

spotlight on **benefits**



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In Memoriam: Gil Cates

Legendary director, producer and DGA-Producer Pension and Health Plans Trustee, Gil Cates, passed away on October 31, 2011. Mr. Cates, who served on the Plans' Finance Committee, joined the DGA-PPHP's Board of Trustees in 1999.

In addition to his years of service to the DGA-PPHP, Mr. Cates was active in leadership at the Directors Guild of America, serving as DGA President from 1983-1987 and Secretary-Treasurer from 1997 to 2011.

Mr. Cates chaired the DGA's Negotiating Committee for contract negotiations in 2002, 2005, 2008 and, most recently, in 2011, when he led efforts to negotiate an increase in the Health Plan's contributions rate as well as several other changes that are helping to ensure the long-term stability of the retirement and health benefits available to DGA members.

"For 30 years, Gil's strong leadership, foresight, love for the Guild, the industry and sense of the future, set the path for hundreds of thousands of people. He was one of the most important figures in our industry. Gil was my close friend and my partner as we sat side by side in many negotiations. I will miss him immensely. My thoughts are with his wife Judy, his family and the many people who were so fortunate to have him in their lives, and I count myself among them," said Jay D. Roth, Chair of the DGA-PPHP's Board of Trustees.

In addition to his years of service to the Pension and Health Plans and the Directors Guild of America, Mr. Cates was the founder and producing director of the Geffen Playhouse in Westwood and the founding dean of the UCLA School of Theater, Film and Television.

Our Trustees and staff will truly miss the knowledge, guidance and dedication that Mr. Cates exemplified and imparted during his many years of dutiful service to the pension and health plans. We join all those who knew and respected this extraordinary man, in extending our deepest sympathies to Mr. Cates' family. **PH**



INSIDE SPOTLIGHT

2 Supplemental Pension Plan Improvements

Removal of the age restrictions on SupPlan partial distributions and rollovers, as well as a new option for participants required to take a required minimum distribution.

4 Health Plan Minimum Earnings Thresholds for 2012

Change to the Health Plan's minimum earnings requirements for earnings periods beginning in 2012.

5 Health Plan's Non-Network Out-of-Pocket Limit

Increase to the non-network out-of-pocket limits effective January 1, 2012.

6 Medco Mail Order Facts

An overview of Medco's mail order service for long-term prescriptions.

6 Bronze Plan Changes

Some changes to the DGA Bronze Plan, the Health Plan's low cost self-pay option.

7 Therapy Benefit Change

Effective April 1, 2012, the maximum allowable charge for therapy visits will be reinstated and the visit limits will be eliminated.

Supplemental Pension Plan Rollover Age Limits, Add

SHORT TAKES

- » There will no longer be any age restrictions placed on SupPlan partial distributions and rollovers.
- » Participants required to take a minimum distribution will now have the option of taking partial withdrawals from their SupPlan account.

In 2012, the age limitations that currently apply to Supplemental Pension Plan (SupPlan) partial withdrawals and rollovers will be eliminated. In addition, if you are required to take a minimum distribution from the SupPlan, you will have more flexibility on how you receive your benefit.

SupPlan Partial Distributions

Effective January 1, 2012, any participant, surviving spouse, surviving same-sex spouse and surviving same-sex domestic partner eligible to retire from the SupPlan can take a partial withdrawal from their SupPlan account. Previously, system limitations required the Pension Plans to restrict partial withdrawals to retirees age 60-68.

Partial withdrawals give you the flexibility of accessing part of your SupPlan account balance, while maintaining the balance in the SupPlan's diverse investment portfolio. Participants have several partial

withdrawal payment options, including:

- ▶ Ad hoc payments of \$5,000 or more as often as once per quarter;
- ▶ Fixed monthly payments of \$2,000 or more;
- ▶ Fixed quarterly payments of \$5,000 or more; and
- ▶ Fixed semi-annual payments of \$5,000 or more.

If you are eligible to receive a SupPlan benefit, you can request a partial distribution by submitting the Partial Distribution form with your retirement application. The form is also available on the *Documents and Forms* section of dgaplans.org.

Rollovers into the SupPlan

Effective January 1, 2012, all participants will be eligible to roll qualified monies into their SupPlan account. Previously, rollovers were limited to participants under age 70½.

