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.khpa.ks.gov>

Phone: 800-766-9012

KENTUCKY – Medicaid

Website: <http://chfs.ky.gov/dms/default.htm>

Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: www.dhh.louisiana.gov/offices/?ID=92

Phone: 1-888-342-6207

MAINE – Medicaid

Website: <http://www.maine.gov/dhhs/oms/>

Phone: 1-800-321-5557

MASSACHUSETTS – Medicaid and CHIP

Medicaid & CHIP Website: <http://www.mass.gov/MassHealth>

Medicaid & CHIP Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: <http://www.dhs.state.mn.us/>

Click on Health Care, then Medical Assistance

Phone: 800-657-3739

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/index.htm>

Phone: 573-751-6944

MONTANA – Medicaid

Website: <http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml>

Telephone: 1-800-694-3084

NEBRASKA – Medicaid

Website: <http://www.dhhs.ne.gov/med/medindex.htm>

Phone: 1-877-255-3092

NEVADA – Medicaid and CHIP

Medicaid Website: <http://dwss.nv.gov/>

Medicaid Phone: 1-800-992-0900

CHIP Website: <http://www.nevadacheckup.nv.org/>

CHIP Phone: 1-877-543-7669

NEW HAMPSHIRE – Medicaid

Website: <http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm>

Phone: 1-800-852-3345 x 5254

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Medicaid Phone: 1-800-356-1561

CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710

NEW MEXICO – Medicaid and CHIP

Medicaid Website: <http://www.hsd.state.nm.us/mad/index.html>

Medicaid Phone: 1-888-997-2583

CHIP Website: <http://www.hsd.state.nm.us/mad/index.html>

Click on Insure New Mexico

CHIP Phone: 1-888-997-2583

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <http://www.nc.gov>

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>

Phone: 1-800-755-2604

OKLAHOMA – Medicaid

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Medicaid Website: <http://www.oregon.gov/DHS/healthplan/index.shtml>

Medicaid Phone: 1-800-359-9517

CHIP Website: http://www.oregon.gov/DHS/healthplan/app_benefits/ohp4u.shtml

CHIP Phone: 1-800-359-9517

PENNSYLVANIA – Medicaid

Website: <http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm>

Phone: 1-800-644-7730

RHODE ISLAND – Medicaid

Website: www.dhs.ri.gov

Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: <http://www.scdhhs.gov>
Phone: 1-888-549-0820

TEXAS – Medicaid

Website: <https://www.gethipptexas.com/>
Phone: 1-800-440-0493

UTAH – Medicaid

Website: <http://health.utah.gov/medicaid/>
Phone: 1-866-435-7414

VERMONT– Medicaid

Website: <http://ovha.vermont.gov/>
Telephone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: <http://www.dmas.virginia.gov/rcp-HIPP.htm>
Medicaid Phone: 1-800-432-5924
CHIP Website: <http://www.famis.org/>
CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid

Website: <http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm>
Phone: 1-877-543-7669

WEST VIRGINIA – Medicaid

Website: <http://www.wvrecovery.com/hipp.htm>
Phone: 304-342-1604

WISCONSIN – Medicaid

Website: <http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <http://www.health.wyo.gov/healthcarefin/index.html>
Telephone: 307-777-7531

To see if any more States have added a premium assistance program since January 22, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor U.S. Department of Health and Human Services
Employee Benefits Security Administration Centers for Medicare & Medicaid Services
www.dol.gov/ebsa www.cms.hhs.gov
1-866-444-EBSA (3272) 1-877-267-2323, Ext. 61565

To request special enrollment or obtain more information, please contact the Health Plan's Eligibility Department at the address below or by calling one of the phone numbers below.

DGA-Producer Health Plan
8436 West Third Street
Suite 900
Los Angeles, CA 90048
(323) 866-2200, Extension 402 or toll-free (877) 866-2200, Extension 402