SupPlan rollovers give you the ability to transfer money from a retirement plan to your SupPlan account. You can roll money over from:

- ▶ **An outside retirement plan.** Qualified accounts include IRAs, 401(k) plans, 403(b) plans and 457 plans, among others;
- ▶ **A defined benefit pension plan, including the DGA-Producer Basic Pension Plan.** If you are eligible to receive a lump sum payment from a defined benefit pension plan, such as our Basic Pension Plan, you can

Plan Ends Partial Withdrawal and Adds New Minimum Distribution Option

transfer all or part of your lump sum into your SupPlan account. This option is especially attractive to those participants that wish to take a lump sum from the Basic Pension Plan, but would like to continue taking advantage of the Plans' diverse investment portfolio.

If you would like more information on some of the benefits of SupPlan rollovers, refer to the *SupPlan Rollovers Could Be the Right Choice for You* article in the Spring 2011 issue of *Spotlight on Benefits* (available on the *Documents and Forms* section of dgaplans.org) or contact the Pension Department at (323) 866-2200, ext. 404 or toll-free at (877) 866-2200, ext. 404.

The SupPlan rollover form is also available on the *Documents and Forms* section of dgaplans.org.

Required Minimum Distributions

When you reach age 70½, you are required to take a minimum distribution from your SupPlan account by April 1 of the following year. These minimum distributions are then required each subsequent year. Currently, you must choose between taking these distributions in the form of a lump sum or as an annuity purchased from an insurance company.

Effective January 1, 2012, you will have one additional option for receiving your required minimum distribution: SupPlan partial withdrawals. This will give you the flexibility to choose between:

- ▶ **A lump sum payment** where you



receive the entire balance of your SupPlan account.

- ▶ **An annuity** where you use the entire balance of your SupPlan account to purchase an annuity that pays you a monthly payment.
- ▶ **Partial withdrawals** where you only withdraw a portion of your SupPlan account. The balance remains in your SupPlan account and continues to take advantage of the SupPlan's investment portfolio. If your partial withdrawals in a calendar year total less than your required minimum distribution, the Pension Plans office will issue you a check in December to bring the total of your withdrawals up to your minimum distribution amount.

Participants, surviving spouses, surviving same-sex spouses or surviving same-sex domestic partners who have begun receiving their required minimum distributions from the SupPlan but have not yet retired from the Plan, can subsequently elect to retire and receive payment of their SupPlan benefits via any of the SupPlan distribution options.

If you have any questions regarding any of these changes, please contact the Pension Department at (323) 866-2200, ext. 404 or toll-free at (877) 866-2200, ext. 404. [PH](#)

All of the changes to the mandatory distribution rules pertain to participants, surviving spouses, surviving same-sex spouses and surviving same-sex domestic partners only. The requirements and rules for all other beneficiaries are not being changed.

Health Plan Minimum Earnings Thresholds Established for 2012

Following a two-year period where no changes were made to the DGA Choice Plan's minimum earnings threshold, and in light of continuing increases in Health Plan expenses, the Health Plan's Board of Trustees has decided to increase the Health Plan's minimum earnings thresholds for earnings periods that begin in 2012.

Accordingly:

- ▶ For the DGA Choice Plan, the minimum earnings threshold will be \$34,100; and
- ▶ For the DGA Premier Choice Plan, the minimum earnings threshold will be \$106,000.

As this change applies to earnings periods beginning on January 1, 2012, the first benefit period that will be affected is April 1, 2013 to March 31, 2014. See the chart below for a detailed illustration of Health Plan earnings periods and their corresponding benefit periods.

Health Plan earnings periods begin at the start of each calendar quarter (January 1, April 1, July 1, and October 1). Once

you meet the minimum earnings threshold during an earnings period, there is a one-quarter waiting period before the start of your benefit period.

Reasons for the Change

The minimum earnings threshold for the DGA Choice Plan has not been increased since January 1, 2010 (the Premier Choice Plan threshold was increased in 2011). Since then, the Health Plan has seen costs continue to rise, both as a reflection of the overall rising trend in healthcare costs and as a direct result of changes mandated by healthcare legislation. Through October, Health Plan claims costs have increased 8.8% over the same period in 2010. Therefore, the modest increases in the Health Plan's minimum earnings threshold represent prudent steps to ensure and sustain the continuity of benefits for Health Plan participants and their dependents.

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

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	October 2013	November 2013	December 2013	January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	July 2014	August 2014	September 2014	October 2014	November 2014	December 2014
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This chart illustrates the four 2011 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.



Health Plan Increases Out-of-Pocket Limit

In response to rising health claims costs, the Health Plan's Board of Trustees has decided to increase the non-network out-of-pocket limit for the first time in eight years. Accordingly, effective January 1, 2012:

- ▶ For the DGA Choice Plan, the non-network out-of-pocket limit will be increased from \$7,500 to \$8,900; and
- ▶ For the DGA Premier Choice Plan, the non-network out-of-pocket limit will be increased from \$3,000 to \$3,550.

The network out-of-pocket limit, \$1,000 for both the DGA Choice and DGA Premier Choice Plans, will not change.

The new out-of-pocket limits apply to all medical, mental health and chemical dependency claims.

Reasons for the Change

Given that the out-of-pocket limit has not changed since 2003, and in light of the continued rise in claims costs, the Health Plan's Board of Trustees determined that a modest increase in the non-network out-of-pocket limit would be prudent and in keeping with the Health Plan's mission of providing DGA members and their families with the best possible set of health benefits.

Out-of-Pocket Limit Explained

The Health Plan places a cap on the amount of covered expenses that you pay. This cap, called the out-of-pocket limit, is applied on a calendar-year basis. So, in a calendar year, after you meet your deductible and you reach the



out-of-pocket limit, the Health Plan pays 100% of your covered expenses (excluding co-payments).

Take, for example, a single participant who incurs \$15,000 in network claims during a calendar year. The first \$325 is paid by the participant. This is the participant's deductible. Then, the participant will pay \$1,000 of the next \$10,000 in claims (for network claims, the Health Plan pays 90% and the participant pays 10%). After that, the Health Plan will pay 100% of covered expenses for the rest of the year (in this example, \$4,675). So, of the \$15,000 in covered expenses, the participant pays \$1,325 (the \$325 deductible and 10% of the first \$10,000) and the Health Plan pays \$13,675 (90% of the first \$10,000 and 100% of the next \$4,675).

There are separate out-of-pocket limits for network and non-network expenses. Any network claims that are applied to the network out-of-pocket limit cannot be applied to the non-network out-of-pocket limit, and vice versa.

There are separate out-of-pocket limits for each person covered under a participant's Health Plan coverage.

The out-of-pocket limits only limit covered expenses. Non-covered expenses

are always the responsibility of the Health Plan participant. Non-covered expenses include:

- ▶ charges for services that are not covered by the Health Plan; and
- ▶ amounts charged by a non-network provider for covered services that are in excess of what is covered by the Health Plan, which is known as the reasonable and customary charge (R&C). The R&C is the average of what 80% of doctors in a specific area would charge for a specific service, and once that amount is calculated, any amount in excess of it becomes the participant's responsibility. A network provider will never charge you for a covered service an amount that is in excess of what is covered by the Health Plan. Remember, using a network provider will save you and the Health Plan money.

For more information about out-of-pocket limits, refer to page 55 of the January 2010 Health Plan Booklet and the Health Plan Booklet Updates available for download at www.dgaplans.org. If you have any questions, contact the Participant Services Department at (323) 866-2200, ext. 401 or toll-free at (877) 866-2200, ext. 401. **PH**

Get the Facts about Medco Mail Order

SHORT TAKES

- » If you're going out of town for more than three months, you can contact the Health Plan office to obtain a vacation override.
- » Medco's Worry-Free Fills program allows participants to set-up automatic refills of their long-term prescriptions.

The Health Plan's prescription drug program gives you a convenient and cost-effective way to fill your long-term maintenance medications: Medco Mail Order. The program is designed to save you money and ensure you get the medication you need, for as long as you need it.

Cost Savings

With Medco Mail Order, you receive a 90-day supply of your maintenance medications. Since you are purchasing your medication in bulk, you save money on the co-pay. For example, a 30-day supply of a brand name prescription from a retail pharmacy costs you \$24. From Medco Mail Order, you pay \$60 for a 90-day supply (a savings of \$12). Over the course

of one year you save \$48.

Long-Term Prescriptions Only

The mail order program is designed to fill your long-term prescriptions. If you fill your short-term (less than a 90-day) prescriptions through mail order, the long-term co-pay will still apply. In the example above, you would pay \$60 for a 30-day supply, rather than the \$24 you would have paid at the retail pharmacy. So it's best to fill short-term prescriptions through your local retail pharmacy.

When You Go Out of Town

If you are planning to be out of town or out of the country for more than 90 days, you can contact the Health Plan office to obtain a "vacation or location override" on your prescriptions. Since mail order prescriptions cannot be delivered outside of the U.S., a vacation or location override allows you to purchase enough medication to ensure that you will not run out of your prescription while away.

To receive a vacation or location override, contact the Participant Services Department at (323) 866-2200, ext. 401 or toll-free at (877) 866-2200, ext. 401.

Worry-Free Fills

Medco's Worry-Free Fills program allows you to set-up automatic refills of your long-term prescriptions. When you enroll

in Worry-Free Fills, Medco will automatically send your next refill using your existing address and payment information. So you don't need to remember to order your refills.

For safety and other concerns, certain medications are not eligible for the program, such as specialty medications and controlled substances. Further, when your prescription expires, you will need to get a new prescription and resubmit it to the program.

To enroll in the Worry-Free Fills program, visit medco.com or call Medco's Member Services at (800) 987-7828. **PH**

Bronze Plan Changes

Effective January 1, 2012, inpatient mental health benefits will be covered under the DGA Bronze Plan self-pay option. Previously, only outpatient mental health benefits were covered. The deductible will apply to inpatient mental health benefits, but not to outpatient mental health benefits. The \$50 emergency room co-pay and \$500 hospital admission co-pay are payable in addition to the deductible. Chemical dependency and prescription drug benefits will continue to be excluded. **PH**

Health Plan Changes Therapy Benefit Limits

In response to a steep rise in claims costs resulting from changes mandated by health care reform legislation, the limits applied to the Health Plan's therapy benefit are being changed effective April 1, 2012. This change only applies to physical therapy (and other related therapies) and does not affect mental health or chemical dependency benefits.

Effective April 1, 2012:

- ▶ The \$85 maximum allowable charge for therapy visits that existed prior to January 1, 2011 will be reinstated; and
- ▶ The annual 50-visit limit will be eliminated. However, the Health Plan will continue to monitor the medical necessity of these visits.

Services covered under the Health Plan's therapy benefit can include physical therapy, speech therapy, biofeedback, occupational therapy and vision therapy (see pages 72-73 of the January 1, 2010 Health Plan Booklet for a more detailed explanation of the Health Plan's therapy benefit).

How Will the Change Affect You

If you receive physical therapy (or other services covered under the therapy benefit), the Health Plan will not cover any amount charged by your provider over \$85 per visit. You will be responsible for any amounts over the \$85 limit. In addition, you will no longer be limited to 50 covered visits under the Health Plan's therapy benefit in a calendar year.

If you receive multiple treatments in one day by the same provider, those visits will be treated as one visit, and are subject to the \$85 limit.

Reasons for the Change

The Patient Protection and Affordable Care Act of 2010 (PPACA) required that the Health Plan implement certain changes effective January 1, 2011 (see the Winter 2010 issue of *Spotlight on Benefits* for a detailed discussion of the PPACA-required changes). To comply with PPACA's mandate, the Health Plan eliminated the maximum allowable charge in connection with the Health Plan's therapy benefit, but retained the annual visit limit. However, since the change was made, the Health Plan has seen a significant, unanticipated spike in costs related to this change. As a result, to help protect the Health Plan from further cost increases and remain in compliance with PPACA, the Board of Trustees has decided to reinstate the previous maximum allowable charge and remove the annual visit limit.

In order to provide participants who are currently using the Plan's therapy benefit with adequate time to prepare for this change, the Board decided to make the change effective on April 1, 2012.

If you have any questions about this change or the physical therapy coverage, please contact the Participant Services Department at (323) 866-2200, ext. 401 or toll-free at (877) 866-2200, ext. 401. **PH**

Spotlight on Benefits

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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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Important Notices for Health Plan Participants

HIPAA Notice

You can always obtain a copy of the Health Plan's Notice of Privacy Practices by going to the Documents and Forms section of www.dgaplans.org.

You can also request that we mail you a hard copy by calling (323) 866-2200, Ext. 401 or toll-free outside the Los Angeles area at (877) 866-2200, Ext. 401.

If you have any questions regarding the Notice of Privacy Practices, please contact Andrea Britton, the Plan's Privacy Officer at (323) 866-2200, Ext. 305 or toll-free outside the Los Angeles area at (877) 866-2200, Ext. 305.

The Health Plan provides important benefits to women with breast cancer

Women who have had a mastectomy or expect to have one may be entitled to special benefits under the Women's Health and Cancer Rights Act of 1998. The Health Plan provides several important benefits to help women fighting breast cancer.

The following notice is made on an annual basis:

The Health Plan provides medical and surgical benefits for certain types of reconstructive surgery in connection with a mastectomy. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

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